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Behavioral Health and Developmental Disabilities Administration

State Fiscal Year 2021 External Quality Review Technical Report *for* Prepaid Inpatient Health Plans

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

The Behavioral Health and Developmental Disabilities Administration (BHDDA)[1-1] within MDHHS administers and oversees the Michigan Behavioral Health Managed Care program, which contracts with 10 prepaid inpatient health plans (PIHPs) in Michigan to provide Medicaid waiver benefits for people with intellectual and developmental disabilities (IDD), serious mental illness (SMI), and serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs).[2-1] The PIHPs contracted with MDHHS during state fiscal year (SFY) 2021 are displayed in Table 1-1.

Table 1-1—PIHPs in Michigan

PIHP Name	PIHP Short Name
NorthCare Network	NorthCare
Northern Michigan Regional Entity	NMRE
Lakeshore Regional Entity	LRE
Southwest Michigan Behavioral Health	SWMBH
Mid-State Health Network	MSHN
Community Mental Health Partnership of Southeast Michigan	CMHPSM

[1-1] The Health and Aging Services Administration (HASA) was created under Executive Order 2021-14, combining the Aging and Adult Services Agency and the Medical Services Administration (MSA) under one umbrella within MDHHS effective December 14, 2021. The Executive Order can be accessed at: https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-573368--,00.html. MDHHS also announced that HASA will become the Behavioral and Physical Health and Aging Services Administration (BPHASA) effective March 21, 2022. BHDDA will become part of BPHASA to demonstrate equal prominence of behavioral and physical health.

[1-2] The PIHPs serve Medicaid members who require the Medicaid services included under the following: the 1115 Demonstration Waiver, 1915(i); those eligible for the 1115 Healthy Michigan Plan (HMP), the Flint 1115 Waiver, or Community Block Grant, who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW); those eligible for the 1915(c) Children Waivers (Serious Emotional Disturbance Waiver [SEDW] and Children's Waiver Program [CWP]), who are enrolled in program; or those whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHPs also serve individuals covered under the SUD Community Grant.

PIHP Name	PIHP Short Name
Detroit Wayne Integrated Health Network	DWIHN
Oakland Community Health Network	OCHN
Macomb County Community Mental Health	MCCMH
Region 10 PIHP	Region 10

Member populations receiving services through the PIHPs are commonly referenced throughout this report using the abbreviations displayed in Table 1-2.

Table 1-2—Member Populations

Member Population	Abbreviation
Children diagnosed with serious emotional disturbance	SED Children
Adults diagnosed with mental illness	MI Adults
Children with intellectual and developmental disability	I/DD Children
Adults with intellectual and developmental disability	I/DD Adults
Adults dually diagnosed with mental illness and intellectual and developmental disability	MI and I/DD Adults
Adults diagnosed with substance use disorder	Medicaid SUD

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate State efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2021 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each PIHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 13, 2021.

Table 1-3—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a PIHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures reported and/or calculated by a PIHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a PIHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations

Michigan Behavioral Health Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2021 activities to comprehensively assess the PIHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each PIHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the PIHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all PIHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Behavioral Health Managed Care program managed by BHDDA. Table 1-4 highlights substantive findings and actionable state-specific recommendations, when applicable, for MDHHS, and specifically BHDDA, to target specific goals and objectives in MDHHS' quality strategy to further promote improvement in the quality and timeliness of, and access to healthcare services furnished to its Medicaid managed care members. Refer to Section 6 for more details.

Table 1-4—Michigan Behavioral Health Managed Care Program Substantive Findings

Program Strengths
• **Quality** – Through the PIP activity, the Michigan Behavioral Health Managed Care Program is focusing its efforts on member engagement in appropriate care including medication management, screenings and testing, medication assistance for tobacco use cessation, and post-hospitalization care, which in turn should improve members' overall mental and physical health. – Through the Michigan Mission-Based Performance Indicator System (MMBPIS), MDHHS is focused on driving continuous quality improvement (QI) to increase timely access to services through established minimum performance standards that assist MDHHS in assessing PIHP compliance in

Program Strengths
several domains including access to care, adequacy and appropriateness of services provided, efficiency, and outcomes. As part of these continuous efforts, MDHHS and the Performance Indicator Workgroup determined the need for revisions to the MMBPIS measure indicators to identify program areas in need of improvement, including the need to remove exceptions, clearly document indicator specifications in order to remove variation in measurement across the PIHPs and Community Mental Health Services Programs (CMHSPs), establish minimum performance standards after two years of measurement, and conduct performance improvement initiatives to address performance related to the new indicator specifications. • **Timeliness** and **Access** – As demonstrated through performance indicator results in comparison to state-established minimum performance standards (MPSs), overall, the Michigan Behavioral Health Managed Care Program's PIHPs, CMHSPs, and contracted providers are conducting timely pre-admission screening for psychiatric inpatient care, seeing patients in a timely manner for follow-up care after psychiatric inpatient or substance abuse detox, and engaging with members to reduce inpatient psychiatric readmissions, suggesting members are able to access these providers in a timely manner for necessary follow-up care.
Program Weaknesses
• **Quality** – As indicated through the PIP activity, six of 10 PIHPs experienced a decline in the SFY 2021 performance rate over the SFY 2019 baseline rate for at least one study indicator, indicating that the implemented interventions were not effective in increasing or sustaining QI. – Although the MMBPIS was identified as a strength of the program, not all performance indicators included as part of the MMBPIS had established performance benchmarks. Although MDHHS is collecting and analyzing performance measurement data for the new indicators, MPSs have not yet been determined. The lower-scoring rates for the new indicators confirm members are not always receiving timely services, suggesting the PIHPs may be prioritizing their efforts only on those indicators with an established MPS. – Through the compliance review activity, five of 10 PIHPs received scores below 75 percent in the Coverage and Authorization of Services standard primarily due to incomplete adverse benefit determination (ABD) notices. Although MDHHS has standardized ABD notice template language, PIHPs and/or their contracted providers sent notices with insufficient and/or inaccurate information about the denied service(s). • **Timeliness** and **Access** – New PIHP members are not always able to receive a completed biopsychosocial assessment and access timely non-emergency services as indicated by Performance Indicator (Indicator) #2 and Indicator #2e rating below 75 percent for all individual populations, and Indicator #3 rating below 83 percent for all individual populations. – All 10 PIHPs scored between 0 percent and 50 percent in Standard IV—Assurances of Adequate Capacity and Services, and five of 10 PIHPs scored below 75 percent in Standard III—Availability of Services within the compliance review activity, indicating significant opportunities at the program level for MDHHS and the PIHPs to enhance processes for monitoring timeliness and access to services and reporting to MDHHS network adequacy compliance in accordance with state-established network adequacy standards.

Program Recommendations
Quality Strategy Goals/Objectives to Target for Improvement
• **Goal 1:** Ensure high-quality and high levels of access to care – **Objective 1.2**: Assess and reduce identified racial disparities – **Objective 1.3**: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services • **Goal 3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external) – **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems • **Goal 4:** Reduce racial and ethnic disparities in healthcare and health outcomes – **Objective 4.5**: Expand and share promising practices for reducing racial disparities
To enhance monitoring efforts and improve all members' access to timely care and services, HSAG recommends the following: • **SFY 2022 PIP—**For SFY 2022, the PIHPs will be implementing a new PIP. MDHHS has elected to focus the statewide PIP topic on reducing racial or ethnic disparities. As part of the PIP process, and specifically when PIHPs are in the process of developing PIP interventions, MDHHS should consider the following: – To ensure interventions are actionable and will support performance improvement, MDHHS should review the PIHPs' planned interventions prior to implementation and provide feedback and/or approval on any planned interventions. MDHHS could consult with HSAG through this process. – Once interventions have been developed and implemented, MDHHS could consider assessing the PIHPs' processes to continuously measure and analyze intervention effectiveness through required quarterly status updates. These updates could include a summary of the PIHPs' intervention effectiveness, including any noted barriers, steps to mitigate those barriers, and any revisions that have been made to the interventions to support improvement. This is especially important through the coronavirus disease 2019 (COVID-19) pandemic as the PIHPs have continued to report COVID-19 as a barrier to successfully improving performance. MDHHS could leverage the HSAG-developed Intervention Progress Form to obtain feedback; however, this recommendation is specifically for MDHHS as MDHHS could provide valuable feedback to the PIHPs through its knowledge of the environment in Michigan. – MDHHS could also consider having the PIHPs, through a dedicated workgroup session, share promising practices (e.g., effective interventions) for reducing racial disparities and improving performance specifically through the PIP activity. This session could also be used to discuss how COVID-19 was considered when developing interventions that could be successful even through a pandemic. • **MMBPIS New Indicators—**To enhance processes to monitor, track, and trend the quality, timeliness, and availability of care and services, MDHHS should consider establishing quality metrics (e.g., MPS) and performance improvement initiatives for the new performance indicators. To support this effort, MDHHS could consider the following: – Using the aggregated statewide SFY 2021 performance indicator rates, MDHHS could informally establish a benchmark for the PIHPs to work toward in SFY 2022 to ensure a prioritized focus on the

Program Recommendations

indicators that do not already have an established MPS. The performance data results should then be shared through public forums to promote accountability.

  - For SFY 2022, MDHHS should also require the PIHPs to develop and implement a performance improvement initiative that focuses on Indicator #2, Indicator #2e, and/or Indicator #3. This initiative must be included as part of the PIHP's QAPIP for SFY 2022.
    - The QAPIP should include, at a minimum, a description of the initiative, workplan goals and objectives, and data collection and analysis methods.
    - At least annually, or as determined by MDHHS, the PIHP's QAPIP evaluation should contain the outcomes of the initiative, including any barriers identified and modifications made to the initiative to support performance improvement in the associated rates. MDHHS should review this information through the next annual QAPIP submission.
  - For SFY 2023, MDHHS should then use the performance measure data collected in both SFY 2021 and SFY 2022 to establish a formal MPS to hold the PIHPs accountable to performance improvement.

- **MDHHS Codebook Revisions—**To ensure the PIHP rates accurately reflect the true member experience with accessing timely follow-up care after discharge from a substance abuse detox unit, MDHHS should modify the allowable exceptions for Indicator #4b within *Michigan's Mission-Based Performance Indicator System PIHP Reporting Codebook* (MDHHS Codebook), removing exceptions that artificially inflate PIHP rates. While it is reasonable to allow exceptions in some situations, the current exception methodology allows the PIHPs to document exceptions for a wide variety of cases. Limiting exceptions to only extraordinary cases will ensure the member experience is accurately portrayed in rates. If the MDHHS Codebook is updated to modify or remove exception criteria, HSAG further recommends that MDHHS revisit the MPS for Indicator #4b since the PIHPs achieved 95 percent using the exception methodology. The PIHPs are therefore unlikely to achieve a 95 percent or higher rate without using the current exception methodology.
- **Network Adequacy Monitoring—**To support ongoing PIHP monitoring of the MDHHS-established network adequacy standards identified through the MDHHS PIHP Network Adequacy Standard Procedural Document and to identify gaps in network adequacy that may impact members' timely access to care, MDHHS should consider the following:
  - MDHHS should identify specifications to uniformly calculate member/provider ratios and time/distance standards to ensure network adequacy standards are reported consistently across all PIHPs.
    - MDHHS should host a meeting with the PIHPs to discuss the network adequacy specifications to ensure consistent application of the network adequacy requirements.
  - MDHHS should establish a due date for the PIHPs to annually submit their assurances and supporting documentation to demonstrate their capacity in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document. MDHHS should update the SFY 2022 contract to include this date in the Schedule E Contractor Reporting Requirements and develop a standardized template for the annual submission.
  - MDHHS should use the PIHPs' network adequacy submissions to identify gaps in specific provider types and/or specific regions that may have a negative impact on member access to care. MDHHS could implement corrective actions or other interventions, as appropriate, to improve network capacity.
  - After the annual network adequacy submissions, MDHHS should host a meeting with the PIHPs to discuss the network adequacy results and any required next steps to improve network capacity.

Program Recommendations
Quality Strategy Goals/Objectives to Target for Improvement
• **Goal 5:** Improve quality outcomes and disparity reduction through value-based initiatives and payment reform – **Objective 5.2**: Align value-based goals and objectives across programs
To align value-based goals and objectives across programs, HSAG recommends the following: • **MDHHS Collaborative—**MDHHS is responsible for several separate Medicaid managed care programs. These programs are managed separately by multiple teams within MDHHS with minimal program alignment. To support the sharing of best practices and potentially reduce duplicative efforts, HSAG recommends the following: – MDHHS should establish a collaborative workgroup whose membership consists of representation from all Medicaid managed care programs. As part of this workgroup, MDHHS should implement a communication channel and protocol for ongoing collaboration between the managed care programs. Through the workgroup, MDHHS could: o Determine processes within the programs that could be streamlined to reduce efforts. o Team members from each program area could report regularly on program-level activities, including successes and challenges, and solicit feedback from other program team members, when necessary, to identify potential opportunities for improvement and program enhancements.

2. Overview of the Prepaid Inpatient Health Plans

Managed Care in Michigan

In Michigan, management of the Medicaid program prior to an October 2021 executive reorganization under Executive Order No. 2021-14[2-1] was spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services were managed by the Managed Care Plan Division in the Medical Services Administration (MSA). Three different MDHHS program areas implemented long-term services and supports (LTSS), including the Long-Term Care Services Division (MI Choice Program), the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly), and BHDDA. BHDDA also administers Medicaid waivers for people with IDD, SMI, and SED, and it administers prevention and treatment services for SUDs. Table 2-1 displays the Michigan managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program in SFY 2021.

Table 2-1—SFY 2021 Michigan Managed Care Programs

Medicaid Managed Care Program	MCEs	MDHHS Division
Comprehensive Health Care Program (CHCP), including: • Children's Health Insurance Program (CHIP)—MIChild • Children's Special Health Care Services Program • Healthy Michigan Plan (HMP) (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)	MSA
Managed LTSS, including: • MI Health Link Demonstration	Integrated Care Organizations (ICOs) PIHPs	MSA
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • HMP Dental	Prepaid Ambulatory Health Plans (PAHPs)	MSA
Behavioral Health Managed Care	PIHPs	BHDDA

[2-1] HASA was created under Executive Order 2021-14, combining the Aging and Adult Services Agency and MSA under one umbrella within MDHHS effective December 14, 2021. The Executive Order can be accessed at: https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-573368--,00.html. MDHHS also announced that HASA will become BPHASA effective March 21, 2022. BHDDA will become part of BPHASA to demonstrate equal prominence of behavioral and physical health.

Behavioral Health Managed Care

BHDDA within MDHHS administers and oversees the Behavioral Health Managed Care program, which operates under Section 1115 waivers. BHDDA services and supports in Michigan are delivered through county-based CMHSPs. Michigan uses a managed care delivery structure including 10 PIHPs who contract for service delivery with 46 CMHSPs and other not-for-profit providers to provide mental health, substance abuse prevention and treatment, and developmental disability services to eligible members. PIHPs are required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults, and family-driven and youth-guided services for children. Through a combination of different PIHP/CMHSP management and service delivery models, CMHSPs are normally contracted to directly provide or contract for the majority of direct services including evaluation, service plan development/authorization, and certain QI activities related to clinical service delivery.

Overview of Prepaid Inpatient Health Plans

MDHHS selected 10 PIHPs to manage the Behavioral Health Managed Care program. MDHHS defined regional boundaries for the PIHPs' service areas and selected one PIHP per region to manage the Medicaid specialty benefit for the entire region and to contract with CMHSPs and other providers within the region to deliver Medicaid-funded mental health, IDD, and SUD supports and services to members in their designated service areas. Each region may comprise a single county or multiple counties. Table 2-2 provides a profile for each PIHP.

Table 2-2—PIHP Profiles[2-2]

PIHP	Operating Region	Affiliated CMHSP(s)
NorthCare	Region 1	Pathways Community Mental Health [CMH], Copper Country CMH, Hiawatha CMH, Northpointe CMH, Gogebic CMH
NMRE	Region 2	AuSable CMH, Centra Wellness Network, North Country CMH, Northern Lakes CMH, Northeast CMH
LRE	Region 3	Allegan CMH, Muskegon CMH, Network 180, Ottawa CMH, West MI [Michigan] CMH
SWMBH	Region 4	Barry CMH, Berrien CMH, Kalamazoo CMH, Pines CMH, St. Joseph CMH, Summit Pointe CMH, Van Buren CMH, Woodlands CMH

[2-2] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration. *10 Region PIHP Directors & Affiliates.* Available at: https://www.michigan.gov/documents/PIHPDIRECTOR_97962_7.pdf. Accessed on: Oct 13, 2021.

PIHP	Operating Region	Affiliated CMHSP(s)
MSHN	Region 5	Bay-Arenac CMH, CMH for Central MI, CEI [Clinton-Eaton-Ingham] CMH, Gratiot CMH, Huron CMH, Ionia CMH, Lifeways CMH, Montcalm CMH, Newaygo CMH, Saginaw CMH, Shiawassee CMH, Tuscola CMH
CMHPSM	Region 6	Washtenaw CMH, Lenawee CMH, Livingston CMH, Monroe CMH
DWIHN	Region 7	Detroit-Wayne CMH
OCHN	Region 8	Oakland CMH
MCCMH	Region 9	Macomb CMH
Region 10	Region 10	Genesee CMH, Lapeer CMH, Sanilac CMH, St. Clair CMH

Quality Strategy

The 2020–2023 MDHHS Comprehensive Quality Strategy (CQS) provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, LTSS, dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. Michigan's CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Ojectives[2-3]

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes consumers' health and safety.
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1**: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.

[2-3] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Oct 13, 2021.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care	Drive value in Medicaid	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
MDHHS Pillar #4: Use data to drive outcomes	Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.2:** Align value-based goals and objectives across programs.

The CQS also includes a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule. The common domains include:

- Network Adequacy and Availability
- Access to Care
- Member Satisfaction
- Health Equity

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the CQS.

Quality Initiatives and Interventions

Through its CQS, MDHHS has also implemented many initiatives and interventions that focus on QI. Examples of these initiatives and interventions include:

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or the Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring MHPs and ICOs to coordinate behavioral health services and services for persons with disabilities with the CMHSPs/PIHPs. While contracted MHPs and ICOs

may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.

- **Value-based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology (IT)/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. Managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize QI and improved outcomes.
- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.
- **National Core Indicators (NCI)® Adult Consumer Survey**—Michigan participates in the NCI survey, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with IDD. Performance indicators within the survey assess individual outcomes, health, welfare, and rights (e.g., safety and personal security, health and wellness, and protection of and respect for individual rights); and system performance (e.g., service coordination, family and individual participation in provider-level decisions, the utilization of and outlays for various types of services and supports, cultural competency, and access to services).

3. Assessment of Prepaid Inpatient Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2021 review period to evaluate the performance of the PIHPs on providing quality, timely, and accessible healthcare services to Behavioral Health Managed Care program members. Quality, as it pertains to EQR, means the degree to which the PIHPs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS' network adequacy standards) and §438.206 (adherence to MDHHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the PIHPs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality and timeliness of, and access to care furnished by each PIHP.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each PIHP to identify strengths and weaknesses that pertain to the domains of quality, timeliness, and access to services furnished by the PIHP for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about overall quality and timeliness of, and access to care and services furnished by the PIHP.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weakness in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the PIHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2021 PIP validation, the PIHPs continued their MDHHS-mandated PIP topics, reporting Remeasurement 2 data and outcomes for each study indicator. HSAG conducted validation on the PIP study Design, Implementation, and Outcomes stages of the selected PIP topic for each PIHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS Protocol 1).

Table 3-1 outlines the selected PIP topics and study indicator(s) for all PIHPs.

Table 3-1—PIP Topic and Study Indicators(s)

PIHP	PIP Topic	Study Indicator(s)
NorthCare	*Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*	1. The percentage of discharged members ages 6 to 20 years, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge. 2. The percentage of discharged members ages 21 and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge.
NMRE	*Follow-Up Care for Children Prescribed Attention-Deficit /Hyperactivity Disorder (ADHD) Medication*	1. The percentage of members 6 to 12 years of age as of the IPSD [Index Prescription Start Date] with an ambulatory prescription dispensed for ADHD [Attention-Deficit/Hyperactivity Disorder] medication, who had a follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. The percentage of members 6 to 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.
LRE	*Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*	The percentage of members with schizophrenia and diabetes who had an HbA1c [Hemoglobin A1c] and LDL-C [low-density lipoprotein cholesterol test] test during the measurement period.
SWMBH	*Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*	The percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period.
MSHN	*Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.
CMHPSM	*Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*	The percentage of members ages 18 to 64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year.

PIHP	PIP Topic	Study Indicator(s)
DWIHN	*Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.
OCHN	*Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.
MCCMH	*Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness (SMI)*	30-day Hospital Readmission
Region 10	*Medical Assistance for Tobacco Use Cessation*	The proportion of adult Medicaid members with SMI identified by the PIHP as tobacco users who have at least one medical assistance service event pertaining to tobacco use cessation during the measurement year.

Performance Measure Validation

For the SFY 2021 PMV, HSAG validated the PIHPs' data collection and reporting processes used to calculate rates for a set of performance indicators identified through the MDHHS Codebook that were developed and selected by MDHHS for validation. The data collection and reporting processes evaluated included the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), Behavioral Health Treatment Episode Data Set (BH-TEDS) data production, and the PIHP's oversight of affiliated CMHSPs. The PMV was conducted in accordance with CMS' EQR protocol for the validation of performance measures (CMS Protocol 2) and included a PIHP information systems capabilities assessment (ISCA) and a review of data reported for the first quarter of SFY 2021.

Based on all validation methods used to collect information during the Michigan SFY 2021 PMV, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. The performance indicators developed and selected by MDHHS for the PMV are identified in Table 3-2.

Table 3-2—Performance Indicators

Indicator Number and Description	
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.

Indicator Number and Description	
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.
#5	The percent of Medicaid recipients having received PIHP managed services.
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.
#8	The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.
#9	The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

Compliance Review

SFY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the MDHHS-contracted PIHPs comprise 13 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable state-specific contract requirements and areas of focus identified by MDHHS. For SFY 2021, HSAG conducted a review of six standards as identified in Table 3-3 under Year One. Table 3-3 also delineates the compliance review activities, and standards with their associated federal citations, that will be reviewed in Year Two and Year Three of the three-year cycle. The compliance review activity was conducted in accordance with CMS' EQR protocol for the review of compliance with Medicaid and CHIP managed care regulations (CMS Protocol 3).

Table 3-3—Compliance Review Standards

Compliance Review Standards	Federal Standards and Associated Citations[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Mandatory Standards				
Standard I—Member Rights and Member Information	§438.100	✓		Review of PIHP implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan Medicaid health plans. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[2]The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3]The Health Information Systems standard includes an assessment of each PIHP's information system.

External Quality Review Activity Results

Region 1—NorthCare Network

Validation of Performance Improvement Projects

Performance Results

Table 3-4 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-4—Overall Validation Rating for NorthCare

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older	*Not Met*	1. The percentage of discharged members ages 6 to 20 years, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge.	65.5%	61.5% ⇔	63.8% ⇔	77.9%
		2. The percentage of discharged members ages 21 and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge.	60.3%	62.0% ⇔	61.1% ⇔	66.4%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-5 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-5—Remeasurement 2 Interventions for NorthCare

Intervention Descriptions	
Developed electronic resources for clinicians to access when providing emergency services and discharge planning.	Addressed training needs through various committees and developed strategies to enhance providers' capabilities for co-occurring SUDs.

Intervention Descriptions	
Sent discharge notifications for shared members to Upper Peninsula Health Plan upon discharge for follow-up appointments scheduled post-discharge.	Provided members with discharge planning that included housing information, transportation assistance resources, and alternative means of follow-up.
Required the use of evidenced-based standards for determining levels of care relating to authorization for inpatient admissions.	Provided training on transition from inpatient psychiatric services policy requirements to the committees.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NorthCare Network designed a methodologically sound PIP. [**Quality**]

Strength #2: NorthCare Network used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers to improve member outcomes. [**Quality**, **Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: NorthCare Network demonstrated a decrease in the percentage of members ages 6 to 20 years receiving a follow-up visit with a mental health practitioner within seven days of a hospital discharge for mental illness during the second remeasurement period as compared to the baseline measurement period. [**Timeliness** and **Access**]

Why the weakness exists: While it is unclear what led to the decrease in performance, **NorthCare Network** noted that several implemented interventions had an indirect impact on the study indicators and were difficult to evaluate for effectiveness.

Recommendation: HSAG recommends that **NorthCare Network** reassess barriers linked to members 6 to 20 years of age and develop active targeted interventions that can be tracked and trended to determine the impact on the study indicator outcomes. The results should be used to guide decisions for QI efforts.

Performance Measure Validation

HSAG evaluated **NorthCare Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system, BH-TEDS data production, or oversight of affiliated CMHSPs.

NorthCare Network received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **NorthCare Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-6 presents **NorthCare Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-6—Performance Measure Results for NorthCare

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	100.00%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	70.00%	NA
MI–Adults—Indicator #2b	65.57%	NA
I/DD–Children—Indicator #2c	75.00%	NA
I/DD–Adults—Indicator #2d	66.67%	NA
Total—Indicator #2	67.39%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	62.34%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	76.87%	NA
MI–Adults—Indicator #3b	76.44%	NA
I/DD–Children—Indicator #3c	69.23%	NA
I/DD–Adults—Indicator #3d	86.36%	NA
Total—Indicator #3	76.92%	NA

Performance Indicator	Rate	Minimum Performance Standard
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	94.87%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	66.67%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.73%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.47%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	16.51%	—
I/DD–Adults—Indicator #8b	8.93%	—
MI and I/DD–Adults—Indicator #8c	9.63%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	96.60%	—
I/DD–Adults—Indicator #9b	47.10%	—
MI and I/DD–Adults—Indicator #9c	58.62%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	10.53%	15.00%
MI and I/DD–Adults—Indicator #10b	12.05%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	15.66%	—
MI and I/DD–Adults	23.57%	—

Performance Indicator	Rate	Minimum Performance Standard
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	52.41%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: To continue its efforts for ensuring the quality of claims and encounter data and sufficient oversight of its subcontractors, during the first quarter of SFY 2019, **NorthCare Network** started conducting quarterly audits of randomly selected services, in addition to annual on-site desk audits that occurred in years prior, for each CMHSP and SUD provider. Sufficient oversight of subcontractors is essential for ensuring accurate data are used for calculating the individual performance measure rates for performance measure reporting. [**Quality**]

Strength #2: NorthCare Network continues to have sufficient oversight of its five subcontracted CMHSPs. All CMHSPs were required to follow the same operating procedures outlined by the PIHP. The PIHP and CMHSPs effectively participated in a collaborative effort on finding solutions, if an issue occurred, and worked together through process improvements and changes, when necessary. [**Quality**]

Weaknesses and Recommendations

Weakness #1: During the measurement period, **NorthCare Network** received paper claims from institutional providers for inpatient services. During the SFY 2020 audit, HSAG recommended that **NorthCare Network** work toward allowing inpatient services to be directly entered into ELMER, the PIHP's electronic health record (EHR) system, to increase the completeness and accuracy of data. [**Quality**]

Why the weakness exists: HSAG followed up with **NorthCare Network** based on the SFY 2020 HSAG audit recommendation to allow institutional providers to directly enter into ELMER. **NorthCare Network** had discussed potential updates with Peter Chang Enterprise, Inc. (PCE), the PIHP's EHR vendor, based on HSAG's recommendation, to allow inpatient services to be directly entered into ELMER; however, the updates had not yet occurred or been implemented.

Recommendation: HSAG recommends that **NorthCare Network** and PCE continue to work together on implementing the required updates to allow institutional providers to enter claims directly into ELMER to increase the quality and completeness of inpatient services claims data.

Weakness #2: One MI Health Link member was erroneously included in the PIHP's Indicator #3 member-level detail data provided for the PMV as the member did not meet the criteria to receive services through the PIHP (i.e., members with a mild-to-moderate level of care). [**Quality**]

Why the weakness exists: **NorthCare Network** indicated that, as of April 2021, PCE logic had been updated to exclude MI Health Link members with a mild-to-moderate level of care from future performance indicator reporting. However, the Indicator #3 data reported prior to April 2021 still included the mild-to-moderate members.

Recommendation: While **NorthCare Network** worked with PCE to update the logic to exclude mild-to-moderate MI Health Link members to mitigate future reporting issues, HSAG recommends that **NorthCare Network** carefully review all applicable performance indicator data each time logic is updated to assess the impact on previously reported data.

Weakness #3: HSAG identified a difference in data counts and rates between the member-level data provided to HSAG and the final reported rates to MDHHS. [**Quality**]

Why the weakness exists: **NorthCare Network** indicated that historically it used the CMHSP performance indicator (PI) event output sorted by Medicaid to aggregate and total all CMHSP data for reporting to MDHHS. However, to include Medicaid enrollment begin and end dates in the 2021 member-level detail file submission to HSAG, **NorthCare Network** requested that PCE add the enrollment data fields into the PIHP PI event report and re-run the PIHP PI event output. HSAG requested to review the CMHSP member-level data and final PI reports to see if the CMHSP-level data aligned closer with the reported rates to MDHHS. Upon reviewing the CMHSP member-level data and PI reports, HSAG noted that the data counts did align with the final reported rates to MDHHS.

Recommendation: Although **NorthCare Network** was able to later provide copies of the detailed data for the PIHP Medicaid members that aligned with the data reported to MDHHS, HSAG recommends that **NorthCare Network** implement an additional level of validation to ensure future member-level data provided to HSAG align with the final reported rates to MDHHS. Additionally, since **NorthCare**

Network uses the CMHSP PI event output sorted by PIHP only (Medicaid) to total all CMHSP data for reporting to MDHHS, for future reporting, HSAG recommends that **NorthCare Network** confirm its reporting logic is accurately capturing new members for indicators #2 (i.e., #2a through #2e) and #3, as defined in the MDHHS Codebook (i.e., never seen by the PIHP for mental health services or for services for I/DD, or it has been 90 days or more since the individual has received mental health or I/DD services from the PIHP). This is important since the individual CMHSP data may identify a member as new (because the member is new to the CMHSP), whereas the member may have previously received services from the PIHP through a different CMHSP, thereby the member would not truly be a new PIHP member.

Weakness #4: While **NorthCare Network** met the MPS for all but two indicators, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to members after discharge from a substance use detox unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for Indicator #4b fell below the MPS by over 28 percentage points, indicating that members discharged from a substance use detox unit were not always receiving timely follow-up care.

Recommendation: While **NorthCare Network** indicated that a contracted SUD provider had a CAP put in place to improve scheduling rates, demonstrating its efforts for improving the performance indicator, HSAG recommends that **NorthCare Network** evaluate its other contracted SUD providers as well and explore further options to increase timely access to follow-up care for members discharged from a substance use detox unit.

Compliance Review

Performance Results

Table 3-7 presents **NorthCare Network**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **NorthCare Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **NorthCare Network** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-7—Summary of Standard Compliance Review Scores for NorthCare

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	13	1	0	**93%**
VI	Coverage and Authorization of Services	11	11	9	2	0	**82%**
Total		**65**	**65**	**54**	**11**	**0**	**83%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NorthCare Network received a score of 93 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for care coordination of services, initial health screening, comprehensive assessments, person-centered service planning, integration of physical and mental healthcare, and primary care coordination. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: NorthCare Network received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: NorthCare Network received a *Not Met* score for three elements. Specifically:

- The PIHP had not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, while the PIHP's Demand Capacity Report included MDHHS' member/provider ratio standards, these standards have not been reviewed since 2019.
- The PIHP did not annually submit its assurances and supporting documentation to demonstrate that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards; member/provider ratio standards; timely appointment standards; or language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **NorthCare Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: NorthCare Network received a score of 71 percent in the Availability of Services program area. Adequate processes for providing covered services that are available and accessible to priority populations are necessary to ensure timely access to those services and to ensure members are not inappropriately billed for covered services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NorthCare Network received a *Not Met* score for two elements. Specifically:

- The PIHP's single case agreements did not include a prohibition on balance billing members for services rendered.
- The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards in accordance with MDHHS' Access Standards policy; for example, adherence to admission time frames for pregnant women receiving services for a SUD.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **NorthCare Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **NorthCare Network** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **NorthCare Network** across all EQR activities to identify common themes within **NorthCare Network** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings as demonstrated through the compliance review and PIP activities show that **NorthCare Network** generally had adequate processes to assess and coordinate care for its membership and had in place a methodologically sound PIP to support improvement in the prevalence of members accessing timely follow-up care after hospitalization for mental illness. However, even with these efforts in place, the PIP interventions implemented appear to have had minimal impact on the study indicators for the *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older* PIP; the two PIP study indicators did not demonstrate a statistically significant improvement from the baseline rate, and **NorthCare Network** did not meet its established goals [**Quality, Timeliness**, and **Access**].

Additionally, through the compliance review activity, gaps were identified in **NorthCare Network**'s processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards defined by MDHHS [**Access**]. **NorthCare Network** should further enhance its network adequacy and care coordination efforts to ensure members are able to access providers and receive timely follow-up care after hospitalization for mental illness [**Quality, Timeliness**, and **Access**]. Patients hospitalized for mental health issues are vulnerable after discharge, and follow-up care by trained mental health clinicians is critical for their health and well-being.

Further, **NorthCare Network** did not meet MDHHS' established MPS for *the percent of discharges from a psychiatric inpatient unit during the quarter who were seen for follow-up care within 7 days* for adult members, or *the percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* for members who met criteria under this indicator. These findings support the need for continued focus on these measures to increase the number of members who can access providers and receive a timely follow-up visit after discharge from an inpatient psychiatric unit or a substance abuse detoxification unit [**Quality**, **Timeliness**, and **Access**]. However, **NorthCare Network** demonstrated strengths within its program as it met or exceeded the MPS for Indicator #1 and Indicator #10.

NorthCare Network's members received timely pre-admission screenings for psychiatric inpatient care, and many members did not experience a readmission to an inpatient psychiatric unit within 30 days of discharge [**Timeliness** and **Access**]. **NorthCare Network** should analyze better performance demonstrated through improved measure rates to determine if initiatives were implemented that supported the improved outcomes and determine whether similar initiatives or interventions would be appropriate to support improvement in areas demonstrating worse performance.

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 2—Northern Michigan Regional Entity

Validation of Performance Improvement Projects

Performance Results

Table 3-8 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-8—Overall Validation Rating for NMRE

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	*Not Met*	1. The percentage of members 6 to 12 years of age as of the IPSD [Index Prescription Start Date] with an ambulatory prescription dispensed for ADHD medication who had a follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	65.2%	51.9% ↓	56% ↓	72.5%
		2. The percentage of members 6 to 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.	96.8%	93.6% ⇔	76.7% ↓	91.4%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Northern Michigan Regional Entity** revised the Remeasurement 1 data results from the data reported in the prior annual submission. The PIHP described that a substantial quantity of prescription data was missing for the remeasurement period, resulting in additional members meeting the exclusion.

Table 3-9 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-9—Remeasurement 2 Interventions for NMRE

Intervention Descriptions	
Implemented a process for psychiatric clerical staff to make routine reminder calls to members regarding scheduled appointments.	Coordinated care with the primary care physician (PCP) who originally prescribed the medications to obtain records as needed for tracking.
Provided education to school prevention workers and service staff on continued communication with the family regarding the importance of follow-up with PCPs.	Provided an informational packet to members regarding recommendations for follow-up care after being prescribed an ADHD medication.
Developed standard of care guidelines and implemented a procedure to meet the Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] measure.	Notified and educated psychiatrists to schedule the initial follow-up visit within 30 days.
Educated clinical supervisors who in turn educated their staff members.	Conducted chart reviews.
CMHSP hired a full-time child psychiatrist to address the limited number of staff members available to achieve the procedure of scheduling an appointment within the initial 30 days.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Northern Michigan Regional Entity designed a methodologically sound PIP. **[Quality]**

Strength #2: Northern Michigan Regional Entity used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers to improve member outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Michigan Regional Entity had inconsistencies with the revised Remeasurement 1 data reported. [**Quality**]

[3-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Why the weakness exists: While it is unclear what led to the discrepancies in the data reported, the rationale provided by **Northern Michigan Regional Entity** supporting the revised data did not support the increase in the eligible population size.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** ensure data are collected accurately and its interpretation of the results is described appropriately.

Weakness #2: Northern Michigan Regional Entity demonstrated significant decreases in the percentage of members ages 6 to 12 years who were compliant for both study indicators. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear what led to the decrease in performance, **Northern Michigan Regional Entity** had opportunities for improvement in the collection and reporting of evaluation results for each intervention.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** develop evaluation methods for each intervention to demonstrate its effectiveness on the study indicator outcomes and guide decisions for QI efforts. HSAG further recommends that **Northern Michigan Regional Entity** conduct a root cause analysis to identify the reasons for the decrease in performance rates.

Performance Measure Validation

HSAG evaluated **Northern Michigan Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, BH-TEDS data production, or oversight of affiliated CMHSPs.

Northern Michigan Regional Entity received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Northern Michigan Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-10 presents **Northern Michigan Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-10—Performance Measure Results for NMRE

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	99.30%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
Adults—Indicator #1b	99.23%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	69.72%	NA
MI–Adults—Indicator #2b	61.56%	NA
I/DD–Children—Indicator #2c	81.82%	NA
I/DD–Adults—Indicator #2d	80.77%	NA
Total—Indicator #2	65.52%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	75.81%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	71.81%	NA
MI–Adults—Indicator #3b	69.90%	NA
I/DD–Children—Indicator #3c	86.89%	NA
I/DD–Adults—Indicator #3d	86.96%	NA
Total—Indicator #3	72.17%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	97.73%	95.00%
Adults	99.27%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	95.56%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.73%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	94.95%	—

Performance Indicator	Rate	Minimum Performance Standard
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	19.27%	—
I/DD–Adults—Indicator #8b	11.52%	—
MI and I/DD–Adults—Indicator #8c	16.98%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	99.23%	—
I/DD–Adults—Indicator #9b	48.48%	—
MI and I/DD–Adults—Indicator #9c	75.00%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	9.62%	15.00%
MI and I/DD–Adults—Indicator #10b	11.27%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	21.89%	—
MI and I/DD–Adults	30.86%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	49.93%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility to care.

Strengths

Strength #1: Northern Michigan Regional Entity continued to have excellent processes in place regarding oversight of its affiliated CMHSPs. The PIHP continued to perform a full evaluation of each affiliated CMHSP. This process included virtual desk audits and medical record reviews for compliance with data capture and reporting requirements. The PIHP also performed an additional data quality check, wherein each file submitted by the CMHSPs was subjected to primary source verification (PSV) and information in the data file was reconciled with information housed in each individual CMHSP's transactional system. This was performed to further ensure that correct information was captured for performance indicator reporting and to ensure full evaluation of each affiliated CMHSP was in place. [**Quality**]

Strength #2: Although this system change did not occur during the reporting period, **Northern Michigan Regional Entity** implemented a new mechanism for the CMHSPs to submit their indicators. Since all five CMHSPs, as well as the PIHP, are on a PCE system, a new way for the CMHSPs to submit their data quarterly was created. Previously, all CMHSPs would submit data through a Microsoft (MS) Excel worksheet, which would require the PIHP to manually update some information. With the reporting all done within the PCE system, no manual changes need to be made, which can lead to errors. The new reporting mechanism allows for better data completeness and quality of data. [**Quality**]

Strength #3: Northern Michigan Regional Entity demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: During the PSV portion of the review for Indicator #4b, clear documentation of an exception within RECON, the PIHP's EHR system, was not available (i.e., member no-showed to appointment). Additional training and proper documentation for Indicator #4b was a recommendation from the SFY 2020 audit. [**Quality**]

Why the weakness exists: HSAG followed up with **Northern Michigan Regional Entity** based on the SFY 2020 audit recommendation to deliver additional training to SUD providers on proper documentation regarding Indicator #4b as it relates to exclusions. Although additional training did occur based on this recommendation, most of the information was still only being documented within the SUD providers' EHR systems. Additional documentation and proper notes were not always populated within RECON.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** continue to provide additional training to its SUD providers regarding proper documentation for exclusions for Indicator #4b. Since HSAG does not have access to the SUD providers' systems during the PSV, all notes and proper documentation need to be stored within RECON. This will further ensure data completeness and quality when reporting the indicator.

Weakness #2: During the PSV portion of the review, HSAG noted that the date of discharge on the member-level detail file did not match the date of discharge documented within one of the CMHSP's PCE system. [**Quality**]

Why the weakness exists: When receiving discharge summary information from a facility, the date of discharge was not always easily accessible or legible because of how it was inputted. Some were handwritten, and sometimes the location of the date of discharge was not readily available to review.

Recommendation: HSAG recommends that the CMHSPs do additional spot checks on indicators (i.e., indicators #4a, #4b, and #10) when discharge information is sent over from a facility to properly identify the correct date of discharge. Follow-up with the facility may be necessary if the date is not clear.

Compliance Review

Performance Results

Table 3-11 presents **Northern Michigan Regional Entity**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Northern Michigan Regional Entity**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Northern Michigan Regional Entity** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-11—Summary of Standard Compliance Review Scores for NMRE

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	7	0	0	**100%**
IV	Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
V	Coordination and Continuity of Care	14	14	14	0	0	**100%**
VI	Coverage and Authorization of Services	11	11	7	4	0	**64%**
Total		**65**	**65**	**56**	**9**	**0**	**86%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Northern Michigan Regional Entity received a score of 100 percent in the Availability of Services program area, demonstrating the PIHP has adequate processes and monitoring mechanisms to ensure all services covered under the State plan are available and accessible to members through the delivery network, timely access standards, access and cultural considerations, and accessibility considerations. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Northern Michigan Regional Entity received a score of 100 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for care coordination of services, initial health screenings, comprehensive assessments, person-centered service planning, integration of physical and mental healthcare, and primary care coordination. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Michigan Regional Entity received a score of 50 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Northern Michigan Regional Entity received a *Not Met* score for two elements. Specifically:

- Although the PIHP submitted a Network Adequacy and Provider Stability Plan, which included member-to-provider ratios, it did not include time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards or timely appointment standards. Additionally, while the PIHP's Network Adequacy and Provider Stability Plan included sections on language, cultural competency, and physical accessibility, the information was limited and did not consider how the PIHP's plan would evaluate its provider network's capabilities as they relate to language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Northern Michigan Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Northern Michigan Regional Entity received a score of 64 percent in the Coverage and Authorization of Services program area, demonstrating gaps in the PIHP's processes for processing service authorization requests and generating ABD notices. Adequate implementation of service authorization requirements is needed to ensure members receive timely and adequate notice of an ABD with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Northern Michigan Regional Entity received a *Not Met* score for four elements. Specifically:

- Although the PIHP is required to use MDHHS-mandated template language for its ABD notices, all but one case reviewed as part of the case file review demonstrated that there were significant issues with the ABD notices during the time period under review. Specifically, the ABD notices did not consistently include:
  - The appropriate action being taken.
  - The services that were requested and subsequently denied, reduced, suspended, or terminated.
  - A clear explanation for why the services were being denied, reduced, suspended, or terminated.
  - Sufficient legal basis/authority citations.
  - Accurate appeal rights and procedures.
  - A clear process for filing an expedited appeal.
  - Allowance for the member to request documents related to the ABD.
  - Correct continuation of benefits language.

  The ABD notices also did not comply with 42 CFR §438.10, as they did not include taglines in the prevalent non-English languages.
- The PIHP did not provide sufficient evidence of implementation to support understanding of when an ABD notice for a denial of payment should be sent to a member.
- The case file review confirmed that timely ABD notices were not consistently sent.
- The PIHP's policy did not include the oral and written notification procedures that must occur when a service authorization time frame extension is taken. PIHP staff members confirmed they are not currently exercising the option to extend authorization decision time frames and do not currently have the ability to track an authorization time frame extension except by reviewing the time frame.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Northern Michigan Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice requirements.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Northern Michigan Regional Entity** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Northern Michigan Regional Entity** across all EQR activities to identify common themes within **Northern Michigan Regional Entity** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings as demonstrated through the compliance review and PIP activities show that **Northern Michigan Regional Entity** had adequate processes to assess and coordinate care for its membership and had in place a methodologically sound PIP to support improvement in the appropriate management of children prescribed ADHD medications. However, **Northern Michigan Regional Entity** demonstrated statistically significant declines in performance for the *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* PIP study indicator rates, indicating children were not accessing timely follow-up care to ensure medications were being monitored appropriately [**Quality**, **Timeliness**, and **Access**]. **Northern Michigan Regional Entity** should enhance efforts to ensure medication is prescribed and monitored by an appropriate pediatric provider. When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration.

Through the PMV activity, **Northern Michigan Regional Entity** demonstrated effective processes were in place to appropriately manage the behavioral and SUD needs of its membership. Specifically, the PIHP ensured timely pre-admission screening for psychiatric inpatient care [**Timeliness** and **Access**], ensured timely follow-up care after discharge from a psychiatric inpatient unit or substance use detoxification unit [**Timeliness** and **Access**], and reduced readmissions after discharge from an inpatient psychiatric unit [**Quality**].

However, although compliance review results indicated **Northern Michigan Regional Entity** had adequate processes and monitoring mechanisms to ensure all services were available and accessible to members through the delivery network, performance indicator rates, as validated through the PMV activity, supported the need for **Northern Michigan Regional Entity** to focus efforts on performance indicators without an established MPS, including those indicators that measure access to timely care for nonemergent services. Lower performance indicator rates suggested there are opportunities to increase members' access to providers and timely services for ongoing and nonemergent services as determined through the rates for Indicator #2e: *The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD* and Indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* [**Quality**, **Timeliness**, and **Access**].

As revealed through compliance review findings for the Assurances of Adequate Capacity and Services standard, **Northern Michigan Regional Entity** should develop a robust plan to effectuate time/distance standards and timely appointment standards and use the results of its network adequacy analyses to

determine where it should prioritize efforts to increase provider network capacity to support improvement in members' timely access to nonemergent services.

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 3—Lakeshore Regional Entity

Validation of Performance Improvement Projects

Performance Results

Table 3-12 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-12—Overall Validation Rating for LRE

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	*Not Met*	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.	32.4%	37.9% ↑	36.7% ⇔	50.0%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-13 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-13—Remeasurement 2 Interventions for LRE

Intervention Descriptions	
Provided education to each of the CMHSP leadership, conducted staff meetings, convened the QI Regional Operations Advisory Team (ROAT), and conducted PIHP leadership and physicians' meetings on the purpose of and importance of the PIP.	Developed a new Integrated Care Data Platform (ICDP) report for each CMHSP that includes members with dual Medicare/Medicaid enrollment and from which CMHSP services are received. Four of the five CMHSPs and plan staff members have access to the system housing Medicare claims to review receipt of HbA1c and LDL-C testing.
Developed a reminder card/note to give to members at the time of services to inform them it is time for their annual HbA1c and LDL-C lab test. The reminder provides instructions for members to contact their PCP to schedule their lab test.	Generated a monthly report for each of the CMHSPs. The report included the names of members who have not had their HbA1c and LDL-C testing completed.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Lakeshore Regional Entity designed a methodologically sound PIP. **[Quality]**

Strength #2: Lakeshore Regional Entity met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Although improvement was demonstrated, **Lakeshore Regional Entity** did not achieve the goal of sustained improvement during the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Lakeshore Regional Entity noted that the COVID-19 pandemic impacted the study indicator as its members were unable or unwilling to leave their homes to seek care.

Recommendation: HSAG recommends that **Lakeshore Regional Entity** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Lakeshore Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

Lakeshore Regional Entity received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Lakeshore Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-14 presents **Lakeshore Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-14—Performance Measure Results for LRE

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	97.02%	95.00%
Adults—Indicator #1b	97.68%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	51.45%	NA
MI–Adults—Indicator #2b	82.11%	NA
I/DD–Children—Indicator #2c	60.19%	NA
I/DD–Adults—Indicator #2d	92.98%	NA
Total—Indicator #2	79.52%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	71.52%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	83.92%	NA
MI–Adults—Indicator #3b	78.71%	NA
I/DD–Children—Indicator #3c	66.37%	NA
I/DD–Adults—Indicator #3d	90.00%	NA
Total—Indicator #3	80.33%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.78%	95.00%
Adults	92.60%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	97.56%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	5.33%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	88.71%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	15.60%	—
I/DD–Adults—Indicator #8b	9.05%	—
MI and I/DD–Adults—Indicator #8c	8.70%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	98.43%	—
I/DD–Adults—Indicator #9b	69.68%	—
MI and I/DD–Adults—Indicator #9c	70.78%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	7.62%	15.00%
MI and I/DD–Adults—Indicator #10b	14.12%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	14.51%	—
MI and I/DD–Adults	22.00%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	45.55%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Lakeshore Regional Entity developed a thorough mechanism to oversee the CMHSP tracking of Indicator #2e, which included a detailed reconciliation process to validate the data against programmed rules in alignment with the MDHHS Codebook. Additional manual review was also performed to ensure accuracy of the tracking of expired requests. [**Quality**]

Strength #2: Lakeshore Regional Entity demonstrated appropriate oversight, implementation, and monitoring of CAPs that had been implemented with its CMHSPs throughout the measurement period. While HSAG identified errors during the PMV process, no errors were identified during the CY 2021 PMV for the CMHSP that were subject to a CAP from the CY 2020 PMV, as corrective action was appropriately implemented and monitored by the PIHP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted four **Lakeshore Regional Entity** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in four member records are not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Lakeshore Regional Entity** and the CMHSPs make additional enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in wage and income values.

Weakness #2: For Network180 CMHSP, three adult member cases and 12 child member cases were inaccurately reported as compliant in the PIHP's submission of Indicator #2a data to MDHHS. [**Quality**]

Why the weakness exists: Network180 CMHSP was confirmed to have an issue within its Indicator #2a reporting logic that resulted in reporting a default value of a request for service date equal to the assessment completion date when the request for service date was missing.

Recommendation: While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to mitigate future reporting issues, HSAG recommends that the PIHP deploy reporting logic that identifies all cases where the service request date is equal to the assessment completion date and require each CMHSP to manually review for accuracy. Additionally, **Lakeshore Regional Entity** should track each CMHSP's confirmation of this review as part of its routine CMHSP oversight.

Weakness #3: HealthWest CMHSP had significant encounter data completeness issues throughout the reporting period, resulting in a risk to MDHHS calculating accurate **Lakeshore Regional Entity** rates for indicators #5 and #6, which are encounter data dependent. [**Quality**]

Why the weakness exists: HealthWest CMHSP implemented a new EHR system during the reporting period, resulting in delayed encounter data submissions.

Recommendation: While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to require timeliness of encounter data submissions, the PIHP was not readily able to identify potential performance indicator-specific rate impact. HSAG therefore recommends that the PIHP identify and implement a mechanism through which it can monitor encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future.

Weakness #4: While **Lakeshore Regional Entity** met all but one MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to adult members after discharge from a psychiatric inpatient unit as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*) and also demonstrated a decline in performance since the prior year. [**Quality, Timeliness, and Access**]

Why the weakness exists: **Lakeshore Regional Entity** indicated that although telehealth services were generally in use throughout the COVID-19 pandemic public health emergency, some outpatient services may have had a decrease in utilization as a result of the pandemic.

Recommendation: While **Lakeshore Regional Entity** required a CAP from each CMHSP for any performance indicator that did not meet the MPS, HSAG recommends that the PIHP work with its CMHSPs to closely monitor adults' discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of Indicator #4a.

Compliance Review

Performance Results

Table 3-15 presents **Lakeshore Regional Entity**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Lakeshore Regional Entity**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Lakeshore Regional Entity** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-15—Summary of Standard Compliance Review Scores for LRE

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	17	2	0	**89%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Availability of Services	7	**7**	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
V	Coordination and Continuity of Care	14	14	11	3	0	**79%**
VI	Coverage and Authorization of Services	11	11	8	3	0	**73%**
Total		**65**	**65**	**53**	**12**	**0**	**82%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any substantial strengths of **Lakeshore Regional Entity** through the compliance review activity.

Weaknesses and Recommendations

Weakness #1: Lakeshore Regional Entity received a score of 50 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Lakeshore Regional Entity received a *Not Met* score for two elements. Specifically:

- The PIHP did not annually submit its assurances and supporting documentation to demonstrate that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- Although the PIHP conducted network adequacy assessments, it did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that adequately addresses timely appointment standards, language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Lakeshore Regional Entity received a score of 71 percent in the Availability of Services program area. Adequate processes for providing covered services that are available and accessible to priority populations are necessary to ensure timely access to those services and to ensure members are not inappropriately billed for covered services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Lakeshore Regional Entity received a *Not Met* score for two elements. Specifically:

- The PIHP's single case agreements did not include a prohibition on balance billing members for services rendered.
- The PIHP did not adequately demonstrate how it monitored all priority population appointment standards in accordance with MDHHS' Access Standards policy.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.

Weakness #3: Lakeshore Regional Entity received a score of 73 percent in the Coverage and Authorization of Services program area, demonstrating gaps in the PIHP's processes for processing service authorization requests and generating ABD notices. Adequate implementation of service authorization requirements is needed to ensure members receive timely and adequate notice of an ABD with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Lakeshore Regional Entity received a *Not Met* score for three elements. Specifically:

- Although the PIHP demonstrated that it had made significant training and standardization efforts since the time period under review, there were numerous issues with the ABD notices that were included as part of the case file review. Specifically, the ABD notices used across the CMHSPs did not all include state-mandated template language and did not consistently include the appropriate action being taken; a clear explanation for why the services were being denied,

reduced, or terminated; and/or the legal basis/authority were insufficient (i.e., multiple citations included that were not applicable to the member). Additionally, one case did not demonstrate that an ABD notice was sent to the member, and only two ABD notices complied with 42 CFR §438.10 by including taglines in the prevalent non-English languages.

- The PIHP did not adequately demonstrate that a timely ABD notice is sent for all previously authorized services that were terminated or suspended.
- The PIHP did not provide evidence to support that oral and written notification processes were occurring as required when a service authorization time frame is extended.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice requirements.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Lakeshore Regional Entity** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Lakeshore Regional Entity** across all EQR activities to identify common themes within **Lakeshore Regional Entity** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **Lakeshore Regional Entity** designed a methodologically sound PIP and met all requirements for data analysis and implementation of improvement strategies [**Quality**, **Timelines, and Access**], it did not demonstrate sustained improvement or achieve its established goal for the *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)* PIP [**Quality**]. **Lakeshore Regional Entity** should enhance efforts to ensure members diagnosed with schizophrenia and diabetes receive appropriate diabetes monitoring even through the COVID-19 pandemic as individuals with SMI who use antipsychotics are at increased risk of diabetes; therefore, screening for and monitoring these conditions is important to address this physical need.

Additionally, through the compliance review activity, gaps were identified in **Lakeshore Regional Entity**'s overall processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards defined by MDHHS [**Access**]. These gaps in monitoring timely services may have also contributed to **Lakeshore Regional Entity** not achieving the MPS for performance indicator #4a: *The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days* and lower performance rates in several indicators for which the MPS has not yet been established by MDHHS, including those indicators that measure how quickly members diagnosed with SUD are able to access nonemergent treatment and how quickly new PIHP members can start ongoing, nonemergent medically necessary services with a mental health provider [**Quality**, **Timeliness**, and **Access**].

Lakeshore Regional Entity demonstrated strengths in the timeliness and access domains in certain areas of its program as confirmed through achievement of the MDHHS-established MPS for both adult

and child members under Indicator #1, child members under Indicator #4a, all eligible members under Indicator #4b, and child and adult members under Indicator #10. Strong performance in these areas indicates that many members received timely pre-admission screenings for psychiatric inpatient care and timely follow-up care after discharge from a psychiatric inpatient unit and substance abuse detoxification unit, and many members were not readmitted to an inpatient psychiatric unit within 30 days of discharge [**Quality**, **Timeliness**, and **Access**]. However, although the PIHP exceeded the MPS for Indicator #4a for the child population, the adult population fell below the MPS, indicating continued opportunities for increasing the number of members who receive timely follow-up care after discharge from an inpatient psychiatric unit [**Timeliness** and **Access**].

This determination was further corroborated through the compliance review activity as **Lakeshore Regional Entity** received a score of 79 percent in the Coordination and Continuity of Care standard, 71 percent in the Availability of Services standard, and 50 percent in the Assurances of Adequate Capacity and Services standard, indicating there may be opportunities to improve processes for coordinating care after members are discharged from inpatient services and ensuring providers are available to see members in a timely manner for follow-up care [**Quality**, **Timeliness**, and **Access**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 4—Southwest Michigan Behavioral Health

Validation of Performance Improvement Projects

Performance Results

Table 3-16 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-16—Overall Validation Rating for SWMBH

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication	*Not Met*	The percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period.	76.9%	76.4% ⇔	69.6% ↓	80.0%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Southwest Michigan Behavioral Health** revised the Remeasurement 1 data results reported in the prior year. The PIHP regenerated the Remeasurement 1 data using the most recent HEDIS specifications available at the time of the prior annual submission.

Table 3-17 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-17—Remeasurement 2 Interventions for SWMBH

Intervention Descriptions	
Instituted outreach targeting members served by the MHPs rather than the CMHSPs. Outreach included member mailings and phone calls to encourage members to receive their HbA1c or fasting blood glucose screenings.	Sent monthly member lists of individuals without a diabetes screening to the CMHSP physical health providers since the IT systems of the CMHSPs' physical health providers are not integrated.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Southwest Michigan Behavioral Health designed a methodologically sound PIP. **[Quality]**

Strength #2: Southwest Michigan Behavioral Health used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers to improve member outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Southwest Michigan Behavioral Health's eligible population demonstrated a decrease in the percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who were screened for diabetes. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Southwest Michigan Behavioral Health noted that the COVID-19 pandemic impacted its ability to conduct interventions.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Southwest Michigan Behavioral Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system and medical services data system (claims and encounters). Concerns were noted with the PIHP's BH-TEDS data production and the oversight of affiliated CMHSPs that resulted in a *Do Not Report* designation for four indicators.

Southwest Michigan Behavioral Health received an indicator designation of *Reportable* for eight indicators signifying that **Southwest Michigan Behavioral Health** had calculated eight indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Southwest Michigan Behavioral Health** received an indicator designation of *Do Not Report* for Indicator #1, Indicator #2, Indicator #3, and Indicator #4a, indicating that **Southwest Michigan Behavioral Health** did not calculate these indicators in compliance with MDHHS Codebook specifications. Additionally, Indicator #2e received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Results

Table 3-18 presents **Southwest Michigan Behavioral Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-18—Performance Measure Results for SWMBH

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	DNR	95.00%
Adults—Indicator #1b	DNR	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	DNR	NA
MI–Adults—Indicator #2b	DNR	NA
I/DD–Children—Indicator #2c	DNR	NA
I/DD–Adults—Indicator #2d	DNR	NA
Total—Indicator #2	DNR	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	66.85%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	DNR	NA
MI–Adults—Indicator #3b	DNR	NA
I/DD–Children—Indicator #3c	DNR	NA
I/DD–Adults—Indicator #3d	DNR	NA
Total—Indicator #3	DNR	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	DNR	95.00%
Adults	DNR	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	93.94%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.74%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.18%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	17.05%	—
I/DD–Adults—Indicator #8b	9.36%	—
MI and I/DD–Adults—Indicator #8c	8.22%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	98.96%	—
I/DD–Adults—Indicator #9b	82.41%	—
MI and I/DD–Adults—Indicator #9c	79.57%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	5.00%	15.00%
MI and I/DD–Adults—Indicator #10b	12.32%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	21.32%	—
MI and I/DD–Adults	22.77%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	51.77%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

DNR indicates the indicator was not calculated in compliance with specifications and received a *Do Not Report* designation.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Southwest Michigan Behavioral Health continued to diligently work with its CMHSPs to ensure state-indicated benchmarks were being met. **Southwest Michigan Behavioral Health** was providing timely reporting to the CMHSPs to ensure they were aware of their progress in meeting State thresholds. The PIHP's CAPs helped document and institute direction in order to improve rates with individual CMHSPs. [**Quality**]

Strength #2: Southwest Michigan Behavioral Health had also taken additional strides to better report BH-TEDS data. The PIHP directly deployed additional validation checks within its system to strengthen the completeness of the data being entered. Some of the additional checks were to create "stops" if a required field was not populated and also provide additional drop-down designations in required fields to help create continuity in reporting. These additional checks were above and beyond the already 1,300 validation checks previously completed through automated validation. [**Quality**]

Weaknesses and Recommendations

Weakness #1: During initial review of the member-level file detail provided to HSAG and during PSV, HSAG noted that non-Medicaid members were being included in reporting for indicators #1, #2, and #3. [**Quality**]

Why the weakness exists: Non-Medicaid members were included in the member-level detail file submission provided to HSAG for indicators #1, #2, and #3.

Recommendation: While **Southwest Michigan Behavioral Health** provided updated files, the PIHP should implement additional validation checks to ensure requirements within the MDHHS Codebook are being met with regard to appropriate populations being included in performance indicator reporting.

Weakness #2: During PSV, HSAG noted that both Berrien County and Calhoun County CMHSPs had contradicting information as it related to designating compliance of performance indicators based on performance specifications. [**Quality**]

Why the weakness exists: Both CMHSPs had cases marked as compliant within HSAG's member-level file detail, but during PSV and follow-up, both CMHSPs acknowledged the cases were out of compliance.

Recommendation: As part of **Southwest Michigan Behavioral Health**'s monthly review of performance indicator rates, the PIHP should conduct a detailed review of CMHSP-reported

compliant cases to ensure the CMHSPs are appropriately categorizing cases as compliant and noncompliant for future reporting.

Weakness #3: For Van Buren County CMHSP, disposition start and stop time data for multiple cases for Indicator #1 were not able to be reported.

Why the weakness exists: Van Buren CMHSP indicated that it did not have Internet access at the local hospitals; therefore, staff completed paper pre-screenings and documented the start and stop times on the paper copies. The start and stop times were not able to be manually entered into the EHR because the system only included a drop-down selection that indicated whether the disposition was completed within three hours rather than fields to populate the start and stop times. **Southwest Michigan Behavioral Health** was unable to provide the disposition start and stop times to HSAG for review; therefore, HSAG removed these cases for reconciliation since sufficient documentation could not be provided by the CMHSP. [**Quality** and **Timeliness**]

Recommendation: Although Van Buren CMHSP indicated that it will be switching to a new EHR in October 2021, which will allow tracking of disposition start and stop times for future reporting of Indicator #1, all disposition start and stop time data reported from Van Buren CMHSP until October 2021 will not be able to be included in reporting for Indicator #1. HSAG therefore recommends that **Southwest Michigan Behavioral Health** work with Van Buren CMHSP on appropriate tracking of disposition start and stop times and ensure validation checks are in place to confirm the accuracy of drop-down selections based on manually tracked disposition start and stop times.

Weakness #4: Member-level documentation provided to HSAG did not match the information provided to MDHHS for final indicator counts. Indicators #1, #2, #3, and #4a had a more significant difference than 5 percentage points between the final reported rates to MDHHS and the member-level data provided. Therefore, the reported rates for these indicators were determined to be materially biased and should not be reported. [**Quality**]

Why the weakness exists: **Southwest Michigan Behavioral Health** was unable to provide complete and accurate member-level data to HSAG to match the final counts provided to MDHHS. Due to the incomplete member-level file, HSAG had to make multiple requests for clarification and additional documentation to gain clarity on member enrollment status, dates of service, and indicator compliance.

Recommendation: As recommended during the prior year's PMV activity, **Southwest Michigan Behavioral Health** should extract and lock member-level data for the indicator counts reported to MDHHS. In addition, **Southwest Michigan Behavioral Health** should provide additional oversight to ensure CMHSPs are providing all pertinent details in its member-level data for future reporting.

Weakness #5: **Southwest Michigan Behavioral Health** demonstrated opportunity for significant improvement as its performance was unable to be compared to other PIHPs' performance due to receiving a *DNR* designation for multiple indicators. Additionally, Indicator #4b did not meet the MPS and demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Southwest Michigan Behavioral Health**'s delegated CMHSP data were unreliable for multiple performance indicators, and the PIHP did not appear to have sufficient data

oversight in place to assure data accuracy. Additionally, the PIHP did not always have processes in place to ensure its members received appropriate follow-up after a substance abuse detox discharge.

Recommendation: To improve overall performance, HSAG recommends that **Southwest Michigan Behavioral Health** work with its CMHSPs to ensure that accurate and complete member-level data are provided for future reporting for all performance indicators and that these data align with the indicator counts reported to MDHHS. In addition, **Southwest Michigan Behavioral Health** should monitor members' discharges from a substance abuse detox unit within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of Indicator #4b.

Compliance Review

Performance Results

Table 3-19 presents **Southwest Michigan Behavioral Health**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Southwest Michigan Behavioral Health**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Southwest Michigan Behavioral Health** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-19—Summary of Standard Compliance Review Scores for SWMBH

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	6	1	0	**86%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	12	2	0	**86%**
VI	Coverage and Authorization of Services	11	11	11	0	0	**100%**
Total		**65**	**65**	**56**	**9**	**0**	**86%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Southwest Michigan Behavioral Health received a score of 100 percent in the Coverage and Authorization of Services program area, demonstrating the PIHP has adequate processes and monitoring mechanisms for authorizing services, developing ABD notices, mailing timely ABD notices, and implementing extension provisions when applicable. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Southwest Michigan Behavioral Health received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Southwest Michigan Behavioral Health received a *Not Met* score for three elements. Specifically:

- The PIHP has not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, while the PIHP's Network Adequacy Implementation Plan included MDHHS' member/provider ratio standards, these standards have not been reviewed since 2018.
- The PIHP did not annually submit its assurances and supporting documentation to demonstrate that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards, member/provider ratio standards, or timely appointment standards. Additionally, while the 2018 Network Adequacy Implementation Plan included sections for language, cultural competency, and physical accessibility, the information was limited and did not consider how the PIHP's plan would evaluate its provider network capabilities as they relate to language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Southwest Michigan Behavioral Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Southwest Michigan Behavioral Health** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Southwest Michigan Behavioral Health** across all EQR activities to identify common themes within **Southwest Michigan Behavioral Health** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings as demonstrated through the compliance review and PIP activities show that **Southwest Michigan Behavioral Health** generally had adequate processes to assess, authorize, and coordinate care for its membership and had in place a methodologically sound PIP to support improvement in the prevalence of preventive care for members diagnosed with schizophrenia or bipolar disorder [**Quality**]. However, even with these efforts in place, the PIP interventions implemented appear to have had minimal to no impact on the study indicator for the *Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication* PIP as performance in this area declined significantly since initiation of the PIP and the PIHP did not meet the established goal [**Quality** and **Access**].

Additionally, through the compliance review activity, gaps were identified in **Southwest Michigan Behavioral Health**'s processes for monitoring and reporting on all provider network adequacy standards defined by MDHHS, and two reportable measure indicators (#2e and #4b) through the PMV activity suggested that members discharged from a substance abuse detox unit were not always being seen for follow-up care within the required seven days and new members diagnosed with SUD were not always able to start services in a timely manner [**Quality**, **Timeliness**, and **Access**]. Although a thorough assessment of **Southwest Michigan Behavioral Health**'s performance related to accessibility and timeliness of care could not be conducted due to issues identified with the calculation of performance measurement data, the available findings indicated that, overall, **Southwest Michigan Behavioral Health** should enhance monitoring and CMHSP oversight efforts to ensure all members have access to providers, receive appropriate preventive and follow-up care, and are able to start treatment in a timely manner to stay mentally and physically well [**Quality**, **Timeliness**, and **Access**].

Southwest Michigan Behavioral Health did demonstrate strength in ensuring members are not readmitted to an inpatient psychiatric hospital after discharge. Therefore, HSAG recommends that **Southwest Michigan Behavioral Health** analyze its performance in this area to determine whether the initiatives implemented to support positive outcomes would be appropriate to support improvement in other areas demonstrating worse performance, particularly related to members' timely access to care [**Quality**, **Timeliness**, and **Access**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 5—Mid-State Health Network

Validation of Performance Improvement Projects

Performance Results

Table 3-20 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-20—Overall Validation Rating for MSHN

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	*Met*	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.	33.6%	36.1% ⇔	49.2% ↑	38.6%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-21 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-21—Remeasurement 2 Interventions for MSHN

Intervention Descriptions	
Developed and implemented a process for quarterly data validation to ensure data received from the CareConnect 360 (CC360) extract in the ICDP [Integrated Care Data Platform] are consistent with the HEDIS specifications and are completed within the expected time frames.	The CMHSP used care alerts to determine who does not have a claim for a completed lab. A record review is then completed to identify if a lab was ordered. If the results are in the record and a claim was submitted to Medicare, the CMHSP entered "addressed" into the ICDP.
Implemented a process for lab services to be obtained on-site at each CMHSP location, including mobile lab, trained medical staff members, and an on-site lab draw station.	Developed an information sheet to provide to members at the time of their appointment with instructions for accessing the transportation available in each CMHSP's geographical location.
Developed and provided a brief document to the PCPs and CMHSP clinicians explaining when it is appropriate for protected health information (PHI) to be shared for coordination of care, treatment, and payment. The PIHP medical director provided education related to PHI to be shared for coordination of care, treatment, and payment to the joint group of medical directors and PCPs.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Mid-State Health Network met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Mid-State Health Network achieved the goal of statistically significant improvement over the baseline rate for the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although no weaknesses were identified, HSAG recommends that **Mid-State Health Network** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measure Validation

HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

Mid-State Health Network received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Mid-State Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-22 presents **Mid-State Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-22—Performance Measure Results for MSHN

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	99.53%	95.00%
Adults—Indicator #1b	99.35%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	70.56%	NA
MI–Adults—Indicator #2b	63.21%	NA
I/DD–Children—Indicator #2c	64.88%	NA
I/DD–Adults—Indicator #2d	70.27%	NA
Total—Indicator #2	65.69%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	86.28%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	68.30%	NA
MI–Adults—Indicator #3b	74.52%	NA
I/DD–Children—Indicator #3c	73.94%	NA
I/DD–Adults—Indicator #3d	57.14%	NA
Total—Indicator #3	72.04%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.00%	95.00%
Adults	97.53%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	98.31%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.80%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	94.28%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	17.62%	—
I/DD–Adults—Indicator #8b	8.49%	—
MI and I/DD–Adults—Indicator #8c	9.46%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	98.41%	—
I/DD–Adults—Indicator #9b	56.49%	—
MI and I/DD–Adults—Indicator #9c	57.91%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	6.82%	15.00%
MI and I/DD–Adults—Indicator #10b	13.11%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	19.77%	—
MI and I/DD–Adults	25.86%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	48.73%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Mid-State Health Network proactively created supplemental materials to support staff interpretation and system configuration of the new MDHHS performance indicators and met with all CMHSPs in its region as a group to walk through the MDHHS Codebook and supplemental materials prior to system configuration and staff training. [**Quality**]

Strength #2: Mid-State Health Network worked with the CMHSPs and PCE, the PIHP's EHR vendor, to continuously evaluate opportunities for front-end data validation edits to reduce the amount of record review and validation needed prior to MDHHS submission. [**Quality**]

Strength #3: Mid-State Health Network demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV it was determined that one CMHSP (CEI) reported noncompliant cases as compliant for Indicator #3. [**Quality**]

Why the weakness exists: The source code for the indicator was pulling no-show appointments and identifying those dates as follow-up services.

Recommendation: CEI CMHSP should consider adding a validation step to its source code to look for billed services associated with the service date in the service activity log (SAL). If a nonbillable code is associated with no-show appointments in the SAL, this code should be excluded in the source code from identifying compliant records. **Mid-State Health Network** should consider performing additional validation of the quarterly submissions against its own encounter data prior to MDHHS submission to ensure that no-show appointments are not being confused for follow-up services.

Weakness #2: During PSV it was determined that one CMHSP (Newaygo) reported two non-Medicaid member cases for Indicator #1 and Indicator #3. [**Quality**]

Why the weakness exists: The Newaygo CMHSP source code did not identify these records as missing Medicaid eligibility and excluded them from the quarterly submission, and **Mid-State Health Network** did not perform any validation of Medicaid eligibility for the records submitted by the CMHSPs quarterly.

Recommendation: Newaygo CMHSP should consider reviewing the two cases to identify factors that led to the source code not excluding the records from the final submission (e.g., retroactive eligibility changes, source code limitations) and use that information to update the source code. **Mid-State Health Network** should consider performing a final validation step of the quarterly submissions against its own eligibility data to ensure that all non-Medicaid members are excluded from the measures.

Compliance Review

Performance Results

Table 3-23 presents **Mid-State Health Network**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Mid-State Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Mid-State Health Network** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-23—Summary of Standard Compliance Review Scores for MSHN

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	13	1	0	**93%**
VI	Coverage and Authorization of Services	11	11	10	1	0	**91%**
Total		**65**	**65**	**55**	**10**	**0**	**85%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Mid-State Health Network received a score of 93 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for care coordination of services, initial health screening, comprehensive assessments, person-centered service planning, integration of physical and mental healthcare, and primary care coordination. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Mid-State Health Network received a score of 91 percent in the Coverage and Authorization of Services program area, demonstrating the PIHP has adequate processes and monitoring mechanisms for authorizing services, mailing timely ABD notices, and implementing extension provisions when applicable. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Mid-State Health Network received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Mid-State Health Network received a *Not Met* score for three elements. Specifically:

- The PIHP has not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. The draft MSHN Network Adequacy Assessment did not address the time/distance standards specific to the provider types within MDHHS' defined time/distance standards (inpatient psychiatric and other select providers by adults and pediatric).
- While the PIHP demonstrated that a network adequacy plan was internally approved in May 2021, it did not annually submit to MDHHS its assurances and supporting documentation to demonstrate that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards in accordance with MDHHS' PIHP Network Adequacy Standard Procedural Document. The PIHP's network adequacy

assessment considered the percentage of members who speak non-English languages but did not identify those languages or assess the languages spoken by its provider network. The consideration of physical accessibility was also limited.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Mid-State Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Mid-State Health Network received a score of 71 percent in the Availability of Services program area. Adequate processes for providing covered services that are available and accessible to priority populations are necessary to ensure timely access to those services, and to ensure members are not inappropriately billed for covered services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Mid-State Health Network received a *Not Met* score for two elements. Specifically:

- The PIHP's single case agreements did not include a prohibition on balance billing members for services rendered, nor did any other documentation provided support that an out-of-network provider will not balance bill a member.
- The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for a SUD, which are more stringent than the appointment standards tracked and reported via Michigan's MMBPIS.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Mid-State Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Mid-State Health Network** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Mid-State Health Network** across all EQR activities to identify common themes within **Mid-State Health Network** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that **Mid-State Health Network**'s data analysis efforts and improvement strategies for its *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test* PIP were appropriate as the study indicator rates demonstrated statistically significant improvement over the baseline rate, and **Mid-State Health Network** exceeded its established goal [**Quality**]. These findings demonstrate that **Mid-State Health Network** implemented successful interventions to increase the number of members diagnosed with schizophrenia and diabetes who also

received appropriate diabetes monitoring. Because persons with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening for and monitoring these conditions is important.

Through the PMV activity, **Mid-State Health Network** also demonstrated strengths within its program as it met or exceeded the MPS for all performance indicators with an established MPS. Strong performance in the compliance review activity in the areas of Coordination and Continuity of Care and Coverage and Authorization of Services, along with the performance indicator results, further confirmed that **Mid-State Health Network** has effective processes in place to coordinate care for and appropriately manage the behavioral and SUD needs of its membership. Specifically, the PIHP ensured timely pre-admission screening for psychiatric inpatient care [**Quality**, **Timeliness** and **Access**], ensured timely follow-up care after discharge from a psychiatric inpatient unit or substance use detoxification unit [**Quality**, **Timeliness**, and **Access**], and reduced readmissions after discharge from an inpatient psychiatric unit [**Quality**].

Although **Mid-State Health Network** performed well overall in ensuring members' timely access to services, gaps were identified through the compliance review activity in **Mid-State Health Network**'s processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards defined by MDHHS [**Quality**, **Timeliness**, and **Access**]. To ensure continued high performance with providing timely and accessible services, and to also ensure appropriate monitoring of those performance indicators without an MPS, **Mid-State Health Network** should develop a robust, documented process for demonstrating the adequacy of the provider network and the range of covered services available to its membership.

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 6—Community Mental Health Partnership of Southeast Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-24 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-24—Overall Validation Rating for CMHPSM

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	*Not Met*	The percentage of members ages 18–64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year.	65.6%	65.8% ⇔	48.6% ↓	72.2%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-25 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-25—Remeasurement 2 Interventions for CMHPSM

Intervention Descriptions	
Opened EHR access to printing log of printed lab orders so all treatment team members had the ability to view a member's lab printing log if assigned to the member's care.	Created a local workflow that manages technical abilities to access completed labs.
Added assistance to transportation for getting labs done in the clinical record under progress notes. Updated workflow and trained case managers on transportation resources and data entry. Updated the CMHSP coordination policy with clear steps and expectations of allowable coordination.	Used telehealth options to expand case management outreach efforts. Ensured providers had sufficient resources for staff and members to reduce controllable barriers to attending labs. Assisted members in getting vaccinated for the COVID-19 virus when possible.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Community Mental Health Partnership of Southeast Michigan designed a methodologically sound PIP. **[Quality]**

Strength #2: Community Mental Health Partnership of Southeast Michigan used appropriate QI tools to conduct a causal/barrier analysis and developed a collaborative team to identify and prioritize barriers to improve member outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Community Mental Health Partnership of Southeast Michigan's eligible population demonstrated a decrease in the percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Community Mental Health Partnership of Southeast Michigan noted that the COVID-19 pandemic created additional barriers and limited existing interventions. Factors such as shelter-in-place orders, social distancing, masking, and provider network staff shortages restricted the ability of members to complete the required face-to-face lab work needed to become numerator compliant.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Community Mental Health Partnership of Southeast Michigan**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of its affiliated CMHSPs.

Community Mental Health Partnership of Southeast Michigan received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Community Mental Health Partnership of Southeast Michigan** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-26 presents **Community Mental Health Partnership of Southeast Michigan**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-26— Performance Measure Results for CMHPSM

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	98.58%	95.00%
Adults—Indicator #1b	98.05%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	68.27%	NA
MI–Adults—Indicator #2b	64.74%	NA
I/DD–Children—Indicator #2c	80.65%	NA
I/DD–Adults—Indicator #2d	66.67%	NA
Total—Indicator #2	67.35%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	65.48%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	83.89%	NA
MI–Adults—Indicator #3b	77.73%	NA
I/DD–Children—Indicator #3c	88.24%	NA
I/DD–Adults—Indicator #3d	80.00%	NA
Total—Indicator #3	81.25%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	95.52%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	98.85%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.42%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	89.98%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	15.75%	—
I/DD–Adults—Indicator #8b	9.42%	—
MI and I/DD–Adults—Indicator #8c	9.74%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	98.39%	—
I/DD–Adults—Indicator #9b	58.89%	—
MI and I/DD–Adults—Indicator #9c	68.93%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	7.14%	15.00%
MI and I/DD–Adults—Indicator #10b	10.29%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	25.85%	—
MI and I/DD–Adults	35.01%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	35.28%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Community Mental Health Partnership of Southeast Michigan demonstrated overall strength in its partnerships and consistent processes used across all of its CMHSPs. Since all CMHSPs followed standardized processes related to enrollment data, claims data, BH-TEDS data, and performance indicator reporting, the PIHP has assurances of consistency in the data collection processes. Through these standardized processes and routine communication, **Community Mental Health Partnership of Southeast Michigan** was able to maintain oversight of its CMHSPs to monitor that the performance indicator data were reported in alignment with the MDHHS Codebook requirements. [**Quality**]

Strength #2: Community Mental Health Partnership of Southeast Michigan maintained a robust repository of system-based reports to monitor both performance indicator data quality and completeness, as well as to monitor estimated performance indicator results throughout each reporting period. The PIHP's formalized committee structure ensures data anomalies are readily identified and addressed, and also ensures the PIHP can monitor access and timeliness of care for its members and can take prompt action if necessary. [**Quality**]

Strength #3: Community Mental Health Partnership of Southeast Michigan demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted two **Community Mental Health Partnership of Southeast Michigan** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While two member records are not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** and the CMHSPs employ enhancements to their BH-TEDS validation process to ensure no discrepant data are entered. This validation process should account for discrepancies in wage and income values.

Weakness #2: Multiple cases were reported for each CMHSP that had an elapsed time of zero minutes for Indicator #1. Although the cases were determined to be compliant for Indicator #1 as they were still within the appropriate pre-admission decision time frame requirement, the zero minutes elapsed time was inaccurate, which could result in future reporting of noncompliant cases as compliant if the issue is not corrected. While not impactful to the PIHP's rates, the identified issue does suggest the potential to improve the accuracy of data used in future reporting of Indicator #1. [**Quality**]

Why the weakness exists: Individual staff member data entry errors were determined to be the reason for this weakness. However, the PIHP confirmed that based on the CMHSPs' manual review, a few cases could reasonably have been determined to have had a very short, elapsed time frame that supported the documented zero minutes.

Recommendation: Upon identification of this weakness during the PMV process, **Community Mental Health Partnership of Southeast Michigan** confirmed corrective action was completed with three of the four CMHSPs, including additional training of staff members responsible for documenting the pre-admission decision time within the system. Two CMHSPs also implemented enhanced oversight for reviewing cases with an Indicator #1 elapsed time of zero prior to submission to the PIHP. One CMHSP did not implement corrective action as its zero elapsed minutes case was determined to be accurately documented; however, the CMHSP did communicate the difference between the different system fields to its staff members. In alignment with the PIHP's documented steps provided to HSAG after the virtual review, HSAG recommends that the PIHP monitor the corrective action which was implemented as a result of these findings and conduct additional final review of the detailed data for all Indicator #1 cases with zero minutes reported as the elapsed time. HSAG also supports the PIHP's plan to explore any system changes that PCE (the PIHP's EHR vendor) could complete, which could assist in preventing inaccurate data entry of the time of decision for reporting Indicator #1.

Weakness #3: Two members were included in Monroe CMHSP's Indicator #1 reporting who were not Medicaid members as required by the MDHHS Codebook. [**Quality**]

Why the weakness exists: An isolated error occurred in the review of Monroe CMHSP's quarterly performance indicator review process to ensure only PIHP-enrolled members are included within the Indicator #1 data.

Recommendation: Community Mental Health Partnership of Southeast Michigan should confirm member enrollment time frames in comparison to its internally housed Medicaid member enrollment data to ensure only members who qualify for reporting in alignment with the MDHHS Codebook are included in the Indicator #1 data prior to submitting results to MDHHS.

Compliance Review

Performance Results

Table 3-27 presents **Community Mental Health Partnership of Southeast Michigan**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Community Mental Health Partnership of Southeast Michigan**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Community Mental Health Partnership of Southeast Michigan** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-27—Summary of Standard Compliance Review Scores for CMHPSM

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	11	3	0	**79%**
VI	Coverage and Authorization of Services	11	11	9	2	0	**82%**
Total		**65**	**65**	**52**	**13**	**0**	**80%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any substantial strengths of **Community Mental Health Partnership of Southeast Michigan** through the compliance review activity.

Weaknesses and Recommendations

Weakness #1: Community Mental Health Partnership of Southeast Michigan received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Community Mental Health Partnership of Southeast Michigan received a *Not Met* score for three elements. Specifically:

- The PIHP has not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, while the PIHP's Network Adequacy Plan included MDHHS' member/provider ratio standards, these standards have not been reviewed since 2018.
- While the PIHP demonstrated regular submission of network stability reports to MDHHS in response to the pandemic, it did not annually submit its assurances and supporting documentation to MDHHS to demonstrate it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards, member/provider ratio standards, or timely appointment standards. Additionally, while the 2018 Network Adequacy Plan included sections on language, cultural competency, and physical accessibility, the information was limited and did not consider how the PIHP's plan would evaluation its provider network's capabilities as they relate to language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Community Mental Health Partnership of Southeast Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Community Mental Health Partnership of Southeast Michigan received a score of 71 percent in the Availability of Services program area. Adequate processes for providing covered services that are available and accessible to priority populations are necessary to ensure timely access to those services and to ensure members are not inappropriately billed for covered services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Community Mental Health Partnership of Southeast Michigan received a *Not Met* score for two elements. Specifically:

- The PIHP's single case agreements included varying language and did not consistently include a provision prohibiting balance billing members for services rendered. PIHP staff members explained that, for hospitals, single case agreements are received from the provider, not agreements developed by the PIHP/CMHSP.
- The PIHP's documentation did not confirm it had implemented processes to actively monitor all walk-in, screening, referral, and admission time frames according to MDHHS' Access Standards policy during the time period of the review.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Community Mental Health Partnership of Southeast Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Community Mental Health Partnership of Southeast Michigan** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Community Mental Health Partnership of Southeast Michigan** across all EQR activities to identify common themes within **Community Mental Health Partnership of Southeast Michigan** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that **Community Mental Health Partnership of Southeast Michigan** had in place a methodologically sound PIP to support improvement in the prevalence of members with schizophrenia and diabetes obtaining the HbA1c and LDC-C tests, used appropriate QI tools to conduct a causal/barrier analysis, and developed a collaborative team to identify and prioritize barriers. However, even with these efforts in place, the PIP interventions implemented appear to have had minimal impact on the study indicator for the *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test* PIP; the PIP study indicator demonstrated a statistically significant decline from the baseline rate, and **Community Mental Health Partnership of Southeast Michigan** did not meet its established goals [**Quality, Timeliness**, and **Access**].

Additionally, through the compliance review activity, gaps were identified in **Community Mental Health Partnership of Southeast Michigan**'s processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards defined by MDHHS [**Access**]. **Community Mental Health Partnership of Southeast Michigan** demonstrated strengths within its program as it met or exceeded the MPS for all performance indicators with an established MPS, which confirmed members received timely pre-admission screening for psychiatric inpatient care [**Timeliness** and **Access**], timely follow-up care after discharge from a psychiatric inpatient unit or substance use detoxification unit [**Timeliness** and **Access**], and reduced readmissions after discharge from an inpatient psychiatric unit [**Quality**].

However, **Community Mental Health Partnership of Southeast Michigan** should further enhance its network adequacy and care coordination efforts to ensure all members, including those who have

schizophrenia and diabetes and those seeking nonemergent mental health and SUD treatment, are able to access providers in a timely manner to receive appropriate testing and preventive care, and have timely access to nonemergent mental health and SUD services in order to stay well both physically and mentally. Additionally, these efforts may potentially identify network gaps that **Community Mental Health Partnership of Southeast Michigan** could address, which could positively effect performance indicator rates. [**Quality, Timeliness**, and **Access**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 7—Detroit Wayne Integrated Health Network

Validation of Performance Improvement Projects

Performance Results

Table 3-28 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-28—Overall Validation Rating for DWIHN

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	*Not Met*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.	81.4%	76.9% ↓	64.3% ↓	83.2%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-29 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-29—Remeasurement 2 Interventions for DWIHN

Intervention Descriptions	
Monitored compliance with diabetes screening through clinical treatment chart audits. Findings from the chart audits were shared with providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.	Measured and monitored compliance with labs ordered and drawn no less than quarterly through review of the HEDIS-like data in the healthcare analytics tool. Findings were share with providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.
Educated members on the importance of having labs completed through community outreach initiatives and training.	Educated providers through community outreach initiatives and training on the importance of diabetes screening.
Provided education on clinical guideline procedures to service providers, practitioners, and plan staff members through the workgroup and committee meetings.	Conducted monthly care coordination meetings with MHPs to develop care plans for members, including those diagnosed with diabetes who had been prescribed atypical antipsychotic medications.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Detroit Wayne Integrated Health Network designed a methodologically sound PIP. **[Quality]**

Strength #2: Detroit Wayne Integrated Health Network used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers to improve member outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Detroit Wayne Integrated Health Network's eligible population demonstrated a decrease in the percentage of screenings for members with schizophrenia or bipolar disorder taking an antipsychotic medication. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Detroit Wayne Integrated Health Network noted that restrictions related to the COVID-19 pandemic impacted its members' ability to obtain face-to-face services, including the completion of labs draws, and interrupted the PIHP's ability to conduct some interventions.

Recommendation: HSAG recommends that **Detroit Wayne Integrated Health Network** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Detroit Wayne Integrated Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **Detroit Wayne Integrated Health Network** works directly with service providers and the Medicaid population. As a result, oversight of affiliated CMHSPs was not applicable to the PIHP's PMV.

Detroit Wayne Integrated Health Network received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Detroit Wayne Integrated Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-30 presents **Detroit Wayne Integrated Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-30—Performance Measure Results for DWIHN

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	99.41%	95.00%
Adults—Indicator #1b	95.04%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	51.45%	NA
MI–Adults—Indicator #2b	48.02%	NA
I/DD–Children—Indicator #2c	63.18%	NA
I/DD–Adults—Indicator #2d	42.59%	NA
Total—Indicator #2	50.12%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	68.43%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	82.70%	NA
MI–Adults—Indicator #3b	86.93%	NA
I/DD–Children—Indicator #3c	78.38%	NA
I/DD–Adults—Indicator #3d	91.67%	NA
Total—Indicator #3	84.84%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	92.75%	95.00%
Adults	97.52%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.20%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.04%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	12.12%	—
I/DD–Adults—Indicator #8b	8.90%	—
MI and I/DD–Adults—Indicator #8c	6.05%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	99.39%	—
I/DD–Adults—Indicator #9b	53.87%	—
MI and I/DD–Adults—Indicator #9c	50.91%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	8.94%	15.00%
MI and I/DD–Adults—Indicator #10b	17.94%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	21.76%	—
MI and I/DD–Adults	27.65%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	37.49%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Detroit Wayne Integrated Health Network continued to show strides in improving indicator performance. Most notable was its development of a recidivism workgroup of both internal and external stakeholders to improve rates related to Indicator #10. The workgroup members engaged in collaborative quarterly meetings to ensure the continuity of quality of care. **Detroit Wayne Integrated Health Network** actively worked with Clinically Responsible Service Providers (CRSPs) to help define the responsibilities of these providers, create chart alerts for frequent patients, and define protocols to direct members to the appropriate service levels of care based on observation. The efforts from this group produced a 2.5 percent drop in Indicator #10 as of Quarter 1 (Q1) FY 2020–2021. [**Quality**]

Strength #2: Detroit Wayne Integrated Health Network also improved its BH-TEDS reporting. PCE, the PIHP's EHR vendor, worked with the MH-WIN (the PIHP's EHR system) software company to update validations within **Detroit Wayne Integrated Health Network**'s system to ensure that all required fields had to be populated before saving. In addition, disability designation data values within MH-WIN were updated to provide additional options to denote member activity. [**Quality**]

Weaknesses and Recommendations

Weakness #1: During the PSV session of the virtual review, HSAG identified that **Detroit Wayne**'s MH-WIN system was capturing little to no detail from providers in regard to any follow-up they conducted for members who no-showed or cancelled in relation to Indicator #1. In addition, **Detroit Wayne Integrated Health Network** did not capture any explanation as to why a disposition, assessment, or service request might have fallen out of compliance due to an extended amount of time. Supporting documentation, an on-site meeting agenda, provided by **Detroit Wayne Integrated Health Network** from August 2019 acknowledged the issues and noted discussions on how to address them. [**Quality**]

Why the weakness exists: Detroit Wayne Integrated Health Network noted that prior detail was not requested from the providers. In addition, providers were not documenting enough detailed information regarding interaction with the members as it related to Indicator #1.

Recommendation: While **Detroit Wayne Integrated Health Network** did acknowledge the issues related to capturing additional member notes and has recently asked for additional member detail from providers regarding Indicator #1, HSAG recommends that **Detroit Wayne Integrated Health Network** continue to monitor and provide guidance to providers on notating additional details in

regard to member interactions, documenting follow-up requests with members, and denoting any circumstances that may cause services to be out of compliance based on the MDHHS Codebook specifications.

Weakness #2: During the PSV session of the virtual review, HSAG noted that **Detroit Wayne Integrated Health Network** found an issue with its program logic related to Indicator #2a. The program language was not capturing assessment completion dates appropriately when the nonemergency request date fell on the same day as the assessment. **Detroit Wayne Integrated Health Network** identified the issue after Q1 SFY 2021 and made updates to ensure the program logic for Q2 SFY 2021 is now correct. [**Quality**]

Why the weakness exists: The source code to calculate Indicator #2a was not allowing nonemergency request dates and assessment completion dates to populate on the same day for indicator reporting. The prior Indicator #2a source code logic underreported the rates for **Detroit Wayne Integrated Health Network**.

Recommendation: While no other cases reviewed during PSV contained this anomaly, to improve rates related to Indicator #2a and meet MDHHS Codebook requirements, HSAG recommends that **Detroit Wayne Integrated Health Network** continue to monitor quarterly reporting to MDHHS and review member-level detail data to ensure established source code is still viable and capturing the components necessary to report accurate rates to MDHHS.

Weakness #3: During the opening session of the virtual review, **Detroit Wayne Integrated Health Network** noted that for Indicator #2a, the PIHP reporting percentages were the lowest amongst regions. [**Quality**]

Why the weakness exists: The turnout of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a nonemergency request for service has been low.

Recommendation: While HSAG noted that a workplan has been implemented by **Detroit Wayne Integrated Health Network**, which includes current reporting being sent to the providers to review the status of the indicator and missing gaps of information that needs to be populated by the provider, HSAG recommends that **Detroit Wayne Integrated Health Network** conduct an additional root cause analysis to determine why members are not receiving follow-up services within 14 days of a completed assessment.

Weakness #4: While **Detroit Wayne Integrated Health Network** met the MPS for all but two indicators, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to children after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*). Additionally, an opportunity exists for the PIHP to reduce readmissions for MI and I/DD adults to an inpatient psychiatric unit within 30 days of discharge, as the PIHP also did not meet the MPS for this indicator (i.e., *#10: The percentage of readmissions of MI and I/DD adults during the quarter to an inpatient psychiatric unit within 30 days of discharge*). [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Detroit Wayne Integrated Health Network** did not have processes in place to reliably ensure children received appropriate timely follow-up care after a discharge from a psychiatric inpatient unit. Additionally, while its Indicator #10 rate improved over the prior year, the PIHP did not always have consistent processes in place to ensure its MI and I/DD adult members were not readmitted to an inpatient psychiatric unit.

Recommendation: HSAG recommends that the PIHP closely monitor children's discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of performance indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter who were seen for follow-up care within 7 days—Children*. Additionally, while **Detroit Wayne Integrated Health Network** reduced the number of inpatient psychiatric unit readmissions for its MI and I/DD Adult population when compared with the prior year's rate for Indicator #10, HSAG recommends that **Detroit Wayne Integrated Health Network** continue to further work toward reducing the number of inpatient psychiatric unit readmissions and follow any best practices that led to the decrease in inpatient psychiatric unit readmissions from the prior year.

Compliance Review

Performance Results

Table 3-31 presents **Detroit Wayne Integrated Health Network**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Detroit Wayne Integrated Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Detroit Wayne Integrated Health Network** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-31—Summary of Standard Compliance Review Scores for DWIHN

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	6	1	0	**86%**
IV	Assurances of Adequate Capacity and Services	4	4	0	4	0	**0%**
V	Coordination and Continuity of Care	14	14	11	3	0	**79%**

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
VI	Coverage and Authorization of Services	11	11	7	4	0	**64%**
	Total	**65**	**65**	**50**	**15**	**0**	**77%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any substantial strengths of **Detroit Wayne Integrated Health Network** through the compliance review activity.

Weaknesses and Recommendations

Weakness #1: Detroit Wayne Integrated Health Network received a score of 0 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Detroit Wayne Integrated Health Network received a *Not Met* score for four elements. Specifically:

- The PIHP's Annual Assessment of the Network Availability of Providers & Practitioners did not include member/provider ratios or time/distance standards by provider or service types required in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not annually submit its assurances and supporting documentation to MDHHS to demonstrate that it has the capacity to serve the expected enrollment in its service area in

accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.

- Documentation and discussion with PIHP staff members did not confirm awareness of the requirement to notify MDHHS within seven days of any changes to the composition of the provider network that negatively affect access to care.
- The Annual Assessment of the Network Availability of Providers & Practitioners did not consider time/distance standards or member/provider ratios in accordance with MDHHS' PIHP Network Adequacy Standard Procedural Document, timely appointments, or physical accessibility. Of note, the annual assessment included an evaluation of members' ethnic and linguistic preferences, languages spoken by providers, and the geographical distribution of its ethnic providers.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Detroit Wayne Integrated Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Detroit Wayne Integrated Health Network received a score of 64 percent in the Coverage and Authorization of Services program area, demonstrating gaps in the PIHP's processes for processing service authorization requests and generating ABD notices. Adequate implementation of service authorization requirements is needed to ensure members receive timely and adequate notice of an ABD with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Detroit Wayne Integrated Health Network received a *Not Met* score for three elements. Specifically:

- Although the PIHP's template ABD notices complied with the MDHHS-mandated template language, issues were identified within the ABD notices that were included as part of the case file review. Specifically, the documented action being taken did not concur with the actual action being taken. All ABD notices indicated an action of "denied" when in fact the ABD notices reviewed were either a reduction in services or partial denials. Additionally, at least two cases referred to an inpatient admission being denied when none of the cases were about admissions. Appeal rights were included, but the letter required the member to submit a written appeal if filed orally. This is no longer a requirement and should be removed from the notices. Related to continuation of benefits, the date for requesting continuation of benefits was based on the effective date of the action, when the requirement is that the member has 10 days from the date of the ABD notice to request continuation of benefits.
- The PIHP did not consistently provide members with a 10-day advance notice as required. Additionally, the PIHP did not provide adequate documentation or a clear explanation for the processes used to identify instances when a denial of payment is required or processes for sending members a denial of payment ABD notice on the date the claim is denied. Also, results from the case file review confirmed that ABD notices were not consistently sent within the standard authorization time frame. Further, PIHP staff members confirmed the PIHP had not been denying service authorization requests or sending an ABD notice when authorizations were not determined within the standard or expedited time frames.

- The extension notice template inaccurately indicated the extension time frame for an expedited request as 72 hours. Additionally, the PIHP did not provide evidence to support that it has procedures in place to make attempts to orally notify the member of the extension and, during the interview session, PIHP staff members confirmed that they were not making oral attempts to notify the member during the time period under review.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Detroit Wayne Integrated Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice requirements.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Detroit Wayne Integrated Health Network** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Detroit Wayne Integrated Health Network** across all EQR activities to identify common themes within **Detroit Wayne Integrated Health Network** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that **Detroit Wayne Integrated Health Network** had in place a methodologically sound PIP to support improvement in the prevalence of members with schizophrenia who had a diabetes screening, and the PIHP used appropriate QI tools to conduct a causal/barrier analysis and prioritize the barriers. However, even with these efforts in place, the PIP interventions implemented appear to have had minimal impact on the study indicator for the *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP; the PIP study indicator demonstrated a statistically significant decline from the baseline rate, and **Detroit Wayne Integrated Health Network** did not meet its established goals [**Quality, Timeliness**, and **Access**].

Additionally, through the compliance review activity, gaps were identified in **Detroit Wayne Integrated Health Network**'s processes for demonstrating the adequacy of the provider network and the range of covered services [**Access** and **Timeliness**]. **Detroit Wayne Integrated Health Network** should further enhance its network adequacy and care coordination efforts with the MHPs in its region to ensure members who have schizophrenia are able to access providers in a timely manner to receive the appropriate diabetes screening [**Quality, Timeliness**, and **Access**]. Patients who use antipsychotics are at increased risk of diabetes, which can lead to worsening physical health in these patients, and appropriate testing is critical for their health and well-being.

Detroit Wayne Integrated Health Network demonstrated some strengths within its program as it met or exceeded the MPS for several performance indicators as indicated through the PMV activity. However, **Detroit Wayne Integrated Health Network** did not ensure that child members discharged from a psychiatric inpatient hospital received timely follow-up care, nor was it able to mitigate some adult members from being readmitted to an inpatient psychiatric hospital after recent discharges.

Additionally, although an MPS has not yet been established for certain indicators, **Detroit Wayne Integrated Health Network** has opportunities to improve timely access to care for members seeking nonemergent services as indicated through lower performance rates. The development of robust processes to assess its provider network capacity should help support the identification of any gaps within its network that may be contributing to members' inability to access timely care for both new and follow-up services. **Detroit Wayne Integrated Health Network** should also analyze better performance demonstrated through improved measure rates to determine if initiatives were implemented that supported the improved outcomes and determine whether similar initiatives or interventions would be appropriate to support improvement in areas demonstrating worse performance.

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 8—Oakland Community Health Network

Validation of Performance Improvement Projects

Performance Results

Table 3-32 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-32—Overall Validation Rating for OCHN

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	*Not Met*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.	73.8%	72.0% ↓	72.2% ↓	83.8%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Oakland Community Health Network** revised the baseline data results reported in the prior year. The PIHP regenerated the baseline data to capture Healthy Michigan claims and members who were not previously included but were captured for the first and second remeasurements.

Table 3-33 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-33—Remeasurement 2 Interventions for OCHN

Intervention Descriptions	
Trained provider staff members on manual data entry into the healthcare analytics tool when diabetes screening is complete in order to refine data and improve accuracy.	Worked with the healthcare analytics tool vendor to ensure system integration and reception of Healthy Michigan claims and members into the dataset.
Sent members served (who meet the criteria), as well as members who do not have a PCP, quarterly reminder letters to complete identified and specific annual screenings/vaccinations.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Oakland Community Health Network designed a methodologically sound PIP. **[Quality]**

Strength #2: Oakland Community Health Network met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Oakland Community Health Network's eligible population demonstrated a decrease in the percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who were screened for diabetes. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Oakland Community Health Network noted that the COVID-19 pandemic created additional barriers to members receiving mental health services and supports, such as reluctance of members to go into the community safely for care and primary care clinic closures.

Recommendation: HSAG recommends that **Oakland Community Health Network** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Oakland Community Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **Oakland Community Health Network** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

Oakland Community Health Network received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Oakland Community Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-34 presents **Oakland Community Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-34—Performance Measure Results for OCHN

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	98.80%	95.00%
Adults—Indicator #1b	95.60%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	64.29%	NA
MI–Adults—Indicator #2b	60.89%	NA
I/DD–Children—Indicator #2c	70.59%	NA
I/DD–Adults—Indicator #2d	79.17%	NA
Total—Indicator #2	62.52%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	87.01%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	98.82%	NA
MI–Adults—Indicator #3b	99.53%	NA
I/DD–Children—Indicator #3c	100.00%	NA
I/DD–Adults—Indicator #3d	100.00%	NA
Total—Indicator #3	99.38%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	96.43%	95.00%
Adults	95.15%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.11%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.57%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	17.24%	—
I/DD–Adults—Indicator #8b	13.25%	—
MI and I/DD–Adults—Indicator #8c	8.19%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	99.30%	—
I/DD–Adults—Indicator #9b	58.90%	—
MI and I/DD–Adults—Indicator #9c	36.10%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	6.25%	15.00%
MI and I/DD–Adults—Indicator #10b	10.16%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	19.34%	—
MI and I/DD–Adults	26.60%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	31.42%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Oakland Community Health Network has moved all reporting checks to the Quality Team. Within this team, it has hired two additional staff members to help with quality control and reporting. This change in structure has aided in additional reviews and better quality control procedures. [**Quality**]

Strength #2: Oakland Community Health Network has created Smart Sheets for review of indicators that are marked as out of compliance. These Smart Sheets have helped providers understand how to properly identify exceptions, if necessary. This is the second year that **Oakland Community Health Network** has used Smart Sheets. [**Quality**]

Strength #3: Oakland Community Health Network has started working on a health information exchange (HIE) calendar that can be shared across provider groups. This will help those providers that do not use Oakland Data Information Network (ODIN), the PIHP's EHR system, to attain better collaboration. Although the calendar has not been implemented yet, it is scheduled to go live in October 2021. [**Quality**]

Strength #4: Oakland Community Health Network demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During the PSV portion of the audit, HSAG found that two members had their biopsychosocial assessment completed outside of the 14-day window but were marked as in compliance for Indicator #2 due to being put on a waitlist until eligible for Medicaid. The PIHP's understanding was that a BPS was to be completed within 14 days of these members becoming eligible. However, according to the specifications, the BPS is to be completed within 14 days of the initial request for services. [**Quality and Timeliness**]

Why the weakness exists: Oakland Community Health Network noted its understanding that any BPS was to be completed within 14 days of becoming eligible for Medicaid services. This led **Oakland Community Health Network** to believe that those members should be marked as in compliance.

Recommendation: HSAG recommends additional spot checks when calculating days or hours to produce indicator rates, to ensure that all members are properly marked as in compliance, out of

compliance, or an exception. These additional spot checks can help ensure that the indicators are being calculated correctly.

Compliance Review

Performance Results

Table 3-35 presents **Oakland Community Health Network**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Oakland Community Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Oakland Community Health Network** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-35—Summary of Standard Compliance Review Scores for OCHN

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	17	2	0	**89%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
V	Coordination and Continuity of Care	14	14	13	1	0	**93%**
VI	Coverage and Authorization of Services	11	11	9	2	0	**82%**
Total		**65**	**65**	**56**	**9**	**0**	**86%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not

associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Oakland Community Health Network received a score of 93 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for care coordination of services, initial health screenings, comprehensive assessments, person-centered service planning, integration of physical and mental healthcare, and primary care coordination. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Oakland Community Health Network received a score of 50 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Oakland Community Health Network received a *Not Met* score for two elements. Specifically:

- While the PIHP demonstrated submission of its Network Adequacy Plan in 2018, the PIHP did not annually submit its assurances and supporting documentation to demonstrate that it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- While the PIHP completed a population assessment in 2019 and monitored network adequacy standards and access standards, the PIHP's current plan on how MDHHS' network adequacy standards will be effectuated in its region did not collectively address time/distance standards; member/provider ratio standards; timely appointment standards; or language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Oakland Community Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Oakland Community Health Network received a score of 71 percent in the Availability of Services program area. Adequate processes for providing covered services that are available and accessible to priority populations are necessary to ensure timely access to those services and to ensure members are not inappropriately billed for covered services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Oakland Community Health Network** received a *Not Met* score for two elements. Specifically:

- The PIHP's single case agreements did not include a prohibition on balance billing members for services rendered.
- The PIHP did not provide adequate evidence of a process to actively monitor adherence to all time frame standards in accordance with MDHHS' Access Standards policy; for example, adherence to admission time frames for pregnant women receiving services for a SUD.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Oakland Community Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Oakland Community Health Network** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Oakland Community Health Network** across all EQR activities to identify common themes within **Oakland Community Health Network** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings as demonstrated through the compliance review and PIP activities show that **Oakland Community Health Network** generally had adequate processes to assess and coordinate care for its membership, including coordination of physical and mental healthcare, and had in place a methodologically sound PIP to support improvement in the prevalence of members with schizophrenia or bipolar disorder who had a diabetes screening. However, even with strong coordination of care and a well-designed PIP in place, the PIP interventions implemented appear to have had minimal to no impact on the study indicator for the *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP; the PIP study indicator demonstrated a statistically significant decline from the baseline rate, and **Oakland Community Health Network** did not meet its established goals [**Quality, Timeliness**, and **Access**].

As indicated through the compliance review activity, gaps were identified in the PIHP's processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards defined by MDHHS, which could have contributed to the lower PIP outcomes related to the necessary preventive care for members with both mental and physical illnesses [**Timeliness** and **Access**]. **Oakland Community Health Network** should further enhance its network adequacy and intervention efforts to ensure members who have schizophrenia and/or bipolar disorder are able to access providers to receive the appropriate diabetes screening [**Quality, Timeliness**, and **Access**]. Patients who use antipsychotics are at increased risk of diabetes, which can lead to worsening physical health in these patients, and appropriate testing is critical for their health and well-being.

Although gaps were identified through the compliance review activity in **Oakland Community Health Network**'s processes for demonstrating the adequacy of its provider network and the range of covered

services available, and staff members did not have an adequate process to monitor adherence to all MDHHS access and time frame standards, through the PMV activity, **Oakland Community Health Network** demonstrated strengths within its program as it met or exceeded the MPS for all indicators with an established MPS. This strong performance indicates that **Oakland Community Health Network** is appropriately managing many of the behavioral and SUD needs of its membership. Specifically, the PIHP ensured timely pre-admission screening for psychiatric inpatient care [**Timeliness** and **Access**], ensured timely follow-up care after discharge from a psychiatric inpatient unit or substance use detoxification unit [**Timeliness** and **Access**], and reduced readmissions after discharge from an inpatient psychiatric unit [**Quality**].

With additional focused efforts to close the gaps in **Oakland Community Health Network**'s processes for monitoring and reporting on all timely screening and appointment standards and provider network adequacy standards, **Oakland Community Health Network** should be able to proactively identify issues, initiate improvement efforts, and see better outcomes for all its members [**Quality**, **Timeliness**, and **Access**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 9—Macomb County Community Mental Health

Validation of Performance Improvement Projects

Performance Results

Table 3-36 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-36—Overall Validation Rating for MCCMH

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness (SMI)	*Not Met*	30-day Hospital Readmission	14.2%	15.3% ⇔	14.8% ⇔	13.0%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-37 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-37—Remeasurement 2 Interventions for MCCMH

Intervention Descriptions	
Implemented team meetings with the Access (intake unit) psychiatrist, Access leadership, and Access managers to identify the appropriate level of care needed following hospitalization.	Increased trainings on Assisted Outpatient Treatment (Kevin's Law) for hospitals, law enforcement, and court staff members.
Access Specialty teams worked with hospital discharge planners to plan for post-hospital services.	Purchased assistance from an outside vendor to create hospital utilization dashboards. The dashboards assist with recidivism data, hospital length of stays, and discharge information.
Development of a post-hospital transition program, providing services to members admitted at least twice within a 60-day period.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Macomb County Community Mental Health designed a methodologically sound PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Macomb County Community Mental Health demonstrated an increase over baseline in the percentage of adults with SMI readmitted to a hospital within 30 days post-discharge. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Macomb County Community Mental Health noted that the COVID-19 pandemic impacted access to community interventions as staffing was a concern due to absenteeism and resignations.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

HSAG evaluated **Macomb County Community Mental Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **Macomb County Community Mental Health** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

Macomb County Community Mental Health received an indicator designation of *Reportable* for 11 indicators, signifying that **Macomb County Community Mental Health** had calculated eight indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Macomb County Community Mental Health** received an indicator designation of *Do Not Report* for Indicator #2, indicating that **Macomb County Community Mental Health** did not calculate this indicator in compliance with MDHHS Codebook specifications. Additionally, Indicator #2e received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Results

Table 3-38 presents **Macomb County Community Mental Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-38—Performance Measure Results for MCCMH

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	99.32%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	DNR	NA
MI–Adults—Indicator #2b	DNR	NA
I/DD–Children—Indicator #2c	DNR	NA
I/DD–Adults—Indicator #2d	DNR	NA
Total—Indicator #2	DNR	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	94.45%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	59.09%	NA
MI–Adults—Indicator #3b	80.74%	NA
I/DD–Children—Indicator #3c	87.76%	NA
I/DD–Adults—Indicator #3d	94.12%	NA
Total—Indicator #3	79.74%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	83.05%	95.00%
Adults	82.89%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	94.75%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	4.66%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	92.82%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	14.38%	—
I/DD–Adults—Indicator #8b	5.28%	—
MI and I/DD–Adults—Indicator #8c	5.16%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	99.49%	—
I/DD–Adults—Indicator #9b	27.05%	—
MI and I/DD–Adults—Indicator #9c	30.59%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	12.16%	15.00%
MI and I/DD–Adults—Indicator #10b	17.50%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	14.93%	—
MI and I/DD–Adults	25.08%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	43.28%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

DNR indicates the indicator was not calculated in compliance with specifications and received a *Do Not Report* designation.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: To enhance the quality and timeliness of BH-TEDS and demographic data, in October 2020, one of **Macomb County Community Mental Health**'s subcontracted providers implemented an EHR from PCE. The subcontracted provider's new EHR integrated clinical information across the chart and included internal system edits to ensure the appropriate collection of data. Practitioners and administrative staff were also provided with a series of dashboard presentations that indicated the status of key chart areas. **Macomb County Community Mental Health** indicated that this has also enhanced patient interaction and communication due to the recent implementation of the new subcontracted provider's patient portal. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: During PSV of member records, HSAG identified one member with an elapsed time of zero minutes for Indicator #1. One additional case was reported with zero elapsed time in the member-level data that the PIHP submitted to HSAG as well. Although the two cases were determined to be compliant for Indicator #1 as they were still within the appropriate pre-admission decision time frame requirement, the zero minutes elapsed time was inaccurate, which could result in future reporting of noncompliant cases as compliant if the issue is not corrected. While not impactful to the PIHP's rates, the identified issue does suggest the potential to improve the accuracy of data used in future reporting of Indicator #1. [**Quality**]

Why the weakness exists: The PIHP indicated that this resulted from an individual staff member making a data entry error.

Recommendation: Although only two member records were identified with an elapsed time of zero minutes, HSAG recommends that in the future the PIHP conduct an additional final review of the detailed data for Indicator #1 members with zero minutes reported as the elapsed time. HSAG also recommends that the PIHP explore potential system changes that PCE could implement which may assist in preventing inaccurate data entry of the time of decision for reporting Indicator #1.

Weakness #2: HSAG noted a mismatch in numerator and denominator counts between what was reported to MDHHS and what was reported in the PIHP member-level detail file provided to HSAG for indicators #1 and #2. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** indicated that the reason behind the numerator and denominator mismatch for both indicators was due to reporting the incorrect numerator and denominator data counts from the PIHP Performance Indicator Report (i.e., reporting the combined total numerator count for adult and children for the adult population for Indicator #1 and reporting Indicator #3's numerator and denominator for Indicator #2's numerator and denominator).

Recommendation: Since there was a rate bias of greater than 5 percent for Indicator #2, the reported rates for Indicator #2 were considered to be materially biased. For future reporting, HSAG recommends that **Macomb County Community Mental Health** implement an additional validation check to ensure that the appropriate data counts and rates are data entered, and that the data entered align with the appropriate indicator and population before reporting the final rates to MDHHS.

Weakness #3: In **Macomb County Community Mental Health**'s member-level data submission to HSAG, HSAG identified that for Indicator #2 18 cases were reported with a completed biopsychosocial assessment date outside of the 14-day time frame and 96 cases with no completed biopsychosocial assessment date listed in the file, but these cases were all listed as in-compliance.

Why the weakness exists: HSAG requested that **Macomb County Community Mental Health** complete a review of the member-level data, through which the PIHP identified 87 cases that needed to be recategorized or removed from in-compliance cases, which was nearly 21 percent of the reported in-compliance case count. This was for various reasons, such as records being manually overridden and erroneously marked as in-compliance, records that should have been counted as omitted due to partial hospitalization and inpatient hospitalization, and providers using non-billable codes or claims not being submitted.

Recommendation: The PIHP indicated that it reviewed all out-of-compliance member records and 20 in-compliance member records from each PIHP-calculated indicator, as well as omissions and exclusions. However, based on the findings for Indicator #2, HSAG recommends that the PIHP implement additional validation checks to further ensure data accuracy for future reporting periods. This additional level of validation could involve thoroughly reviewing records listed in the member-level data to look for discrepancies for Indicator #2, such as biopsychosocial assessments completed outside of the 14-day time frame and no biopsychosocial assessment dates listed for records marked as in-compliance. [**Quality** and **Timeliness**]

Weakness #4: In **Macomb County Community Mental Health**'s member-level data submission to HSAG for Indicator #3, HSAG identified 11 cases with an ongoing service date reported outside of the 14-day time frame, but these cases were all listed as in-compliance cases. [**Quality** and **Timeliness**]

Why the weakness exists: HSAG requested that **Macomb County Community Mental Health** complete a review of the member-level data, through which the PIHP identified that all 11 cases needed to be recategorized or removed from in-compliance. This was for various reasons, such as records that had a non-billable follow-up service, should have been counted as omitted, or were erroneously marked as in-compliance.

Recommendation: With these cases recategorized as noncompliant or omitted, the I/DD child population had a difference in rates reported to MDHHS and the final rates calculated by HSAG greater than 5 percent. However, the difference in reported rates was not significant enough to consider the overall total Indicator 3 rate materially biased. HSAG recommends for future reporting that **Macomb County Community Mental Health** employ enhancements to its BH-TEDS validation process to ensure that the appropriate ongoing service time frames are included in the Indicator #3 data before submitting results to MDHHS.

Weakness #5: Opportunities exist for **Macomb County Community Mental Health** to improve the timeliness of follow-up care provided to adults and children after discharge from a psychiatric inpatient unit (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*), timeliness of follow-up care provided to members after discharge from a substance use detox unit (i.e., *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*), and to reduce readmissions for MI and I/DD adults to an inpatient psychiatric unit within 30 days of discharge (i.e., *#10: The percentage of readmissions of MI and I/DD adults during the quarter to an inpatient psychiatric unit within 30 days of discharge*), as the PIHP also did not meet the MPS for these indicators. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While **Macomb County Community Mental Health** indicated system enhancements were deployed in October 2020 as one of its subcontractor providers initiated a transition to a new EHR that should enhance patient interaction and improve the clinical data available to providers, the PIHP did not reliably ensure its members had timely access to appropriate follow-up care after psychiatric and substance abuse detox unit inpatient discharges. Additionally, the PIHP did not always have consistent processes in place to ensure its MI and I/DD adult members were not readmitted to an inpatient psychiatric unit.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** closely monitor adults' and children's discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of Indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*. Additionally, HSAG recommends that **Macomb County Community Mental Health** identify the root cause of the continued decrease in timely access to follow-up care for members discharged from a substance use detox unit, as the rate decreased from the prior year. Lastly, HSAG recommends that **Macomb County Community Mental Health** focus its efforts on reducing the number of inpatient psychiatric unit readmissions by working with providers on adequate discharge planning and coordination of services post-discharge.

Compliance Review

Performance Results

Table 3-39 presents **Macomb County Community Mental Health**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Macomb County Community Mental Health**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Macomb County Community Mental Health** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-39—Summary of Standard Compliance Review Scores for MCCMH

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	7	0	0	**100%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	11	3	0	**79%**
VI	Coverage and Authorization of Services	11	11	8	3	0	**73%**
Total		**65**	**65**	**53**	**12**	**0**	**82%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Macomb County Community Mental Health received a score of 100 percent in the Availability of Services program area, demonstrating the PIHP has adequate processes and monitoring mechanisms to ensure all services covered under the State plan are available and accessible to members through the delivery network, timely access standards, access and cultural considerations, and accessibility considerations. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Macomb County Community Mental Health received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Macomb County Community Mental Health received a *Not Met* score for three elements. Specifically:

- The PIHP had not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, while the MDHHS Network Adequacy Response included MDHHS' member/provider ratio standards, these standards have not been reviewed since 2018.
- While the PIHP demonstrated submission of network stability reports to MDHHS in response to the pandemic, it did not annually submit its assurances and supporting documentation to demonstrate that it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards; member/provider ratio standards; timely appointment standards; or language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Macomb County Community Mental Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Macomb County Community Mental Health received a score of 73 percent in the Coverage and Authorization of Services program area, demonstrating gaps in the PIHP's processes for processing service authorization requests and generating ABD notices. Adequate implementation of service authorization requirements is needed to ensure members receive timely and adequate notice of an ABD with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Macomb County Community Mental Health received a *Not Met* score for three elements. Specifically:

- The PIHP's ABD notices did not consistently include the appropriate action being taken; the services being denied or terminated; a clear explanation for why the services were being denied,

reduced, or terminated; and/or the legal basis/authority citations were insufficient (i.e., incorrect legal citation for the circumstances).

- The PIHP did not provide evidence to support that it had implemented processes and procedures and had an available ABD notice template and documented tracking logs for the denial of payment.
- The PIHP did not provide adequate evidence to support implementation of service authorization time frame extension requirements in alignment with federal regulations.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Macomb County Community Mental Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice requirements.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Macomb County Community Mental Health** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Macomb County Community Mental Health** across all EQR activities to identify common themes within **Macomb County Community Mental Health** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that **Macomb County Community Mental Health** generally had adequate processes to assess and coordinate care for its membership and had in place a methodologically sound PIP to support improvement in the prevalence of members being readmitted for SMI within 30 days of discharge. However, even with these efforts in place, the PIP interventions implemented appear to have had minimal impact on the study indicators for the *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness* PIP; the PIP study indicator did not demonstrate a statistically significant improvement from the baseline rate, and **Macomb County Community Mental Health** did not meet its established goals [**Quality, Timeliness**, and **Access**].

These findings are further corroborated by the PMV activity, as **Macomb County Community Mental Health** did not meet the MPS for the adult population for Indicator #10: *The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge*. Additionally, through the compliance review activity, while **Macomb County Community Mental Health** demonstrated having monitoring mechanisms to ensure all services are available and accessible to members, the PMV activity confirmed that members are not always accessing needed care and services in a timely manner as the PIHP did not meet the MPS for Indicator #4a: *The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 day*s or Indicator #4b: *The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.*

The compliance review activity also identified gaps in **Macomb County Community Mental Health**'s process for monitoring its provider network in accordance with MDHHS' network adequacy standards. **Macomb County Community Mental Health** should further enhance its network adequacy efforts to

ensure all members are able to access providers in a timely manner to receive appropriate testing and preventive care and have timely access to nonemergent mental health and SUD services in order to stay well both physically and mentally. Additionally, these efforts may potentially identify network gaps that **Macomb County Community Mental Health** could address, which could positively effect performance indicator rates [**Quality, Timeliness**, and **Access**]. However, **Macomb County Community Mental Health** demonstrated strengths within its program as it exceeded the MPS for Indicator #1. **Macomb County Community Mental Health**'s members received timely pre-admission screenings for psychiatric inpatient care [**Timeliness** and **Access**].

Macomb County Community Mental Health should analyze better performance demonstrated through improved measure rates to determine if initiatives were implemented that supported the improved outcomes and determine whether similar initiatives or interventions would be appropriate to support improvement in areas demonstrating lower performance.

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Region 10 PIHP

Validation of Performance Improvement Projects

Performance Results

Table 3-40 displays the overall validation status, the baseline, Remeasurement 1 and Remeasurement 2 results, and the PIP-designated goals for the PIP topic.

Table 3-40—Overall Validation Rating for Region 10

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Medical Assistance for Tobacco Use Cessation	*Met*	The proportion of adult Medicaid members with MI identified by the PIHP as tobacco users who have at least one medical assistance service event pertaining to tobacco use cessation during the measurement year.	6.9%	9.9% ↑	17.3% ↑	11.7%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-41 displays the interventions implemented to address the barriers identified by the PIHP using QI and causal/barrier analysis processes.

Table 3-41—Remeasurement 2 Interventions for Region 10

Intervention Descriptions	
Increased staff knowledge of tobacco effects on members' health, including higher death rate, and increased knowledge of tobacco cessation options and resources.	Developed and deployed resources to increase member knowledge and understanding of tobacco effects on health and medication assistance cessation options and resources.
Developed training for staff members. Trained staff members on assessment and interventions for medication-assisted treatment (MAT) for tobacco cessation. Developed a method for staff members to refer members served for MAT for smoking cessation.	Addressed tobacco cessation awareness/education opportunities at the weekly "Wellness Wednesday" by regularly communicating the importance of tobacco cessation, available nicotine replacement therapy (NRT) options, and that tobacco cessation services are safe and effective.
Completed a tobacco use assessment for all members served who have a serious and persistent mental illness diagnosis.	Created an agency environment that supports tobacco cessation.

Intervention Descriptions	
Facilitated the availability of community resources regarding smoking/tobacco use cessation to members served at Sanilac CMHSP.	Offered focus groups to provide support, coping mechanisms, and information regarding the dangers of tobacco use and the benefits of tobacco cessation.
Provided educational materials for, and received feedback from, those staff members who have direct contact with the members served regarding tobacco cessation and services.	CMHSP medical director/designee communicated to all CMHSP SMI programs about the opportunity for members served at the CMHSP to receive NRT at a designated clinic (clinic name redacted for privacy).
Expanded member awareness of the annual Great American Smoke-Out.	Increased member engagement with the PCP.
Implemented staff orientation and annual refresher training in the "5 A's" approach (Ask, Advise, Assess, Assist, and Arrange) to tobacco cessation by the Michigan Department of Community Health.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 PIHP met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**]

Strength #2: Region 10 PIHP achieved sustained improvement over the baseline rate for the second remeasurement period. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although no weaknesses were identified, HSAG recommends that **Region 10 PIHP** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measure Validation

HSAG evaluated **Region 10 PIHP**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of its affiliated CMHSPs.

Region 10 PIHP received an indicator designation of *Reportable* for all indicators except Indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for Indicator #2e, and SFY 2021 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Region 10 PIHP** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-42 presents **Region 10 PIHP**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 3-42—Performance Measure Results for Region 10

Performance Indicator	Rate	Minimum Performance Standard
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	99.81%	95.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children—Indicator #2a	79.71%	NA
MI–Adults—Indicator #2b	71.07%	NA
I/DD–Children—Indicator #2c	81.90%	NA
I/DD–Adults—Indicator #2d	83.02%	NA
Total—Indicator #2	74.79%	NA
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. [1]		
Consumers	67.41%	NA
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children—Indicator #3a	89.71%	NA

Performance Indicator	Rate	Minimum Performance Standard
MI–Adults—Indicator #3b	87.61%	NA
I/DD–Children—Indicator #3c	94.12%	NA
I/DD–Adults—Indicator #3d	87.50%	NA
Total—Indicator #3	88.92%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.88%	95.00%
Adults	98.33%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	95.12%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.90%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.76%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults—Indicator #8a	11.76%	—
I/DD–Adults—Indicator #8b	6.28%	—
MI and I/DD–Adults—Indicator #8c	6.70%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI–Adults—Indicator #9a	98.04%	—
I/DD–Adults—Indicator #9b	54.37%	—
MI and I/DD–Adults—Indicator #9c	61.31%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	11.67%	15.00%
MI and I/DD–Adults—Indicator #10b	10.94%	15.00%

Performance Indicator	Rate	Minimum Performance Standard
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	16.89%	—
MI and I/DD–Adults	23.93%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	47.78%	—

Indicates that the reported rate was better than the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA Indicates that an MPS was not established for the first year of implementation for this measure indicator.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 PIHP performs an additional level of validation of BH-TEDS records submitted by the CMHSPs, during which detailed records for all exception and noncompliant cases and a sample of compliant cases are reviewed and validated. [**Quality**]

Strength #2: Region 10 PIHP is continually evaluating opportunities for front-end data validation edits in MIX, the PIHP's data warehouse, and creating provider templates for reporting to reduce the amount of SUD record review and correction needed prior to MDHHS submission. [**Quality**]

Strength #3: Region 10 PIHP demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV HSAG determined that several records reported for Indicator #1 had identical start and disposition times for pre-screening, and that one record reported for Indicator #2

used the assessment service date for determining compliance when the diagnosis date was completed several days later. [**Quality**]

Why the weakness exists: CMHSP systems (Optimal Alliance Software Information System [OASIS] and Clinical Health Information Program) rely on manually entered service dates for Indicator #1 and, in some instances, have to rely on manually entered diagnosis dates for Indicator #2 (e.g., when the diagnosis is not completed on the same date as the meeting with the member). Manually entered dates can create risk when used in reporting performance indicator rates due to the potential for data entry error and/or manipulation.

Recommendation: **Region 10 PIHP** should consider working with the CMHSPs on adding a level of validation for the review of compliant records for Indicator #1 and Indicator #3 to ensure accuracy of the assessment dates and times, and the PIHP is also encouraged to consider front-end validation edits wherever possible. Additionally, **Region 10 PIHP** should consider talking with the CMHSPs about updating source code to look for the manually entered diagnosis date within the biopsychosocial assessment to ensure alignment with the MDHHS Codebook in cases when the diagnosis was completed after the assessment date.

Weakness #2: HSAG observed that there were some interpretations about compliance for Indicator #10 and exceptions for Indicator #4b that did not align with MDHHS Codebook specifications and led to incorrect reporting of some records. [**Quality**]

Why the weakness exists: During PSV, one case was reported in Indicator #4b that did not have a follow-up care service within seven days due to a disciplinary discharge from the facility. The case was reported as an exclusion but did not meet the exclusion criteria since the member did not refuse follow-up services. Additionally, in its review of the member-level data for Indicator #10, HSAG noted that one case for Lapeer CMHSP had a readmission date occurring within 30 days of discharge; however, the case was listed as noncompliant. HSAG noted that the case should not have been reported as noncompliant for Indicator #10 if a readmission had occurred within 30 days of discharge. HSAG also indicated that if the readmission was accurate, Lapeer CMHSP should have recategorized this case appropriately. HSAG requested an updated copy of the member-level detail file with the correct date and disposition for the case. Lapeer CMHSP responded within the member-level detail file that it was a State psychiatric facility, and it should never have been authorized in the system and did not change the disposition for the case. All readmissions to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit should be counted in the numerator for the indicator. Although **Region 10 PIHP** does work collaboratively with MDHHS and the CMHSPs on interpretation of MDHHS Codebook specifications and system configuration for BH-TEDS records, the communication appears to occur separately as questions come up rather than together as a group.

Recommendation: **Region 10 PIHP** is encouraged to consider having ongoing discussions and review of MDHHS Codebook specifications along with MDHHS guidance during its internally established Quality Management Committee meetings or another similar venue that includes CMHSP representation, the **Region 10 PIHP** performance indicator team, and IT/systems representatives.

Compliance Review

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Performance Results

Table 3-43 presents **Region 10 PIHP**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Region 10 PIHP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. MDHHS required **Region 10 PIHP** to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-43—Summary of Standard Compliance Review Scores for Region 10

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	15	4	0	**79%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	6	1	0	**86%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	12	2	0	**86%**
VI	Coverage and Authorization of Services	11	11	8	3	0	**73%**
Total		**65**	**65**	**52**	**13**	**0**	**80%**

M = Met; NM = Not Met; NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HSAG did not identify any substantial strengths of **Region 10 PIHP** through the compliance review activity.

Weaknesses and Recommendations

Weakness #1: Region 10 PIHP received a score of 25 percent in the Assurances of Adequate Capacity and Services program area, indicating gaps in the PIHP's processes for demonstrating the adequacy of the provider network and the range of covered services available. Evaluation of the provider network is necessary to ensure the PIHP has the capacity to serve the expected enrollment in accordance with MDHHS-set standards for access to care. [**Access**]

Why the weakness exists: Region 10 PIHP received a *Not Met* score for three elements. Specifically:

- The PIHP had not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, while the PIHP's Network Adequacy Standards Plan included MDHHS' member/provider ratio standards, these standards have not been reviewed since 2018.
- While the PIHP demonstrated regular submission of network stability reports to MDHHS in response to the pandemic, it did not annually submit its assurances and supporting documentation to MDHHS to demonstrate that it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document.
- The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards; member/provider ratio standards; timely appointment standards; or language, cultural competency, and physical accessibility.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Region 10 PIHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.

Weakness #2: Region 10 PIHP received a score of 73 percent in the Coverage and Authorization of Services program area, demonstrating gaps in the PIHP's processes for processing service authorization requests and generating ABD notices. Adequate implementation of service authorization requirements is needed to ensure members receive timely and adequate notice of an ABD with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Region 10 PIHP received a *Not Met* score for three elements. Specifically:

- Although the PIHP's template ABD notice complied with the MDHHS-mandated template language and the PIHP had a process in place to annually monitor the CMHSPs' ABD notices, HSAG found numerous issues with the ABD notices that were included as part of the case file

review. Specifically, the ABD notices did not consistently include the appropriate action being taken; the services being denied or terminated; a clear explanation for why the services were being denied, reduced, or terminated; and/or the legal basis/authority citations were insufficient (i.e., incorrect legal citation, multiple citations not applicable to the member). The ABD notices also did not comply with 42 CFR §438.10 as they did not include taglines in the prevalent non-English languages.

- Although the PIHP's ABD notice training included the denial of payment as a reason to provide the member with an ABD notice, the training did not identify the timing for when an ABD notice must be sent for this reason. Additionally, during the interview session, PIHP staff members could not adequately speak to the process for sending an ABD notice when there has been a denial of payment.
- Although the PIHP had in place a member-focused authorization time frame extension letter that included grievance rights, there was no process or procedure document that included the requirements for extending the authorization time frame when not at the request of the member, which includes the specific oral and written notification requirements.

Recommendation: In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Region 10 PIHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice requirements.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Region 10 PIHP** about the quality and timeliness of, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 10 PIHP** across all EQR activities to identify common themes within **Region 10 PIHP** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that **Region 10 PIHP**'s data analysis efforts and improvement strategies for its *Medical Assistance for Tobacco Use Cessation* PIP were appropriate as the study indicator rates demonstrated statistically significant improvement over the baseline rate and **Region 10 PIHP** exceeded its established goal. These findings demonstrate **Region 10 PIHP** has implemented successful interventions to increase the number of members who received tobacco cessation advice, and the number of members who discussed or received cessation medication or discussed or were provided cessation strategies. Smoking and tobacco use are the largest causes of preventable disease and death in the county; therefore, quitting smoking and tobacco use can save lives and improve overall health [**Quality**].

Through the PMV activity, **Region 10 PIHP** also demonstrated strengths within its program as it exceeded the MPS for all indicators with an established MPS. This confirms that **Region 10 PIHP** has effective processes in place to appropriately manage the behavioral and SUD needs of its membership. Specifically, the PIHP ensured timely pre-admission screening for psychiatric inpatient care [**Timeliness** and **Access**], ensured timely follow-up care after discharge from a psychiatric inpatient unit or substance

use detoxification unit [**Timeliness** and **Access**], and reduced readmissions after discharge from an inpatient psychiatric unit [**Quality**].

However, through the compliance review activity, gaps were identified in **Region 10 PIHP**'s process for monitoring its provider network in accordance with MDHHS' network adequacy standards. **Region 10 PIHP** should further enhance its network adequacy efforts to ensure all members are able to access providers in a timely manner to receive appropriate testing and preventive care and have timely access to nonemergent mental health and SUD services in order to stay well both physically and mentally. Additionally, these efforts may potentially identify network gaps that **Region 10 PIHP** could address, which could positively effect performance indicator rates. [**Quality, Timeliness**, and **Access**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

4. Follow-Up on Prior External Quality Review Recommendations for Prepaid Inpatient Health Plans

From the findings of each PIHP's performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Michigan Behavioral Health Managed Care program. The recommendations provided to each PIHP for the EQR activities in the *State Fiscal Year 2020 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 4-1 through Table 4-10. The PIHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-10.

Region 1—NorthCare Network

Table 4-1—Prior Year Recommendations and Responses for NorthCare

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **NorthCare Network** should reassess barriers linked to members 6 to 20 years of age and develop active interventions that can be tracked and trended to determine the impact on the study indicator outcomes. The results should be used to guide decisions for quality improvement efforts.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • Recommendations from our last validation report (October 2020) have been completed in that we addressed all partially met validation scores and general comments and provided additional information on the rationale for revising the data. We have to recognize that 2020 posed many challenges attributed to the COVID-19 pandemic and public health emergency. NorthCare's region did a tremendous job in enhancing telehealth to allow continued services to be provided in a safe manner. Each intervention has been evaluated and next steps identified. NorthCare has made the decision to continue this PIP until a statistically significant improvement is achieved; although there will be some changes in terms of qualifying codes and therefore a new baseline will be established for CY2021.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Although the improvement from Remeasurement 1 (CY2019) to Remeasurement 2 (CY2020) is not statistically significant, we did see an improvement of 2.22 percentage points over remeasurement period 1. This is not an improvement over baseline as our first Remeasurement showed a significant decrease in denominator and in percentage seen over baseline which is contributed to the COVID-19 public health emergency and stay-at-home orders. With continued guidance, services remained distant until recently. There are no identified reasons why a child did not have a follow-up service within 7 days of discharged in our HEDIS measure database, but there are reasons in the MMBPIS [Michigan's

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
Mission-Based Performance Indicator System] database. While not an exact comparison the MMBPIS data for FY21 (10/1/20 - 9/30/21) shows out of 130 total discharges for children, 10 had appointments that were cancelled, rescheduled or were no shows, one was a transfer to a different hospital and 31 were discharged out of region or chose not to follow-up with CMHSP. When individuals choose not to follow up with the CMHSP, CMHSP staff attempt to ensure individuals have an appointment as part of the discharge planning process but have no ability to monitor whether they attend. This equals just over 32% of total discharges that were not seen within 7 days of discharge due to consumer/guardian/parent choice or circumstances. Additionally, there were 14 children that were discharged to the CMHSP for follow up and were provided a follow up service within 7-days but the service they were provided was not a HEDIS qualifying code. This accounts for another 10.8% of total discharges for children. These services are important services in the mental health world, are conducted face-to-face, and make clinical sense to be provided as the first appointment post-discharge to ensure quality and continuity of services.
c. Identify any barriers to implementing initiatives: • Lack of follow through from parent/guardian despite engagement efforts. • Due to utilization of HEDIS specifications for this project, a number of face-to-face follow-up services are not counted due to HEDIS non-qualifying codes. • The issue of recruitment and retaining qualified staff is an ongoing issue. We were hopeful that the new master's level social work program through Northern Michigan University would provide opportunity to improve staffing levels; however, it takes time for new social workers to get licensed and to obtain the CMHP [Certified Mental Health Professional] certification required to serve children. Since June of 2021, a total of 12 new social workers with the CMHP credential were hired for all departments within the respective CMHSPs. However, 8 credentialed staff left CMH [community mental health] employment during this same period. Although this is a net gain of 4 staff, they are not all specific to crisis and follow-up services.
HSAG Assessment: HSAG determined that **NorthCare Network** partially addressed the prior year's recommendations. While the PIHP quantified potential reasons for member noncompliance with receipt of a follow-up visit, the SFY 2021 reviews identified continued opportunities for improvement related to the PIHP's implementation of improvement strategies. Although improvement was not demonstrated for its members ages 6 through 20 years, the PIHP maintained the same interventions implemented in the prior year. The PIHP determined that the interventions indirectly impacted the study indicators and were difficult to evaluate for effectiveness. As such, HSAG recommends that **NorthCare Network** develop active targeted interventions that can be tracked and trended to determine each effort's impact on the study indicator outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • The PIHP mentioned exploring the option of allowing institutional providers to enter claims directly into its electronic health record (EHR), which is not currently set up for 837 file uploads. **NorthCare Network** should work toward allowing inpatient services to be directly entered by institutional providers into its EHR system in order to increase the completeness and accuracy of claims and encounter data. **NorthCare Network** staff members should continue to validate and ensure the accuracy of reported data for all performance indicators and provide sufficient oversight of its CMHSPs.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • NorthCare Network's Systems Analyst and Claims Processing staff continue to work with our EHR vendor, PCE Systems, to expand the use of our current Claims Management and Accounts Payable system to include entry and adjudication of the UB-04 [claim form] and accept electronic uploads of the 837 inpatient/institutional claims. • In response to validation of performance indicator data, NorthCare's QI Coordinator continues to meet quarterly with each CMHSP PI [performance indicator] representative to ensure accurate and complete reporting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • PCE systems will begin building the necessary logic to attain this goal in November 2021, with the estimated time of completion to be no later than April of 2022. • In terms of accuracy of PI reporting, NorthCare has begun reporting PIHP level data, as calculated in the PI module for the region, versus rolling up the CMHSP data into a regional report. This will provide a more accurate picture at the PIHP level but will not match data reported for Medicaid recipients by the CMHSPs. Reporting the PIHP level data began with Q3FY21 PI reporting.
c. Identify any barriers to implementing initiatives: • There are no barriers to completing and implementing the claims data entry and electronic upload in NorthCare Network's EHR for the inpatient/institutional claims. • There are no barriers noted for PI reporting.
HSAG Assessment: HSAG determined that **NorthCare Network** partially addressed the prior year's recommendations. While **NorthCare Network** has put forth effort to work with PCE systems to expand its claims system functionality to allow direct entry of inpatient services, the updates were not implemented for the SFY 2021 audit and will not be fully completed for the SFY 2022 audit. As such, when the updates are completed (projected for April 2022), HSAG recommends that **NorthCare Network** evaluate the impact of the updates on the quality and completeness of inpatient services claims data to ensure timely identification of any further potential updates for future reporting. Regarding the prior year's recommendation to validate and ensure the accuracy of reported data for all performance indicators, during the SFY 2021 audit, HSAG identified a difference in data counts and rates between the member-level data provided to HSAG and the final reported rates to MDHHS, indicating that there continues to be room for improvement in ensuring the accuracy of reported data. While **NorthCare Network** was able to later provide copies of the detailed data for the PIHP Medicaid beneficiaries that aligned with the data reported to MDHHS, HSAG recommends that **NorthCare Network** continue to work toward fully addressing the prior year's recommendation and SFY 2021 recommendation by implementing an additional level of validation to ensure future member-level data provided to HSAG align with the final reported rates to MDHHS for all performance indicators. **NorthCare Network** fully addressed the prior year's recommendation to provide sufficient oversight of its CMHSPs. During first quarter SFY 2019, **NorthCare Network** started conducting quarterly audits of randomly selected services, in addition to annual on-site desk audits that occurred in years prior, for each

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
CMHSP and SUD provider. Additionally, during the SFY 2021 audit, HSAG determined that **NorthCare Network** had sufficient oversight of its five subcontracted CMHSPs. All CMHSPs were required to follow the same operating procedures outlined by the PIHP. The PIHP and CMHSPs effectively participated in a collaborative effort on finding solutions, if an issue occurred, and worked together through process improvements and changes, when necessary.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **NorthCare Network** should revisit its procedures for generating adverse benefit determination (ABD) notices. UM staff members should be reeducated on the appropriate inclusion of the specific policy, authority, or criteria that supports the ABD. HSAG does not recommend that ABD notices include multiple citations or references, but instead, the ABD should include specific criteria used by UM staff that supports the denial of the service. **NorthCare Network**'s UM and claims departments collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Over the course of July 11, 2019 to present a statewide ABD workgroup met to discuss changes to the ABD notice. The ABD Notice underwent its first changes via the statewide workgroup's decisions into the training system on August 9, 2019. It went live on August 28, 2019. It has been undergoing revisions ever since, including making the taglines a larger font (completed) and adding Substance Use Disorder options for those providers. Everyone using PCE's standard ABD notice will have the same notice in their system. The legal authority references were decided upon by the workgroup. However, the ABD notice has a large text box for staff to further clarify or indicate the legal authorities that apply to the reason for the notice. A PowerPoint presentation regarding the changes to the ABD notice and how to complete the notice was created on January 23, 2020 and made available to the region for training on January 28, 2020. This training was updated on March 4, 2021 and was made available to the region on March 22, 2021. Following the recent changes in July, NorthCare created another PowerPoint training, as well as an ABD Notice Help Guide (October 2021) for providers and is in the process of recording a training on completion of the ABD notice within the Electronic Medical Record (EMR). This training, in addition to the Help Guide, will be available for anyone who has access to the EMR to reference at any time starting in November 2021.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA
c. Identify any barriers to implementing initiatives: • The ABD notice is a State specific form which has been incorporated into our PCE electronic health record. The ABD has been standardized across all PCE clients and therefore takes a longer time to update, test and implement. The statewide PCE workgroup developed the matrix used to determine

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
what legal authority pulls into the ABD for the specific reason. When there are multiple authorities, they all do pull into the ABD notice. Users have the ability to add or clarify in a text box.
HSAG Assessment: HSAG determined that **NorthCare Network** partially addressed the prior year's recommendations. While **NorthCare Network** has engaged in efforts to address HSAG's recommendation, the SFY 2021 compliance review activity confirmed there are continued opportunities for improvement in creating ABD notices as they did not consistently include the services that were requested and subsequently denied or terminated, a clear explanation for the action, and/or legal basis/authority citations were not applicable to the member and the services being requested. **NorthCare Network** has implemented action plans after the SFY 2021 compliance review activity to address the deficiency; however, it is unknown to HSAG if these actions have led to enhanced compliance with ABD notice content. As such, HSAG recommends that **NorthCare Network** mandate continued periodic (e.g., quarterly) staff training for developing ABD notices and a review of a random sample of ABD notices. **NorthCare Network** should complete a review of its CMHSPs to determine if there are lower- or higher-performing organizations. **NorthCare Network** could consider enhanced oversight of lower-performing CMHSPs and mandate a quality assurance and accountability process; for example, requiring that every ABD notice is reviewed and approved by management prior to being mailed to the member. Through its oversight and monitoring processes, **NorthCare Network** should consider sharing examples of good and poor ABD notices with all CMHSPs during joint operating meetings.

Region 2—Northern Michigan Regional Entity

Table 4-2—Prior Year Recommendations and Responses for NMRE

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Northern Michigan Regional Entity** should develop evaluation methods for each intervention to demonstrate their effectiveness on the study indicator outcomes and guide decisions for quality improvement efforts. **Northern Michigan Regional Entity** should conduct a root cause analysis to identify the reasons for the decrease in performance rates.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • The internal quality team reviewed each case that was in the denominator but not in the numerator. Then the 5 whys were utilized to drill down during the RCA [root cause analysis] to determine the reasons for each case not meeting the indicator. A review of the interventions was compared to the reasons for the noncompliance to determine if there was any improvement or shift in the reasons for noncompliance. – **Intervention Priority 1:** Reminder calls are completed per psychiatric clerical staff for every appointment. It was recommended that the psych clerical staff receive refresher training regarding the need for follow up appointments to be scheduled within 30 days because 35 or 36 days later will be out of compliant. Overall, it appears that these measures have been effective as only 3 or 4 were scheduled outside of the 30-day window. Staff will contact the Psych Program Director to discuss additional strategies to address the concerns so she can address this with her staff**.** – **Intervention Priority 2:** This did not seem to be a reason for many being missed, so the intervention continues to be successful. – **Intervention Priority 3:** This is still an issue, but most of the medications prescribed was by non-CMH doctors and consumer would have had to follow up with that doctor as there was no overlap between the consumer being seen by the CMH and the prescription follow up time frame. Therefore, there is still an opportunity for improvement. The CMHSPs continue to make efforts to collaborate with the PCPs [primary care physicians] to improve follow up care. – **Intervention Priority 4:** This did not seem to be a concern or a reason why individuals were on this list this time, so the intervention continues to be successful. – **Intervention Priority 5:** Coordination of Care with Primary Care Physicians: This is an ongoing intervention as it remains a challenging barrier to resolve.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At a previous review it was recommended that family should be educated on the importance of obtaining scripts in a timely fashion for children prescribed with ADHD medication. This continues to be done by staff and it appears effective.
c. Identify any barriers to implementing initiatives: • The barriers were broken down into the following five categories:

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
– Unable to distinguish between Crisis or Assessment – Can't control client no show – Client was not open to the CMH at the time medication was prescribed so had no information about the client. – Lack of care coordination between CMH and prescribing physician – Provider did not follow HEDIS Prescribing procedure
HSAG Assessment: HSAG determined that **Northern Michigan Regional Entity** partially addressed the prior year's recommendations. The SFY 2021 reviews identified continued opportunities for improvement related to its implementation of improvement strategies. The PIHP indicated some interventions were effective as the plan determined the corresponding barriers to each of those interventions were not barriers to care. **Northern Michigan Regional Entity** used appropriate QI tools to identify and prioritize barriers and implemented interventions that may reasonably impact the study indicators; however, the PIHP did not develop evaluation methods to demonstrate each intervention's effectiveness or determine each effort's next steps. As such, HSAG recommends that **Northern Michigan Regional Entity** focus on the implementation of interventions to address existing barriers to care and develop active targeted interventions that can be tracked and trended to determine each effort's impact on the study indicator outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Northern Michigan Regional Entity** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicator #4a. • **Northern Michigan Regional Entity** should implement additional training for Substance Use Disorder (SUD) providers on clear documentation of exclusions and exception reasons for Indicator #4b. **Northern Michigan Regional Entity** should complete additional validation checks on reported exceptions for Indicator #4b.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • MDHHS was able to provide some more details on exception criteria which was shared with the CMHSPs quality and compliance committee membership. MDHHS also hosted a workgroup that members from the Region attended. The session included review of exception criteria for indicator 4a. MDHHS provided details around selection methodology and exception methodology. The CMHSPs are using this knowledge the improve their process. • The Northern Michigan Regional Entity did not implement a formal training for all Providers on clear documentation of exclusions and exception reasons for Indicator #4b, but there were one on one instructions with Providers that are completing Detox Discharges and what was required and what the fields meant. There were conversations with each Contracted Detox Provider on how to correctly fill out the Discharge and what the exclusions and exception reasons are for this Standard and what documentation is needed. These trainings will continue to be on-going, on an "as-needed" basis, when issues are found in the review of quarterly data. The NMRE has also updated the process for reviewing

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Performance Indicators for #4b, and now each "exception" and "out-of-compliance" item is reviewed and validated before finalization of the PI report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Details provided by MDHHS around indicator 4a was shared with CMHSPs quality and compliance committee members for review and process improvement. • As a result of the initiatives applied to improve indicator 4b, the numbers for this indicator has improved even above the statewide numbers.
c. Identify any barriers to implementing initiatives: • There were no barriers implementing the trainings, However, high staff turnover makes it challenging for the training to remain effective because information sharing/transfer is not very effective.
HSAG Assessment: HSAG determined that **Northern Michigan Regional Entity** partially addressed the prior year's recommendations. While **Northern Michigan Regional Entity** has engaged in efforts to address HSAG's recommendation, the SFY 2021 audit confirmed there are continued opportunities for improvement. Based on the prior year's recommendations, **Northern Michigan Regional Entity** provided informal training to providers on the specifications for Indicator #4b and how to properly identify exceptions. **Northern Michigan Regional Entity** also continued to check members for all indicators that were marked as exceptions or out of compliance. Additionally, it checked a portion of those members marked as in compliance. However, during the PSV portion of the review for Indicator #4b, clear documentation of an exception within RECON, the PIHP's EHR system, was not available (i.e., member no-showed to appointment). As such, to further improve the accuracy and completeness of the PIHP's performance measure indicator data, HSAG recommends that **Northern Michigan Regional Entity** continue to provide ongoing training to its SUD providers regarding proper documentation of exclusions for Indicator #4b.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Northern Michigan Regional Entity** should revisit its procedures for generating ABD notices. UM staff should be reeducated on the appropriate inclusion of the specific policy, authority, or criteria that supports the ABD and the inclusion of the specific reason why a member did not meet criteria. HSAG does not recommend that ABD notices include multiple citations or references, but instead, the specific criteria used by UM staff that supports the denial of the service. Additionally, **Northern Michigan Regional Entity** should prioritize the review of the CMHSP that had outdated and inaccurate information in its notice and take action as appropriate. **Northern Michigan Regional Entity**'s UM and claims departments should collaborate to develop a process to generate an ABD notice when a payment on a claim is denied. • **Northern Michigan Regional Entity** should develop a standardized template for Critical Incidents (CIs), Sentinel Events (SEs) and Risk Events (REs), and data from the Behavioral Treatment Committee (BTC); and mandate their use across all reporting entities (i.e., CMHSPs, SUD providers, etc.). Further, **Northern Michigan Regional Entity**'s analysis and subsequent interventions should focus on data elements that have the greatest potential to impact member care and outcomes. The results of the analyses and any subsequent actions should be included in **Northern Michigan Regional Entity**'s committee meeting minutes. • **Northern Michigan Regional Entity** should review contract and federal regulations for all activities that are required to be included in a Quality Assessment and Performance Improvement Program (QAPIP).

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
Northern Michigan Regional Entity should develop a comprehensive work plan that identifies measurable goals and objectives, interventions, time frames, and the responsible person or department for each activity. Each activity should be addressed in the annual effectiveness review of the QAPIP and include an evaluation of **Northern Michigan Regional Entity**'s progress on meeting its performance goals.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The NMRE and its Network Providers have been shifting towards utilizing the Notice of Adverse Benefit Determination template included in the current MDHHS-PIHP Contract Attachment P6.3.1 Exhibit A. This document was already in use by some providers on September 2019 when HSAG site review team was onsite, however records reviewed from previous time period did not reflect this. Also, not every provider had fully implemented this form. • The NMRE has so far never had a reason to deny payment for services that were previously authorized. However, if that ever happens, there is a policy and procedure on how to notify the provider and the client. • On the CMHSP side, NMRE continues to monitor their policies and procedures to ensure they have language around how and when to notify the client when a claim is denied. • The NMRE is now able to track service authorization requests by running a report and once the request is open for 14 days; for standard request or 72 hours; for expediated request, the request is denied, and a notification is sent to the requester. • Standardized templates have been created for Critical Incidents (CIs), Sentinel Events (SEs) and Risk Events (REs). These templates have been implemented. Data received from the various CMHPs are reviewed at the Quality Operations Committee (QOC) meeting. Data from BTC is also reviewed at the QOC meeting quarterly by members of the Compliance and Quality Department from the NMRE, the CMHSP compliance and Quality representatives and SUD provider network representatives. During this review, trends are identified and discussed. This information will be documented in the QOC meeting minutes. • A QAPIP work plan has been developed. This workplan was reviewed and approved by the QOC and the Board of Directors to ensure that it meets contractual requirements. The work plan includes SMART goals, and it is being updated annually. The progress from the QAPIP can be found in the QAPIP annual report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Once the new ABD form is fully implemented by all providers there will be standardization across the board which will lead to better quality data. • Discussing the data from the CIs, SEs and REs reports allows room for members to learn from each other and improve their various processes.
c. Identify any barriers to implementing initiatives: • The Initial form received from MDHHS was incorrect. • Once the form was corrected, it was not mandatory therefore providers had variations of language in the form. Moving forward, the MDHHS standardized from will be required for every provider through the electronic health system (PCE).

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• There has been a long delay in implementing the form in PCE (the electronic health system) because PCE is a third-party vendor, and their priorities are different. • NMRE never denies any claims for services that have been provided. However, a policy and procedure has been developed if this ever happens. • Getting all the CMHSPs onboard with standardized templates came with some push back and a delay in implementation.
HSAG Assessment: HSAG determined that **Northern Michigan Regional Entity** partially addressed the prior year's recommendations. While **Northern Michigan Regional Entity** has engaged in efforts to address HSAG's recommendation, the SFY 2021 compliance review activity confirmed there are continued opportunities for improvement in creating ABD notices as they did not consistently include the appropriate action being taken; the services that were requested and subsequently denied, reduced, suspended, or terminated; a clear explanation for why the services were being denied, reduced, suspended, or terminated; sufficient legal basis/authority citations (i.e., incorrect legal citations, multiple citations not applicable to the member); accurate appeal rights and procedures; a clear process for filing an expedited appeal; allowance for the member to request documents related to the ABD; and/or incorrect continuation of benefits language. As such, HSAG recommends that **Northern Michigan Regional Entity** mandate periodic (e.g., quarterly) staff training for developing ABD notices and conduct a random sample of ABD notices. **Northern Michigan Regional Entity** should complete a review of its CMHSPs to determine if there are lower- or higher-performing organizations. **Northern Michigan Regional Entity** could consider enhanced oversight of lower-performing CMHSPs and mandate a quality assurance and accountability process; for example, requiring that every ABD notice is reviewed and approved by management prior to being mailed to the member. **Northern Michigan Regional Entity** should also prioritize full implementation of the most recent version of the MDHHS-mandated ABD notice template. Through its oversight and monitoring processes, **Northern Michigan Regional Entity** should consider sharing examples of good and poor ABD notices with all CMSHPs during joint operating meetings. **Northern Michigan Regional Entity** should also confirm its contract requirements with PCE, a paid vendor of the PIHP, for timeliness standards or requirements for system updates. Additionally, **Northern Michigan Regional Entity** has indicated it has never had a reason to deny payment for services that were previously authorized. However, if the PIHP authorized the services, it would be appropriate not to deny payment. **Northern Michigan Regional Entity** should consider instances wherein services have not been authorized, as it may be appropriate to deny payment on a claim; for example, from an out-of-network or non-Medicaid enrolled provider, or for a service determined to be not medically necessary. Regarding CIs, SEs, and REs, and the QAPIP, **Northern Michigan Regional Entity** appears to have addressed HSAG's recommendations; however, performance improvement as a result of **Northern Michigan Regional Entity**'s interventions will be assessed during future compliance reviews.

Region 3—Lakeshore Regional Entity

Table 4-3—Prior Year Recommendations and Responses for LRE

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • As **Lakeshore Regional Entity** progresses into the second remeasurement, the PIHP should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The LRE [scored 100% in 2019, 95% in 2020 and 91% in 2021. For 2019 and 2020 LRE received a "Met" Score, however for 2021 LRE received a "Not Met" Score, as statistically sustained improvement was not met. • One of the HSAG recommendation stated the PIHP should use the most updated version of the HEDIS specification as appropriate for the measurement period. This recommendation was incorporated into the 2021 report. – Zenith Technology Solutions (ZTS) updated the HEDIS Diabetes Monitoring SMD [Diabetes Monitoring for People With Diabetes and Schizophrenia] specifications from the 2019 specifications to the 2021 specifications in early August 2021. – ZTS regenerated the data used for the PI Project on 8/9/2021. The 2021 specifications did positively affect the data for the PIP. The number of individuals meeting the criteria for the PIP increased from 355 reported in June using the 2019 specifications to 455 using the 2021 specifications. – The main difference between versions, is that the 2019 specifications only allowed one telehealth visit with determining the eligible population for the PIP, where the 2021 specifications changed this restriction.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • The main barrier in the HEDIS Diabetes Monitoring SMD PIP continues to be COVID-19. The number of individuals who met the criteria for this LRE PIP decreased due to COVID-19, as many individuals did not want to go their doctor or get lab work because they did not want to take the chance of being exposed to COVID-19.
HSAG Assessment: HSAG determined that **Lakeshore Regional Entity** addressed the prior year's recommendations. The PIHP used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The PIHP continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to mitigate future reporting issues, **Lakeshore Regional Entity** should oversee the successful implementation of required CMHSP corrective action to ensure complete and accurate performance indicator data in the future. This oversight process should ensure appropriate data entry controls are in place to prevent inaccurate manual entry of dates that are used for performance indicator reporting. • **Lakeshore Regional Entity** and the CMHSPs should employ enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in non-competitive workforce and minimum wage status values. **Lakeshore Regional Entity** and the CMHSPs should continue to perform enhanced data quality and completeness checks before the data are submitted to the State. • Due to the varied level of CMHSP readiness to leverage EHR documentation in reporting the new indicators, **Lakeshore Regional Entity** should conduct additional intensive monitoring efforts to oversee the first year of reporting for all three new indicators. • **Lakeshore Regional Entity** should enhance its oversight processes to ensure that accurate enrollment dates are stored within the CMHSPs' systems for the purposes of measure reporting. Additionally, **Lakeshore Regional Entity** should retain the exact member-level detail data that was used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Lakeshore Regional Entity**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • MDHHS provided a complete BHTEDS [Behavioral Health Treatment Episode Data System] training and Q&A [question and answer] session for LRE on August 3, 2021. It was attended CMHSP staff, both administrated and clinical as well as provider staff who are responsible for BHTEDS. • LRE has created a Regional BHTEDS Workgroup which is scheduled monthly, and the meeting occurs if there are material items for discussion or review. • LRE added additional reports by the Beacon data analytic and reporting team which measures the BHTEDS along a variety of dimensions. These reports help to identify areas for improvement and track progress in achieving those improvements. • LRE staff have implemented a more intensive monitoring effort to oversee the three new MMBPIS Indicator data reported by the CMHSPs. – CMHSPs are required to code all cases out of compliance for both indicators 2 and 3. ▪ These cases and reasons for out of compliance are aggregated for the Region per quarter and reviewed and monitored for trends/ issues.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
– For indicator 2e, a submission form was developed which includes information on all individuals requesting SUD services during the reporting quarter. This data is compared to the BH TEDS data to ensure needed BH TED's records have been completed/ submitted as required. • LRE does retain the member-level data that was used for the final performance indicator rate. Any duplicate cases, or individuals without Medicaid which show up as omissions in this file will be removed prior to future submission to HSAG, this should ensure that the data matches exactly to the data used to calculate the indicators.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improvement noted in the BH TEDs submission rate, accuracy, and completeness.
c. Identify any barriers to implementing initiatives: • CMHSPs are using different EMR systems. Progress is currently being made, as HealthWest is in the process of implementing a PCE Systems EMR application. This will mean 3 of the 5 CMHSPs will be using PCE.
HSAG Assessment: HSAG determined that **Lakeshore Regional Entity** partially addressed the prior year's recommendations. While **Lakeshore Regional Entity** has engaged in efforts to address HSAG's recommendations, the SFY 2021 audit confirmed continued opportunities for improvement in some areas. **Lakeshore Regional Entity** was able to partially address HSAG's recommendation to make enhancements to **Lakeshore Regional Entity**'s BH-TEDS validation process to ensure no discrepant data are entered. During the SFY 2021 audit, **Lakeshore Regional Entity** indicated that it held quarterly quality meetings to discuss monthly and quarterly reporting with the CMHSPs and reviewed BH-TEDS to encounters comparisons. These comparisons included reports identifying where records exist within BH-TEDS without corresponding encounters or encounters that do not have corresponding BH-TEDS records. Though the errors noted in BH-TEDS data were minimal and had no impact on the final rates, **Lakeshore Regional Entity** still has opportunities for improvement in this area, and this recommendation remains in place for future reporting. **Lakeshore Regional Entity** was able to fully address HSAG's recommendation to oversee successful implementation of a required CMHSP corrective action to ensure complete and accurate performance indicator data in the future. **Lakeshore Regional Entity** successfully fully addressed the recommendation by implementing a CAP, which appeared to be effective as no issues were identified for the CMHSP during the SFY 2021 audit. **Lakeshore Regional Entity** was able to fully address HSAG's recommendation for intensive monitoring efforts to oversee first-year reporting of the new performance indicators. **Lakeshore Regional Entity** confirmed this recommendation as fully addressed based on its performance indicator monitoring processes that were implemented throughout SFY 2020 and SFY 2021. **Lakeshore Regional Entity**'s intensive oversight was most clearly demonstrated through its Indicator #2e reconciliation process and its BH-TEDS report monitoring steps in place with its CMHSPs. **Lakeshore Regional Entity** was able to fully address HSAG's recommendation for the PIHP to provide greater oversight to ensure accurate enrollment dates were stored in the CMHSPs' systems for performance measure reporting. This recommendation appeared to be fully addressed based on the reporting enhancements put in place to reconcile enrollment data appropriately. Additionally, during PSV of data during the SFY 2021 audit, HSAG determined that all enrollment dates appeared to be accurately retained within the CMHSPs'

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
systems. **Lakeshore Regional Entity** indicated its oversight process included quality checks on all data provided by the CMHSPs prior to submitting data to MDHHS. **Lakeshore Regional Entity** performed a spot check of members for each CMHSP for each indicator. **Lakeshore Regional Entity** also conducted quarterly MMBPIS meetings on the fourth Wednesday of the quarter, wherein the PIHP and CMHSPs reviewed the performance indicator reports prior to submission to the State.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Lakeshore Regional Entity** should revisit its procedures for generating ABD notices and reeducate staff on the appropriate citation(s) required to be included in a notice, and when a notice must be generated and sent to a member when **Lakeshore Regional Entity** fails to plan timely. **Lakeshore Regional Entity**'s UM and claims departments should also collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Beacon Health Options presented an ABD training with all five CMHSPs in February 2021. – Discussed the need for ABD notices meeting specific State and Federal requirements including timeframes. – Member Denial Statements. – Service Authorization decisions not reached within 14 days for standard request, or 72 hours for an expediated request. – Appeal Resolution Notice Content. – Member Oral Appeals Request.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All five CMHs are now using the correct MDHHS required ABD notice, which includes all required information.
c. Identify any barriers to implementing initiatives: • Some contracted Providers are still not always using the correct ABD notices. It is the responsibility of the contract managers at the CMHSPs to train / in-service the contracted providers on the correct ABD process and correct forms. The PIHP is monitoring for any obsolete forms and any discovered are sent back to the CMHSP contract manager to retrain the affected provider.
HSAG Assessment: HSAG determined that **Lakeshore Regional Entity** partially addressed the prior year's recommendations. While **Lakeshore Regional Entity** has engaged in efforts to address HSAG's recommendation, the SFY 2021 compliance review activity confirmed there are continued opportunities for improvement in creating ABD notices as they did not consistently include state-mandated template language; the appropriate action being taken; a clear explanation for why the services were being denied, reduced, or terminated; and/or the legal basis/authority citations were insufficient. Additionally, one case did not demonstrate that an ABD notice was sent to the member, and only two ABD notices complied with 42 CFR

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
§438.10 by including taglines in the prevalent non-English languages. Also, the PIHP did not adequately demonstrate that a timely ABD notice is sent for services that were terminated, suspended, or reduced. As such, HSAG recommends that **Lakeshore Regional Entity** mandate periodic (e.g., quarterly) staff training for developing ABD notices and conduct a random sample of ABD notices. **Lakeshore Regional Entity** should complete a review of its CMHSPs to determine if there are lower- or higher-performing organizations. **Lakeshore Regional Entity** could consider enhanced oversight of lower-performing CMHSPs and mandate a quality assurance and accountability process; for example, requiring that every ABD notice is reviewed and approved by management prior to being mailed to the member. Through its oversight and monitoring processes, **Lakeshore Regional Entity** should consider sharing examples of good and poor ABD notices with all CMSHPs during joint operating meetings. Additionally, while **Lakeshore Regional Entity**'s response did not specifically address its process to generate an ABD notice when a payment on a claim is denied, the SFY 2022 compliance review activity supported that **Lakeshore Regional Entity** had implemented such a process. However, **Lakeshore Regional Entity**'s Claim Denial ABD Process policy included some inaccurate information; therefore, HSAG recommends that **Lakeshore Regional Entity** review this policy in detail and make any necessary corrections.

Region 4—Southwest Michigan Behavioral Health

Table 4-4—Prior Year Recommendations and Responses for SWMBH

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Southwest Michigan Behavioral Health** should reassess barriers for individuals served both by, and outside of, the CMHSPs (i.e., MHPs) and develop appropriate and active interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Intervention 1: "In absence of integration, SWMBH now sends regular enrollee lists of individuals qualifying for SSD [Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications] in MY [measurement year] with and without screenings. • Remeasurement 2 update: We continue to send monthly reports, with drill-down capacity to the individual level, to the CMHs." • Intervention 6: "SWMBH has instituted outreach targeting people served via Medicaid Health Plans ('MHPs') in lieu of Community Mental Health Service Plans (CMHSPs), including direct consumer mailing and phone calls encouraging them to receive HbA1c or fasting blood glucose screenings, and mailing/phone calls to primary care and/or prescribing behavioral health providers encouraging them to arrange screenings for said individuals. SWMBH initiated contact and coordinated with MHPs, requesting updated addresses, phone numbers, and alternative methods of member/provider engagement when needed. Furthermore, some MHPs stated they would also have their care coordinators reach out to the list of individuals we provided to them as eligible for the measure but not met." • "Interventions (#s 1 and 6) were in force during Remeasurement Period 2. • Intervention 1: SWMBH emailed monthly enrollee lists to CMHs' point persons for the project, indicating which individuals served by the CMH were in need of diabetes screening. Most CMHs handled the lists in their medication clinics, by encouraging individuals to be screened when they presented for their appointments. Email lists were sent twelve times, to each of the eight CMHs in the region. This practice had the effect of boosting diabetes screening rates for CMH-served individuals from Baseline to Remeasurement 1 by 1.7 percentage points (from 77.5% to 79.2%), but in Remeasurement 2, rates of diabetes screening declined for both subgroups, CMH-engaged and Not CMH-engaged, to 69.8% and 70.0%, respectively. Given the aforementioned COVID effect, the efficacy of Intervention 1 is an even greater challenge now than it was during Remeasurement Period 1. However, given that these enrollee lists were still the primary source of enrollee SSD information for CMH personnel during Baseline Period 2, one could infer that the intervention's impact on the Remeasurement Period 2 SSD measure rate remained positive. • Intervention 6: Screening process for persons not served by the CMH system. • SWMBH had made great strides in addressing screening utilization among persons unengaged with CMH's through targeted direct mail campaign and phone-calls. Mail-outs were prepared and mailed by

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
SWMBH personnel, and MHPs assisted in providing PCP information and accurate phone numbers/addresses." b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • SSD measure performance for calendar year 2020, 69.9% (2085/2984) was well below the rates observed during the Baseline Period and Remeasurement Period 1. This decrease from the Baseline Rate is statistically significant at an alpha level of 0.05 (chi-square test; p = 0.0234). This was partly a function of SWMBH having provided a reduced number of screenings relative to Baseline and Remeasurement Period 1, and partly due to the increased measure denominator sizes observed during Remeasurement Period 2." • Regarding MHP-oriented (i.e., CMH-unengaged) individuals, such improvement occurred that the measure performance for this population actually surpassed measure performance among CMH-engaged individuals: 70.03% (694/991) of CMH-unengaged individuals included in the Remeasurement Period 2 denominator received one or more glucose or HbA1c screenings, whereas 69.79% (1391/1993) of CMH-engaged individuals did. Thanks to SWMBH and MHP joint efforts, there is now no longer a significant difference between CMH-engaged and CMH-unengaged rates by any metric (chi-square test; p = .9797). Furthermore, the decrease experienced by the CMH-unengaged rate between Remeasurement Periods 1 and 2 was not statistically significant at an alpha level of 0.05 (chi-square test; p=.2584), whereas the decrease in the CMH-engaged rate was (chi-square test; p = 0.0044). c. Identify any barriers to implementing initiatives: • The COVID-19 pandemic had the effect of depressing service utilization in general across Region 4 (alongside countless other parts of America), including utilization of glucose and HbA1c tests. Despite the lack of improvement observed during Remeasurement Period 2, SWMBH will continue Interventions 1 and 6 going forward, as there is evidence to suggest that both have a beneficial effect on the SSD measure rate. Furthermore, the logic SWMBH uses to assign MHPs to individuals in the SSD measure denominator has been improved, and going forward, it is likely that Intervention 6 will have an even stronger effect on the SSD measure rate. It is SWMBH's belief that once these interventions are applied during a measurement period not overlapping with the COVID pandemic, these efforts would be sufficient to meet the measure goal of 80%.
HSAG Assessment: HSAG determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations. The PIHP used appropriate QI tools to identify and prioritize barriers and developed interventions to target members served by, and external to, its CMHSPs. The interventions implemented were appropriate and could reasonably impact the study indicator outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Southwest Michigan Behavioral Health** and its CMHSPs should employ enhancements to the recently implemented validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered. This validation process should account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system, data entry errors, and discrepancies in non-competitive workforce and minimum wage status values. **Southwest Michigan Behavioral Health** and its CMHSPs should also clearly define the processes for entering the data into the PIHP's EMR and perform additional data quality

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
and completeness checks beyond the state-specified requirements before the data are submitted to the State. Further, **Southwest Michigan Behavioral Health** should implement additional validation processes and procedures to ensure the accuracy of reported data for all performance indicators and ensure there is sufficient oversight of its CMHSPs and continuous monitoring of CAPs. • Upon identification of a data integrity risk in the existing process, **Southwest Michigan Behavioral Health** immediately requested a CAP of the CMHSP to remedy the deficiency related to not recording a disposition date in the pre-admission screening field. The CMHSP indicated that it will be adding signature validations to disallow unpopulated data in the pre-admission screening field. **Southwest Michigan Behavioral Health** should monitor and verify the CMHSP CAP to ensure completeness of the information being captured for future reporting. • **Southwest Michigan Behavioral Health** should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Southwest Michigan Behavioral Health**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • Southwest Michigan Behavioral Health and its CMHSPs will work to identify additional technical and procedural changes to ensure that assessments entered into the CMHSP's EMRs will align with the BH TEDS records entered into the PIHP's EMR. In addition to the 1300 edits developed by the State of Michigan the following validations developed by SWMBH in the PIHP system check for quality and completeness: – Actively Served MH Clients with No Annual BHTED Update – Client ID not found in Client Registry – Exact key duplicate episode - picked as tie-break loser – Inactive MH clients with non-discharged BH TEDS episode – Inactive SUD clients (at least 45 days) with non-discharged BH TEDS episode – Invalid submission route – Invalid value for Client Transaction Type - D record must have a A admission – Invalid value for Client Transaction Type - E record must have a M admission – Invalid value for Client Transaction Type - U record must have a M admission – Mental Health Episodes are not reportable in SWMBH Smartcare – Non-opioid SUD episode open for one year with no treatment – Not a valid client – Not the definitive, source episode – Recent events with all three populations = No

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
– Short Term Treatment found >30 days long – Temporarily blocked – This episode has overlapping start and end dates with another episode of the same type. The PIHP also provides an error report for providers to use in order to correct data entry errors that fail the electronic edits. SWMBH IT and SUD staff assist providers with error correction when requested. SWMBH analysts will investigate opportunities for finding additional validations in non-competitive workforce and minimum wage status values. • Upon identification of a data integrity risk in the existing process, Southwest Michigan Behavioral Health immediately requested a CAP of the Van Buren CMH to remedy the deficiency related to not recording a disposition date in the pre-admission screening field. Van Buren indicated that it will be adding signature validations to disallow unpopulated data in the pre-admission screening field. In early 2021, Van Buren CMHSP made the change from SmartCare to PCE Patient Management Systems. PCE has requires a disposition date be entered in the required field, before it allows the user to proceed to the next module. SWMBH has monitored this through site reviews and through data quality and completeness reports we have available through our Tableau analytics system. • SWMBH will continue to ensure CMHSPs utilize the MMBPIS template to supply monthly performance indicator data to the PIHP. These templates are reviewed and monitored monthly during internal and external Quality Management Committee meetings to ensure accuracy, quality and completeness of the data. To further ensure integrity of the performance indicator data used to calculate final reported rates to MDHHS, SWMBH has created a separate folder on our secure FTP server for the CMHSPs to upload their final quarterly data. This detailed data will be locked, and password protected by each CMHSP, retained and then directly supplied to HSAG by SWMBH for future reviews and to MDHHS for quarterly reports. This way we can ensure our numerator and denominators for each indicator do not change and we have a detailed record of the final data that was submitted to MDHHS. HSAG noted that some CMHSPs included non-Medicaid members in their performance indicator reporting. SWMBH will complete additional validation checks during annual CMH site reviews to ensure only the appropriate Medicaid populations per MDHHS Codebook are included in the performance indicator data. We are also exploring an automated process of doing this against the most current 834 file. SWMBH's current process is to review 10% of total cases against enrollment and quality standards. This is a recommendation that was received from HSAG in 2019 and has been used effectively. SWMBH QAPI [quality assessment and performance improvement] department will also create a PowerPoint training on this topic to provide to both the CMHSPs and Providers to ensure future understanding and compliance. The CMHSP indicator templates are reviewed monthly by SWMBH to ensure completeness and accuracy of all template columns and rows.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improvement of Performance Indicators that have MDHHS Benchmarks tied to them. Through the first 3 quarters for FY21 SWMBH has achieved 20/21 Indicators at the MDHHS Benchmark target.
c. Identify any barriers to implementing initiatives: • Trying to align SmartCare and PCE systems to automate reports to our template.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG Assessment: HSAG determined that **Southwest Michigan Behavioral Health** partially addressed the prior year's recommendations. While **Southwest Michigan Behavioral Health** has engaged in efforts to address HSAG's recommendation, the SFY 2021 audit confirmed there are continued opportunities for improvement in some areas. **Southwest Michigan Behavioral Health** was able to fully address HSAG's recommendation to make enhancements to the recently implemented validation process to compare the original BH-TEDS record in CMHSP documentation with manual data entered into the PIHP's system in order to account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system, data entry errors, and discrepancies in noncompetitive workforce and minimum wage status values. HSAG noted during the SFY 2021 audit that CMHSP source code was updated to ensure disposition dates within the EMR system would be a required field needed for reporting a required performance indicator designation. In addition, clinicians were not able to sign off on encounters until a date was populated within the system as part of the source code update. The update also added additional validations and stop field notifications to ensure completeness of the BH-TEDS data that were submitted to **Southwest Michigan Behavioral Health** for review. Additionally, **Southwest Michigan Behavioral Health** worked with the SmartCare software company directly to deploy additional validation checks within its system to strengthen the completeness of the data being entered. These additional checks were in addition to the already 1,300 validation checks that were being done previously through automated validation. **Southwest Michigan Behavioral Health** was not able to fully address HSAG's recommendation to retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. Member-level documentation provided to HSAG during the SFY 2021 audit did not match the information provided to MDHHS for final indicator counts. Indicators #1, #2, #3, and #4a had a more significant difference than 5 percentage points between the final reported rates to MDHHS and the member-level data provided. Therefore, the reported rates for these indicators were determined to be materially biased and should not be reported. As such, in alignment with the SFY 2020 recommendation, HSAG recommends that **Southwest Michigan Behavioral Health** extract and lock member-level data for the indicator counts reported to MDHHS. In addition, **Southwest Michigan Behavioral Health** should provide additional oversight to ensure CMHSPs are providing all pertinent details in member-level data for future reporting, as HSAG had to make multiple requests for clarification and additional documentation to gain clarity on member enrollment status, dates of service, and indicator compliance.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Southwest Michigan Behavioral Health** should prioritize the remediation of the remaining two deficiencies identified from the CAP review; specifically, provide members with an ABD notice at the time of any action (i.e., a denial of payment) affecting a claim, and review PIHP quality issues at the time of a provider's recredentialing.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Standard V – Element 8:** After consultation with HSAG policy and procedures were reviewed and updated to assure ABD notices are sent as needed to members when a claim is denied or partially denied for payment at the time of the action. • **Provider Credentialing Quality Improvement Process Flow:** As evidence of compliance, SWMBH has uploaded the check-list that was implemented for Practitioners. SWMBH has also uploaded the FY2021 SUD tool that was used that has the Grievance & Appeal information on it, as cited in the HSAG recommendations. SWMBH has updated the SUD Administrative Review tool to include the QI data and sent it for final approval. The tool will be ready for use in FY22.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Standard V-Element 8:** This standard was reviewed again by HSAG in 2021 and SWMBH was found to be in compliance with standard at this time. • **Credentialing:** During the recredentialing process Provider Network (credentialing) requests QI information from the following departments to assess whether there have been any QI Issues in the following areas during the previous credentialing cycle. – Customer Services Department: (review member complaints / adverse events) Grievance / appeals – Compliance Department: Any sanctions, issues related to billing fraud, waste, abuse – Utilization Management Department: Any issues with authorizations, documentation and/or other UM concerns. The responses from each of the departments are included in the recredentialing packet and indicated on the check-list.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations. **Southwest Michigan Behavioral Health** indicated that policies and procedures were reviewed and updated to assure ABD notices are sent as needed to members when a claim is denied or partially denied for payment at the time of the action. A review of **Southwest Michigan Behavioral Health**'s SFY 2021 compliance review activity supported that **Southwest Michigan Behavioral Health** is currently in compliance with this requirement. While **Southwest Michigan Behavioral Health** has implemented action plans to address ensuring a review of PIHP quality issues at the time of a provider's recredentialing, it is unknown to HSAG if these actions have led to enhanced compliance with this requirement. As such, this activity will be further assessed in future compliance reviews.

Region 5—Mid-State Health Network

Table 4-5—Prior Year Recommendations and Responses for MSHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • As **Mid-State Health Network** progresses to the second remeasurement, the PIHP should revisit the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of active interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Mid-State Health Network (MSHN) conducted a causal/barrier analysis following the first remeasurement period. It was determined that the service was billed to Medicare for those individuals who have dual coverage of Medicaid/Medicare. – Sixty percent of the eligible population include individuals with dual coverage (Medicare /Medicaid). – Seventy-three percent (241) of those not screened had dual coverage (Medicare /Medicaid). – The results of the lab work was dependent on the ability to receive the required evidence of the completed lab work from the physician offices, therefore promoting increased coordination among providers. • The Community Mental Health Specialty Program (CMHSP) participants utilized the care alert system in the Integrated Care Data Platform (ICDP) to determine who did not have a claim for a completed lab. – A record review was completed for those who did not have a submitted claim to identify if a lab was ordered. – If ordered, was it in the record or could it be obtained? – If the results were in the record and a claim was submitted to Medicare the CMHSP entered a status of "addressed" into ICDP. – If the required labs were not ordered the CMHSP would utilize/develop a process for coordination with the provider to obtain an order • The number of CMHSP participants who utilized the ICDP system to "address" labs increased from eight during the first measurement period to all twelve utilizing ICDP to "address" labs during the second measurement period.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through health information exchange and individual record review one-hundred and twenty (120) individuals that would have not been reported as receiving the required tests for inclusion in the numerator were "addressed" and included in the calculations of the performance rate.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
c. Identify any barriers to implementing initiatives: • The effects of COVID-19 and Executive Orders / Epidemic Orders issued by the Governor and/or the Michigan Department of Health and Human Services were a significant barrier to the completion of identified interventions. Michigan had been under the following executive orders interfering with the ability for individuals to receive non-essential life sustaining services (limited transportation, limited access to laboratories and physician offices), and resources available for additional record review to verify receipt of lab work for those where a claim is not present. – 3.24.2020 Essential Behavioral Health Services and Stay Home Stay Safe Executive Order 2020-21 – Actions for Non-Emergency Medical Transportation Provided During Covid 19 – 10.14.2020 MIOSHA [Michigan Occupational Safety and Health Administration] Emergency Rules – 4.13.2020- Long Acting Injectables and Antipsychotic Medications • Executive/Epidemic Orders resulted in the closure of laboratories and closure and/or limitations of public transportation. • The number of claims submitted to support this measure decreased since March 2020 (onset of the Executive Orders). The number of telehealth services increased; however, this had minimum impact on the positive results of this measure.
HSAG Assessment: HSAG determined that **Mid-State Health Network** addressed the prior year's recommendations. **Mid-State Health Network** used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. **Mid-State Health Network** continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • As a result of errors [discrepancies between the CMHSPs' EMR system and the data output file submitted to HSAG], **Mid-State Health Network** modified the performance indicator submission layout to include additional data elements to support future validation and reporting. However, **Mid-State Health Network** should continue to work with the CMHSP to evaluate whether front-end data entry edits or data elements should be implemented to support indicator reporting to ensure accurate data are collected up front. Further, **Mid-State Health Network** should implement additional validation processes and procedures to ensure the accuracy of reported data for all performance indicators and continue to have sufficient oversight of CMHSPs. • **Mid-State Health Network** and its CMHSPs should employ enhancements to their Behavioral Health Treatment Episode Data Set (BH-TEDS) validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in non-competitive workforce and minimum wage status values. **Mid-State Health Network** and its CMHSPs should also continue to perform enhanced data quality and completeness checks before the data are submitted to the State.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
• **Mid-State Health Network** should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Mid-State Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • **Mid-State Health Network** implemented additional steps related to the data submitted in support of the performance measures. – The date for the submission was extended to allow for the CMHSP participants to complete quality checks prior to the submission, and to investigate those with a response of "out of compliance" or "exception". – Additional business rules developed within the submission template to ensure the request for service occurred prior to the assessment, and service occurred following the assessment. – An additional Medicaid eligibility check has been added to the submission process at the PIHP level. – Primary source verification completed during the Delegated Managed Care (DMC) review. • **Mid-State Health Network** incorporated quality checks to ensure no discrepant data was/is submitted to the State. – Behavioral Health Treatment Episode Data (BH-TED) submitted are monitored during the DMC review. The fields monitored include but not limited to employment, minimum wage and living arrangements. – A full review of the BH-TED data fields are performed to identify any illogical combinations. Quality improvement initiatives are completed based on the results of the review. • The member level detail file to support the MDHHS submission is stored each quarter. – Those without Medicaid included in the submission for MDHHS (Block grant) are removed from the file when provided to Health Services Advisory Group (HSAG) for the Performance Measure Validation (PMV). The number of removed records are documented within the file submitted to HSAG.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Primary Source Verification indicated full validation of reviewed records submitted for the performance indicators. • Currently baseline data is being collected related to the BH-TEDs fields for each CMHSP/MSHN. The efforts of relevant improvement initiatives will be noted in future years.
c. Identify any barriers to implementing initiatives: • No identified barriers at this time.
HSAG Assessment: HSAG determined that **Mid-State Health Network** addressed the prior year's recommendations. **Mid-State Health Network** developed instructional documents to assist the CMHSPs with interpretation and configuration of the new indicators and a standardized template for submission to ensure the

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
consistent reporting of performance indicators. Further, **Mid-State Health Network** met with all CMHSPs as a group prior to the start of system configuration for the new indicators to walk through the specifications and instructional documents to ensure alignment on interpretation while also providing ongoing technical assistance and training sessions throughout the year. **Mid-State Health Network** also reported that the CMHSPs worked diligently to configure validations at the point front-end clinical and clerical staff members entered the data, wherever possible, based on previous recommendations intended to reduce validation and error correction during the quarterly submission process. HSAG's SFY 2021 activity supported that **Mid-State Health Network** implemented additional validation processes and procedures to ensure the accuracy of performance indicator data and demonstrated sufficient oversight of its CMHSPs. **Mid-State Health Network** also continued several QI initiatives to address challenges and improve indicator rates through its Quality Improvement Council (QIC). **Mid-State Health Network**'s QIC reviewed indicator rates at least quarterly and addressed deficiencies while also identifying solutions for improving rates. If a regionwide issue was identified, **Mid-State Health Network** implemented systemwide interventions to address performance deficiencies.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Mid-State Health Network** should update its chart review tools to reflect a 72-hour time frame standard for expedited authorizations. **Mid-State Health Network** should also implement procedures to ensure it and its delegates are rendering an ABD and sending notice for the failure to make an authorization decision timely (i.e., within 72 hours for expedited requests or 14 calendar days for standard requests). **Mid-State Health Network** should reeducate UM staff of these requirements.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The MSHN DMC Clinical Record review tool has been updated to reflect the standard of no later than 72 hours. The update will go into effect for the 2021 DMC full review cycle beginning January of 2021. • The new MDHHS Service Authorization Denial Quarterly Report includes mechanisms for monitoring timely authorization decisions and issuance of Adverse Benefit Determinations. • MSHN and its CMHSP Participants worked directly with the Electronic Medical Record (EMR) vendor to ensure that date/time of receipt of request and date/time of decision are being gathered in a standard and consistent manner throughout the region. • Each quarter the PIHP reviews the data submissions from the CMHSPs prior to providing to MDHHS. Evidence of Corrective Action will be required if it is determined that a CMHSP or the PIHP is not adhering to timeliness standards (72-Hour for Expedited requests, 14 Days for Standard Requests)
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The number of CMHSP Participants reported having an automated method of tracking authorization timeliness decisions in their EMR has increased from four (4) to twelve (12) CMHSP participants.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• All CMHSP participants currently have a standard automated method of tracking authorization timeliness decisions through the Electronic Medical Record (EMR), including the capability to produce data extract reports.
c. Identify any barriers to implementing initiatives: • MDHHS developed a reporting template and process for service authorizations. MSHN discontinued the template used for submission of the data used for the Timeliness Monitoring report as indicated in the Corrective Action Plan to avoid duplication of data submission. • As indicated above, MSHN will now monitor the timeliness of the CMHSP participants through the quarterly MDHHS tool. • Time frame for EMR vendor to program requested changes and deploy for use by MSHN and its CMHSP participants may take several months. • The updates have been deployed and future quarterly data submissions will allow MSHN to monitor for performance improvement.
HSAG Assessment: HSAG determined that **Mid-State Health Network** addressed the prior year's recommendations. **Mid-State Health Network** updated its clinical record review tool to include the accurate time frame for expedited decisions and reported that all CMHSPs now have an internal mechanism to monitor timeliness of decisions. Additionally, a review of **Mid-State Health Network**'s SFY 2021 compliance review activity supported that **Mid-State Health Network** is currently in compliance with this requirement. Further, **Mid-State Health Network** is now using the MDHHS reporting template to monitor the CMHSPs for compliance with the time frame requirements.

Region 6—Community Mental Health Partnership of Southeast Michigan

Table 4-6—Prior Year Recommendations and Responses for CMHPSM

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • As **Community Mental Health Partnership of Southeast Michigan** progresses to the second remeasurement period, the PIHP should revisit the causal/barrier analysis process to ensure that the barriers identified continue to be barriers. The PIHP should develop active interventions to address the barriers to achieve the desired outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The CMPHSM Clinical Performance Team (CPT) Committee, which oversees the implementation of PI projects for the region, had developed and assigned an Integrated Health Workgroup (IHW) consisting of regional stakeholders who had the expertise and the ability to lead local implementation of the PIP. The IHW conducted causal barriers/analysis functions for the PIP and reported this analysis, interventions, and outcomes analysis to the CPT Committee. At the onset of Remeasurement 2, The regional IHW revisited the casual barrier analysis using the QI tools outlined in the CMHPSM's PIP submission that included using qualitative priority ranking to rank causes and their contributing effect to the problem, then creating SMART [specific, measurable, attainable, relevant, time-bound] goals. Updated/new causes and barriers were ranked numerically and prioritized based on their level of impact with these factors. Barriers that were significantly affected by the COVID-19 pandemic that would have limited success were given a lower priority in that they would be difficult to affect or would have limited impact on getting labs completed based on COVID-19 pandemic limitations. The four top priority causes were identified, and proposed interventions developed to include outcome measure subset data would be used for how those interventions would impact the overall project measurements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Some Community Mental Health Service Providers (CMHSPs) s within the PIHP region were able to find local solutions to meet or exceed the goals of the proposed interventions, yet the overall percentage performance target of the region was not met.
c. Identify any barriers to implementing initiatives: • Some interventions/initiatives took longer than planned and hence did not have as significant of an impact. While some services that would assist with interventions became allowable as telehealth during the pandemic, having labs completed remained a face-to-face contact and proposed interventions to assist consumers in completing their labs were limited in addressing some of the barriers consumers had in attending a lab visit. The pandemic also resulted in significant stability and staff shortages in the provider network that reached crisis proportions, affecting the resources available to assist consumers in having their labs completed.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations. **Community Mental Health Partnership of Southeast Michigan** reassessed its causal/barrier analysis process and used appropriate QI methods to identify and prioritize barriers to care. **Community Mental Health Partnership of Southeast Michigan** developed intervention efforts that may reasonably address the barriers identified.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Community Mental Health Partnership of Southeast Michigan** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicator #4a. • **Community Mental Health Partnership of Southeast Michigan** should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Community Mental Health Partnership of Southeast Michigan**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • CMHPSM reviewed the MDHHS Codebook and worked with our EHR vendor PCE to ensure the data reporting system retains the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS, and only include Medicaid beneficiaries served by the PIHP. This matter was in part related to ensuring PIHP staff maintain the exact member-level detail data and accurately track when it has been re-run. Practices have since been changed in how PIHP maintain these reports to ensure this aim.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • None
HSAG Assessment: HSAG determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations. During the SFY 2021 audit, **Community Mental Health Partnership of Southeast Michigan** submitted a member-level detail file that exactly matched each performance indicator data element reported by **Community Mental Health Partnership of Southeast Michigan** to MDHHS. Additionally, MDHHS and **Community Mental Health Partnership of Southeast Michigan** confirmed that the PIHP attended all MDHHS-led forums to discuss improvements related to performance indicator data accuracy and MDHHS Codebook interpretation.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Community Mental Health Partnership of Southeast Michigan** should reconcile its provider credentialing review tools against initial and recredentialing requirements in contract and update accordingly. **Community Mental Health Partnership of Southeast Michigan** should clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and provider quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Community Mental Health Partnership of Southeast Michigan**'s recredentialing review.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • CMHPSM reviewed the state and federal initial and recredentialing provider requirements and updated the CMHPSM initial and recredentialing tools, through review and revision by the Regional Network Management Committee. The tools clarified and expanded on provider specific performance monitoring to include data related to providers such as grievances, appeals, recipient rights, and performance issues, and incorporate this information in the credentialing review of that provider, with decisions or issues documented on the review forms. All PIHP staff use these same tools in their initial and recredentialing practices. A process was developed to inform where the relevant data was located, which PIHP staff/committee could provide further information on the data where needed, and how to document findings and whether those findings affect the credentialing decision. All regional network management staff that use the tool were oriented to the new revised process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • None
HSAG Assessment: HSAG determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations. **Community Mental Health Partnership of Southeast Michigan** has implemented updated initial and recredentialing tools to clarify and expand on provider-specific performance monitoring, developed a process for all staff to follow to ensure these data are included in the recredentialing cycles, and trained staff on the new process. However, it is unknown to HSAG if these actions have led to enhanced compliance with this requirement. As such, this activity will be assessed in future compliance reviews.

Region 7—Detroit Wayne Integrated Health Network

Table 4-7—Prior Year Recommendations and Responses for DWIHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Detroit Wayne Integrated Health Network** should revisit its causal/barrier analysis to ensure the appropriate barriers were identified and develop active, innovative interventions to address each barrier.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • **Response:** Detroit Wayne Integrated Health Network (DWIHN) has revisited our Quality Improvement (QI) processes which include review of the causal/barrier analysis no less than annually through our Quality Improvement Steering Committee (QISC) and Improving Practices Leadership Team (IPLT) meetings. During the aforementioned meetings, updates are suggested and made to include causal/barrier analysis, Fishbone Diagrams, and data analysis results to identify barriers and implement interventions to address the identified barriers in a timely manner. DWIHN developed evaluation methods for each intervention. The interventions provided qualitative or quantitative data to support the outcome of each intervention and the decision to continue, modify or discontinue each action.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Response:** In FY2020, there were no noted improvements identified for the Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) measure. New interventions have been identified for ongoing performance improvement efforts and will be monitored no less than quarterly through the QISC and IPLT committee meetings.
c. Identify any barriers to implementing initiatives: • **Response:** DWIHN originally used an internal developed programming system to generate HEDIS measures. In October of 2020, DWIHN began to contract with Vital Data Technology (VDT) for reporting of HEDIS measures. The VDT measurement software is HEDIS certified and allows for DWIHN and providers to drill down to specific provider detail reporting for HEDIS measures. Due to the COVID-19 restrictions, DWIHN began to utilize telemedicine services in March of 2020 which allowed members to access behavioral health specialized services virtually. Due to these restrictions, members did not have the ability to obtain face to face services or completion of labs draws. These barriers contributed to the decline for the SSD measure for this reporting period.
HSAG Assessment: HSAG determined that **Detroit Wayne Integrated Health Network** partially addressed the prior year's recommendations. While it used appropriate QI tools to identify and prioritize barriers, **Detroit Wayne Integrated Health Network** demonstrated a decline in performance across both remeasurement periods but maintained the same intervention efforts implemented in the prior year. The year-over-year decline in performance suggests that the barriers identified may not have the greatest impact in the study indicator outcomes. As such, HSAG recommends that **Detroit Wayne Integrated Health Network** determine what additional barriers may be impacting performance or include additional internal and external stakeholders in its

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
causal/barrier analysis process and use the results to develop active targeted interventions that can be tracked and trended to determine each effort's impact on the study indicator outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **Detroit Wayne Integrated Health Network** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicators #4a and #4b.
- **Detroit Wayne Integrated Health Network** should determine if it can leverage any of the successes it has had with lower pediatric Medicaid member readmissions and apply those interventions to its adult Medicaid members. Additionally, **Detroit Wayne Integrated Health Network** should conduct a full root cause analysis or focused study to identify any barriers specific to the adult Medicaid members that could be factors in increased readmission. Upon identification of a root cause and potential programs to leverage that have achieved success for pediatric Medicaid members, **Detroit Wayne Integrated Health Network** should implement appropriate interventions to improve the performance related to Indicator #10.
- **Detroit Wayne Integrated Health Network** should continue to monitor the accuracy of its BH-TEDS data and review BH-TEDS validation processes to ensure they are sufficient to address all logical errors. This review should target the data entry protocols and validation edits in place to account for discrepancies in non-competitive workforce and minimum wage status values.
- **Detroit Wayne Integrated Health Network** should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Detroit Wayne Integrated Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.
- **Detroit Wayne Integrated Health Network** should continue existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes. **Detroit Wayne Integrated Health Network** should continue monitoring performance trends and targeting low performing areas, including an assessment of performance at the PIHP and individual provider level, as well as within core member demographics, to identify systemic patterns of performance. Further, **Detroit Wayne Integrated Health Network** should continue to use existing workgroups to identify root causes for low performance and disseminate best practices.

MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

- **Detroit Wayne Integrated Health Network** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicators #4a and #4b.

  Response: MDHHS code book methodology allows for exceptions for Indicators #4a and #4b. Exceptions include Members who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, do not show for an appointment/reschedule or Members who choose not to use CMHSP/PIHP services. DWIHN

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

maintains documentation through Mental Health Wellness Information Network (MH-WIN) reporting system which is available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual are also documented.

- **Detroit Wayne Integrated Health Network** should determine if it can leverage any of the successes it has had with lower pediatric Medicaid member readmissions and apply those interventions to its adult Medicaid members. Additionally, **Detroit Wayne Integrated Health Network** should conduct a full root cause analysis or focused study to identify any barriers specific to the adult Medicaid members that could be factors in increased readmission. Upon identification of a root cause and potential programs to leverage that have achieved success for pediatric Medicaid members, **Detroit Wayne Integrated Health Network** should implement appropriate interventions to improve the performance related to Indicator #10.

  Response: DWIHN has identified the following interventions and improvement efforts through both internal and external recidivism workgroups. These notable efforts are defined below:

  - Working with DWIHN's Crisis Team and Hospital Liaison group to identify potential delays in care
  - Working on expansion of Med-Drop programs to improve outpatient compliance with goals to decrease need for higher level of care for hospitalizations.
  - Engaged and collaborated with members' outpatient Clinically Responsible Provider (CRSP) providers to ensure continuity of care and when members present to the ED [emergency department] in crisis but may not require hospitalization.
  - Charted alerts which notify the screening entities and the Clinically Responsible Service Provider CRSP of members who frequently present to the ED.
  - Properly navigated and diverted members to the appropriate type of service and level of care.
  - Provided volunteer referrals to Complex Case Management (CCM) for members with high behavioral needs.
  - Implemented the Recidivism Task Force to:
  - Identify Familiar Faces and CRSP responsibility
  - Create a plan to address the needs of persons served
  - Chart alerts developed in MH-WIN
  - Coordinated and collaborated with DWIHN's crisis screeners on measures to decrease inpatient admissions
- **Detroit Wayne Integrated Health Network** should continue to monitor the accuracy of its BH-TEDS data and review BH-TEDS validation processes to ensure they are sufficient to address all logical errors. This review should target the data entry protocols and validation edits in place to account for discrepancies in non-competitive workforce and minimum wage status values.

  Response: DWIHN has improved upon BH-TEDS reporting. The Peter Chang Enterprises (PCE) vendor has worked with MH-WIN software company to update validations within DWIHN's MH-WIN system to ensure that all required fields are populated before saving. In addition, disability designation data values within MH-WIN were updated to provide additional options to denote member activity. DWIHN will continue our ongoing efforts for BH-TEDS reporting.

  Detroit Wayne Integrated Health Network should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Detroit Wayne Integrated Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators. • **Response:** DWIHN locks members level data within the MH-WIN performance module once the data is reported to MDHHS. Once the data is locked the member level detail data is final and is not unlocked or altered. • **Detroit Wayne Integrated Health Network** should continue existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes. **Detroit Wayne Integrated Health Network** should continue monitoring performance trends and targeting low performing areas, including an assessment of performance at the PIHP and individual provider level, as well as within core member demographics, to identify systemic patterns of performance. Further, **Detroit Wayne Integrated Health Network** should continue to use existing workgroups to identify root causes for low performance and disseminate best practices. **Response: Detroit Wayne Integrated Health Network** has identified the following interventions and improvement efforts: – Identification of members that are readmitted more than once during each quarter. – Development of a Recidivism Workgroup both Internal and External to review members that continue to be readmitted, or admitted more than once during a quarter. – Engagement of the CRSP's to conduct Interdisciplinary meetings for members that have multiple readmissions. – Monitoring of the Quality Improvement Project (PIP) data for improving the attendance at Follow-up Appointments with a Mental Health Professional after a Psychiatric Inpatient Admission. – Providing technical assistance and training to our provider network as required. – Review and monitoring of the correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism). – DWIHN has increased the frequency of analysis data during the Quality Operations Technical Workgroup and Performance Indicator meetings and sharing best practices across the network. This process has helped identify trends early on. – DWIHN has also developed dashboards in the MHWIN system, that allow providers to access and review their own cases that are approaching the end of the follow-up period.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Response:** DWIHN has continued to show performance improvements for PI# 10. During the last six (6) quarters, DWIHN has failed to meet the required standard of 15% or less. However, DWIHN's PI# 10 rate continues to decrease slightly from quarter to quarter. Q3 2021 overall rate of 16.23% is the second lowest rate in the last 2 years. DWIHN will continue efforts to work with the Clinically Responsible Providers (CRSP) to engage and collaborate with members to ensure continuity of quality of care when members present to the ED in crisis but may not require hospitalization. These efforts will be accomplished by identifying familiar faces, CRSP's creating plans to address the need of persons served and the development of chart alerts in MH-WIN.
c. Identify any barriers to implementing initiatives: • **Response:** Efforts to decrease hospital admissions and readmissions have continued to be a challenge. DWIHN seeks to reduce psychiatric inpatient admissions and provide safe, timely, appropriate and high-quality treatment alternatives while still ensuring members receive the appropriate required care. DWIHN has expanded our Med- Drop program to incorporate more providers and target recidivistic

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
individuals, with goals to decrease need for higher level of care such as Assertive Community Treatment (ACT) and inpatient hospitalizations.
HSAG Assessment: HSAG determined that **Detroit Wayne Integrated Health Network** addressed the prior year's recommendations. **Detroit Wayne Integrated Health Network** was able to address HSAG's recommendation to continue existing provider and internal workgroups to review progress on improving performance measure rates and monitor trends in targeting low performance areas. **Detroit Wayne Integrated Health Network** noted many interventions and improvement efforts that were put in place to support improving its rates, and HSAG confirmed that **Detroit Wayne Integrated Health Network** showed improvement across multiple performance indicator rates from SFY 2020 to SFY 2021. During the SFY 2021 audit, **Detroit Wayne Integrated Health Network** reported the continuation of provider and internal workgroups coming together to improve performance measure rates and data collection processes. As an ongoing effort to continue improvement, **Detroit Wayne Integrated Health Network** developed an internal Recidivism Workgroup (led by the QI team) and an external Recidivism Workgroup, which include its CRSPs (led by the PIHP Crisis/Access team), collectively referred to as the Recidivism Task Force. These noted efforts decreased the adult recidivism rate from 20.41 percent for Quarter 1 (FY 2019–2020) to 17.94 percent for Quarter 1 (FY 2020–2021), addressing HSAG's prior-year recommendation for Indicator #10. **Detroit Wayne Integrated Health Network** was able to address HSAG's recommendation to review BH-TEDS data to ensure that all required elements are collected and reported appropriately. During the SFY 2021 audit, **Detroit Wayne Integrated Health Network** reported that PCE worked with the MH-WIN software company to update validations within **Detroit Wayne Integrated Health Network**'s system to ensure that all required fields had to be populated before saving. In addition, disability designation data values within MH-WIN were also updated to provide additional options to denote member activity. **Detroit Wayne Integrated Health Network** was able to address HSAG's recommendation to retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. HSAG noted during the SFY 2021 audit that **Detroit Wayne Integrated Health Network** locked down exact member-level detail data within the MH-WIN performance indicator module once these data had been reported to MDHHS. **Detroit Wayne Integrated Health Network** confirmed that once a locked member-level detail was created, the detail does not get unlocked or altered.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: **Detroit Wayne Integrated Health Network** should revisit its procedures for extending authorization decisions. Once updated, education with UM staff members on appropriate extension time frame should be completed. **Detroit Wayne Integrated Health Network**'s utilization management (UM) and claims departments should collaborate in developing a process to generate an ABD notice when a payment on a claim is denied. **Detroit Wayne Integrated Health Network** should reconcile its credentialing checklist to ensure the consideration of grievances, appeal information, and quality issues are considered and documented for each

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
provider. **Detroit Wayne Integrated Health Network** should clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Detroit Wayne Integrated Health Network**'s recredentialing review.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Detroit Wayne Integrated Health Network** should revisit its procedures for extending authorization decisions. Once updated, education with UM staff members on appropriate extension time frame should be completed. **Detroit Wayne Integrated Health Network**'s UM and claims departments should collaborate in developing a process to generate an ABD notice when a payment on a claim is denied. **Response**: DWIHN has revised the policies and procedures and the related documents for extending authorizations decisions to align with the 42 CFR requirements of 14 days. DWIHN UM staff was trained on 10/28/21 and will continue to receive ongoing staff education to ensure staff understand when authorization decisions should be extended and how the process is completed. The UM and Claims departments are evaluating the current claim denials process to determine how to best incorporate notifying members of a denial of payment for a claim. Currently, the explanation of benefits (EOB) is automatically generated by MHWIN once the payment cycle is complete. Providers also have the option of viewing unpaid claims and errors via the adjudication report which provides an in-depth description of the denial and is available for the providers' review notice when a payment for a claim is denied. The language in the Denial of Service policy and the Denial of Medicaid Service Procedures are also being reviewed to ensure it reflects and adheres to 42 CFR requirements. Anticipated date of completion is March 1, 2022. • **Detroit Wayne Integrated Health Network** should reconcile its credentialing checklist to ensure the consideration of grievances, appeal information, and quality issues are considered and documented for each provider. **Detroit Wayne Integrated Health Network** should clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Detroit Wayne Integrated Health Network's** recredentialing review. **Response:** DWIHN has added the use of a Substantiated Complaint Smartsheet (in addition to the credentialing checklist) that is used during the credentialing process to identify Practitioners and/or Organizational Providers that would impact credentialing. The Credentialing/Recredentialing Policy was revised to describe the Recredentialing Process which includes an assessment of quality issues. The quality data and sources that are included in DWIHN's recredentialing review are Customer Services, Office of Recipient Rights, Corporate Compliance, Quality Improvement, Utilization Management and Clinical Services.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Detroit Wayne Integrated Health Network** should revisit its procedures for extending authorization decisions. **Response:** DWIHN recently implemented the new initiatives, therefore there are no noted improvements. • **Detroit Wayne Integrated Health Network** should reconcile its credentialing checklist to ensure the consideration of grievances, appeal information, and quality issues are considered and documented for each provider. **Response:** As a result of the initiatives implemented, the Credentialing Committee engages in a more robust discussion regarding all quality issues that may or may not impact credentialing Practitioners and Organizational Providers. The Credentialing department reviews through Medversant the monthly Credentialing Cumulative Collection Completion Report in comparison with the Substantiated Compliant Smartsheet to determine if any Practitioner or Organizational Providers have any substantiated complaints that would adversely affect recredentialing. To date, we have not processed any adverse credentialing decisions.
c. Identify any barriers to implementing initiatives: • **Detroit Wayne Integrated Health Network** should revisit its procedures for extending authorization decisions. **Response:** DWIHN will continue ongoing training efforts and education of DWIHN's Provider Network regarding timely submission of authorization requests, returning authorization requests back to the UM authorization queue after making the necessary corrections and/or providing additional information, as requested. The UM Department will collaborate with IT Department to review a process for electronically monitoring authorization extensions, which would require a system update. Additional time is needed for further collaboration with the IT Department. Anticipated date of implementation is March 1, 2022. • **Detroit Wayne Integrated Health Network**'s UM and claims departments should collaborate in developing a process to generate an ABD notice when a payment on a claim is denied. **Response:** The UM and Claims department are evaluating the current claim denials process to determine how to best incorporate notifying members of a denial of payment for a claim. Anticipated date of implementation is March 1, 2022. • **Detroit Wayne Integrated Health Network** should reconcile its credentialing checklist to ensure the consideration of grievances, appeal information, and quality issues are considered and documented for each provider. **Response**: No barriers identified.
HSAG Assessment: HSAG determined that **Detroit Wayne Integrated Health Network** partially addressed the prior year's recommendations. **Detroit Wayne Integrated Health Network** has revised its policies and procedures for extending authorization time frames, and UM staff were trained on when to use extensions and how to complete the process. However, a review of the **Detroit Wayne Integrated Health Network** SFY 2021 compliance review indicated that while **Detroit Wayne Integrated Health Network** had an extension process in place, the notification to members incorrectly indicated that the extension time frame for an expedited request was 72 hours; the PIHP is allowed an additional 14 calendar days for extensions on both standard and expedited requests. **Detroit Wayne Integrated Health Network** should ensure that the extension notice template language includes the correct extension time frame. Additionally, **Detroit Wayne Integrated Health Network** is still determining how to best incorporate notification to the member when a payment on a claim is

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
denied. This process is not slated to be completed until March 1, 2022. **Detroit Wayne Integrated Health Network** addressed the prior year's recommendation to ensure the consideration of grievances, appeal information, and quality issues during the recredentialing process by updating its policies and procedures to include the quality data sources used for this process and implementing a Substantiated Complaint Smartsheet to identify practitioners and organizational providers who have had issues that would impact recredentialing. As appeal information was not specifically identified as a data source, HSAG recommends that **Detroit Wayne Integrated Health Network** verify that these data are included in its process. Although **Detroit Wayne Integrated Health Network** indicated that its Credentialing Committee now engages in more robust discussion regarding quality issues for providers being recredentialed and that no providers have been adversely affected to date, it is unknown to HSAG if these actions have led to enhanced compliance with this requirement. As such, this activity will be assessed in future compliance reviews.

Region 8—Oakland Community Health Network

Table 4-8—Prior Year Recommendations and Responses for OCHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Oakland Community Health Network** should use the approved PIP methodology to calculate and report data accurately and consistently for each measurement period. • **Oakland Community Health Network** should use the same methodology for each measurement period. The PIHP should revisit its causal/barrier analysis and develop active interventions to address the barriers identified.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The HSAG amended Performance Improvement Plan returned in August 2021 highlights how OCHN HEDIS vendor, Relias, added the Healthy Michigan (Medicaid Expansion) claims to the 2018, 2019, and 2020 populations. This completion ensured comparable populations and consistent calculations between the baseline and re-measurements. The criteria population includes Medicaid and Healthy Michigan (an approved MDHHS Medicaid expansion) claims for the 2018 baseline, as well as the 2019 and 2020 re-measurement periods. • As requested by HSAG, OCHN re-ran data for the baseline (2018) and re-measurement periods (2019 and 2020) to maintain methodology and criteria for each of the measurement periods. The recommendation was successfully completed, and the updated data was submitted with the corrected HSAG PIP in August 2021. The data going forward also contains consistent criteria as previously noted.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There was no observable performance improvement as result of the initiative, however, the population criteria became consistent for comparability and validity through the project study.
c. Identify any barriers to implementing initiatives: • No known barriers following completion of task.
HSAG Assessment: HSAG determined that **Oakland Community Health Network** addressed the prior year's recommendations. **Oakland Community Health Network** regenerated its data using the approved methodology for each measurement period to allow comparability of annual reporting. **Oakland Community Health Network** used appropriate QI tools to identify and prioritize its barriers to care and developed intervention efforts to address those barriers.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Oakland Community Health Network** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicator #4a. • **Oakland Community Health Network** should conduct a root cause analysis or focused study to determine why some adult Medicaid members are not always getting a psychiatric inpatient care pre-admission screening disposition completed within three hours. Upon identification of a root cause, **Oakland Community Health Network** should implement appropriate interventions to improve the performance related to Indicator #1. • **Oakland Community Health Network** should continue to work with related provider networks on providing clear documentation of exceptions. Additionally, **Oakland Community Health Network** should develop a consistent process for assigning exceptions as it relates to Indicator #4b. • **Oakland Community Health Network** should retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Oakland Community Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members, exactly as reported to MDHHS in support of the performance indicators.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • The MDHHS Code Book is clear on the reasons for exceptions. An inquiry was sent to MDHHS, and it was confirmed that SUD services are PIHP authorized, and are considered follow-up services for 4a. • A root cause analysis was completed for psychiatric inpatient pre-admission screenings. Data errors were impacting the compliance rate, so a weekly review was conducted to correct errors, and a weekly report of corrections was submitted to OCHN by the service provider. Interventions were successful, bringing the performance indicator rate into compliance for Q1 and Q2 of FY21. • OCHN has developed written procedures for identification of exceptions for 4b. The Quality Team worked with providers to educate them on selecting the appropriate reason for discharge from the drop down options in the Discharge Summary. This will help identify the "exceptions" in the logic. • Each quarter, on the date of data submission to MDHHS, the data detail for both PIHP and CMHSP individuals was saved into a Performance Indicator folder. This step was added to the written Performance Indicator procedures. This performance improvement activity is complete.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This request for clarification did not result in a change in performance. • Over 95% of Adult Medicaid members received a psychiatric inpatient care pre-admission screening disposition completed within three hours in Q1 and Q2 of FY21 following implementation of interventions. OCHN demonstrated 2.6% percent increase in performance from FY20 Quarter 4 to FY21 Quarter 1. • This performance improvement activity did not result in a change in performance, but a decrease in manual case review required to calculate the rates.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
• It is expected that the data submitted for the Performance Measure Validation review will be an exact match to the numbers that are reported to Michigan Department of Health and Human Services in FY22, however this activity will not impact the performance rate.
c. Identify any barriers to implementing initiatives: • There were no barriers to the request for clarification from MDHHS. • Difficulty recruiting staff to adequately cover all shifts to conduct psychiatric inpatient care pre- • admission screenings was a barrier to implementing initiatives. • There were no barriers to completion of this task. • There were no barriers to completion of this task.
HSAG Assessment: HSAG determined that **Oakland Community Health Network** addressed the prior year's recommendations. HSAG followed up with **Oakland Community Health Network** based on the SFY 2020 audit recommendation to retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. **Oakland Community Health Network** has moved all of its internal checks for reporting to the Quality Team. Additionally, it has hired two new staff members to help with quality control. HSAG also noted during the SFY 2021 audit that no significant issues were identified with the member-level data provided to HSAG. **Oakland Community Health Network** also addressed HSAG's recommendation to conduct a root cause analysis or a focused study to determine why some adult Medicaid members are not always getting a psychiatric inpatient care pre-admission screening disposition completed within three hours in order to improve the performance indicator rate for Indicator #1. **Oakland Community Health Network** indicated that a root cause analysis was completed for psychiatric inpatient pre-admission screenings and data errors were corrected as a result of the analysis. **Oakland Community Health Network** interventions appear to be successful, as HSAG noted that the rate for Indicator #1 increased from SFY 2020 to SFY 2021.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Oakland Community Health Network** should review its service authorization member notices against federal managed care requirements and update accordingly. Staff education should be complete to ensure staff understanding of what type of notice should be sent and when and what content must be included in each type of notice. Additionally, **Oakland Community Health Network**'s UM and claims departments should collaborate in developing a process to generate an ABD notice when a payment on a claim is denied. • **Oakland Community Health Network** should revise its denied expedited appeal request template letter and educate staff members on the appropriate content that must be included in this notice. Additionally, **Oakland Community Health Network** should complete staff education on the appropriate reason for when an appeal resolution time frame may be extended. This education should ensure that extensions are not applied until near the expiration of the appeal time frame.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Due Process Office (ABD-DP Notice Denial of Payment) - Oakland Data Information Network (ODIN) is the Electronic Health Record Platform for OCHN that contains the Due Process Module, which can issue a Denial of Payment ABD-DP "Denial" Notices when applicable. This activity is complete. The OCHN Utilization Management team put in place the new process of generating a denial of payment letter on 1/15/21. The UM document titled "Utilization Management Review Process" was updated, shared with staff in UM, Customer Services and Budget and Finance and reviewed with HSAG. This process has been in place since this date. This activity is complete. • Due Process Office (Denial Expedited Appeal Request) Due Process Coordinator responded to HSAG auditors on 1-14-2021 and implemented the following regarding the revised "denial expedited appeal request" template letter. Per phone conversation with HSAG auditors on 1-14-2021, the Due Process Coordinator included/added the Grievance Rights statement in the letter template titled "Denial of Expedited Local Appeal Resolution Request". Letter re-submitted. This activity is complete. Due Process Office (Appeal Resolution Time Frame (14-Day) Extension)- Due Process Coordinator responded to HSAG auditors per phone conversation with HSAG auditors on 1-14-2021, the statement: "I am providing you with the required written notification within at least (2) calendar days of the expiration of the time frame of this appeal" was removed from the letter template titled, "Local Appeal 14-Day Extension Request". Clarification was provided that the statement referring to the (2 days) was not intended to be included in the letter to the member but for the Due Process staff to issues, the written notice within 2 days of determining an extension is needed. Letter re-submitted. This activity is complete. The OCHN Utilization Management team developed the (14-Day) Service Authorization Extension (SAE) Letter which replaced the Extended ABD-DP Due Process Notice in our electronic Health Record (EHR) on 2/16/21. UM staff began using this letter immediately with a template. The SAE letter is now live in our EHR and being used as needed. All staff reviewing authorization requests were trained on the new SAE letter process which included a review of timelines and appropriateness of language in the notice. This activity is complete.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Denial Expedited Appeal Request–Due Process Office was able to implement this process immediately upon making the change in the template. This resulted in service authorization member notices meeting federal managed care requirements. • Appeal Resolution Time Frame 14 Day Extension–Due Process Office was able to implement this process immediately upon making the change in the template. This resulted in the denied expedited appeal request template letter meeting federal managed care requirements.
c. Identify any barriers to implementing initiatives: • Denial Expedited Appeal Request–Due Process Office did not have any barriers with implementation. • Appeal Resolution Time Frame 14 Day Extension–Due Process Office did not have any barriers with implementation.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG determined that **Oakland Community Health Network** partially addressed the prior year's recommendations. **Oakland Community Health Network** indicated that it has developed a process for generating a denial of payment letter and has trained staff on this process, and HSAG's review of the SFY 2021 compliance review supported that this process is in place and being used appropriately. **Oakland Community Health Network** developed the Service Authorization Extension template letter and trained staff on its use, and HSAG's review of the SFY 2021 compliance review supported that this process is in place and being used appropriately. However, **Oakland Community Health Network** did not address reviewing its service authorization member notices against federal managed care requirements and updating accordingly. Additionally, a review of **Oakland Community Health Network**'s SFY 2021 compliance review indicated that several ABD notices did not include the specific reasons for the action that was being taken and that some notices included multiple citations that were not applicable to the member's denial. As the information often used for this requirement is based on individual member and service authorization criteria, **Oakland Community Health Network** could consider comprehensive and ongoing training for its UM decision makers to ensure appropriate information regarding the specific reasons for the action being taken is included in each ABD notice. **Oakland Community Health Network** could also mandate a quality assurance and accountability process; for example, requiring that every ABD notice is reviewed and approved by management prior to being mailed to the member. **Oakland Community Health Network** updated its denial of expedited appeal request template letter to include grievance rights and removed the statement regarding notification within at least two calendar days of the expiration of the time frame of the appeal from the Local Appeal 14-Day Extension Request template letter; however, it is unknown to HSAG if these actions have led to enhanced compliance with this requirement. As such, this activity will be assessed in future compliance reviews.

Region 9—Macomb County Community Mental Health

Table 4-9—Prior Year Recommendations and Responses for MCCMH

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • As **Macomb County Community Mental Health** progresses to the second remeasurement, the PIHP should revisit the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Macomb County Community Mental Health** should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • MCCMH staff was meeting on a monthly basis to examine barriers and develop additional interventions to assist with decreasing recidivism.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Quality initiated a process to assist with consumer contact and barriers to hospital follow up appointments.
c. Identify any barriers to implementing initiatives: • We were unable to implement contract for hospital discharge wraparound services, due to coding difficulties.
HSAG Assessment: HSAG determined that **Macomb County Community Mental Health** did not address the prior year's recommendations. Although interventions were in place during the remeasurement period, **Macomb County Community Mental Health** maintained opportunities for improvement, meeting 56 percent of the requirements for data analysis and implementation of improvement strategies. The PIHP did not revisit its causal/barrier analysis or provide complete evaluation results for each intervention implemented. **Macomb County Community Mental Health** should identify and document new or revised barriers that have prevented improvement in PIP outcomes and develop new or revised interventions to better address high-priority barriers associated with the lack of improvement. **Macomb County Community Mental Health** should develop methods to evaluate the effectiveness of each individual intervention and report outcomes of the evaluation analysis. Decisions to continue, revise, or discontinue an intervention must be data driven.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Macomb County Community Mental Health** should consult with MDHHS to clarify the methodology specifically regarding exceptions for Indicator #4a.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • A review and changes to network adequacy and coding.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • n/a
c. Identify any barriers to implementing initiatives: • Available appointments and psychiatric time appear to be the barriers at this time.
HSAG Assessment: HSAG determined that **Macomb County Community Mental Health** addressed the prior year's recommendation. HSAG identified no issues during the SFY 2021 audit regarding exceptions for Indicator #4a.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Macomb County Community Mental Health** should prioritize the remediation of the remaining four deficiencies identified from the corrective action plan (CAP) review; specifically, the PIHP should ensure a comprehensive annual evaluation of its QAPIP, ensure results of assessment of member experience with services are acted upon and appropriately evaluated for effectiveness, include all required content in ABD notices, and re-credential all providers timely.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For FY 21-22 quality administrators met with each department head to do a comprehensive review and development of the annual workplan. This will now move forward to board approval. To ensure satisfaction of member experiences, a PIP was developed on any indicators we fall short of the benchmark. A training was provided to all Managed Care Operations of ABD notices. Quality also initiated a monthly audit on ABD notices. Network Operations and Quality monitor re-credentialing through ongoing auditing.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are currently evaluating the FY 20-21 workplan. We are also able to look at ABD in real time, and educate as necessary.
c. Identify any barriers to implementing initiatives: • n/a

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations. While **Macomb County Community Mental Health** has engaged in efforts to address HSAG's recommendation, the SFY 2021 compliance review activity confirmed there are continued opportunities for improvement in creating ABD notices as they did not consistently include the appropriate action being taken; the services being denied or terminated; a clear explanation for why the services were being denied, reduced, or terminated; and/or the legal basis/authority citations were insufficient (i.e., incorrect legal citation for the circumstances). As such, HSAG recommends that **Macomb County Community Mental Health** mandate periodic staff training for developing ABD notices (e.g., quarterly). While **Macomb County Community Mental Health** can view ABD notices in real-time, **Macomb County Community Mental Health** could mandate a quality assurance and accountability process; for example, requiring that every ABD notice is reviewed and approved by management prior to being mailed to the member. Additionally, while **Macomb County Community Mental Health** has indicated it is currently evaluating the SFY 2021 QAPIP workplan, HSAG recommends that **Macomb County Community Mental Health** ensure that the evaluation considers and aligns with MDHHS' newly implemented QAPIP Checklist. Lastly, while **Macomb County Community Mental Health**'s network operations and quality teams monitor recredentialing through ongoing auditing, it is unknown if these audits have resulted in improvement. HSAG will review **Macomb County Community Mental Health**'s recredentialing timeliness during the SFY 2022 compliance review activity.

Region 10 PIHP

Table 4-10—Prior Year Recommendations and Responses for Region 10

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • As **Region 10 PIHP** progresses into the second remeasurement, the PIHP should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • On June 28, 2021 and August 6, 2021, Region 10 PIHP submitted revised PIP Validation Tools for review by the Health Services Advisory Group (HSAG). • Barrier analyses were completed by each CMH affiliate for the second remeasurement. A new barrier encountered by each CMH affiliate was service engagement constraints linked to the COVID-19 pandemic. • Each CMH affiliate completed an evaluation of the effectiveness of each intervention. CMH affiliate improvement action plans were adjusted to focus on implementing activities feasible and appropriate with the evolving COVID-19 pandemic.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Region 10 PIHP's findings from the comparison of baseline data to the most recent calendar year 2020 data show an increase of 7.78% for the rate of persons with Serious Mental Illness who have received Medical Assisted Treatment for Tobacco Use Cessation. Findings from the comparison of calendar year 2019 to the most recent calendar year 2020 data show an increase of 1.38%.
c. Identify any barriers to implementing initiatives: • Service engagement constraints due to the COVID-19 pandemic.
HSAG Assessment: HSAG determined that **Region 10 PIHP** addressed the prior year's recommendations. The PIHP used appropriate QI tools to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. **Region 10 PIHP** continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Region 10 PIHP** should consult with MDHHS to clarify the methodology specifically regarding the exceptions for Indicator #4b.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • In January 2021, prior to Region 10 receiving the EQR Technical Report, an email from an MDHHS Performance Indicator (PI) Lead suggested PIs #4a and #4b will be reworked with updated instructions. In this correspondence, it was also noted Region PIHP's reporting for PIs #4a and #4b was likely resulting in accurate percentages. • During the Improving Outcomes Conference in June 2021, it was shared during the Michigan Mission-Based Performance Indicator System (MMBPIS) session there would be revisions to PIs #4a and #4b. It was also noted the statewide PI Workgroup would be reconvened. Region 10 PIHP plans to be involved in the PI Workgroup when reconvened to support MDHHS' efforts to clarify and/or revise the methodology. • Region 10 PIHP contacted MDHHS PI Leads in June 2021 to ask about exception methodology for PI #4a. The response to Region 10 PIHP referenced PI #4b. Specific examples of exceptions, such as an individual refusing or no-showing, were provided which supported the PIHP's understanding of the exception methodology for PIs #4a and #4b. • During July, August, and September 2021, the Region 10 PI Team reviewed available data and materials from Substance Use Disorder Treatment Providers to better understand the circumstances and processes related to compliance and exceptions for PI #4b. Work in this area continues with planned outreach to MDHHS after consulting with other Region 10 Departments and Teams. • During September and October 2021, the Region 10 PI Team Leads identified improvement opportunities for PI supporting documentation and PI review processes for PI #4b.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Region 10 PIHP has noted a decrease in the number of exceptions for PI #4b throughout fiscal year 2021. There were 114 exceptions during first quarter, 98 exceptions in second quarter, and 85 exceptions in third quarter. • Region 10 PIHP has not noted improvement in overall compliance percentages for PI #4b throughout fiscal year 2021.
c. Identify any barriers to implementing initiatives: • Region 10 PIHP requested to participate in the PI Workgroup hosted by MDHHS. Region 10 PIHP is awaiting clarification from MDHHS and is also waiting for the PI Workgroup to convene.
HSAG Assessment: HSAG determined that **Region 10 PIHP** partially addressed the prior year's recommendation. While **Region 10 PIHP** indicated it worked collaboratively with MDHHS and the CMHSPs on interpretation of the MDHHS Codebook specifications exception criteria, HSAG observed during the SFY 2021 audit that some interpretations about compliance for Indicator #10 and exceptions for Indicator #4b did not align with MDHHS Codebook specifications and led to incorrect reporting of some records. As such, HSAG recommends that **Region 10 PIHP** consider having ongoing discussions and review of MDHHS Codebook specifications along with MDHHS guidance during its internally established Quality Management

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Committee meetings or another similar venue that includes CMHSP representation, the **Region 10 PIHP** performance indicator team, and IT/systems representatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Region 10 PIHP** should reconcile its credentialing worksheet against credentialing requirements and update accordingly. **Region 10 PIHP** should also clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and provider quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Region 10 PIHP**'s recredentialing review.
MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Region 10 PIHP reviewed and updated the Privileging and Credentialing review worksheets and methodology against credentialing requirements. The review worksheets and methodology were finalized in second quarter of fiscal year 2021. • The Region 10 PIHP Credentialing and Privileging Policy was revised to indicate that quality of care, contract compliance, contract monitoring findings, grievance and appeals information, and recipient rights complaints will be taken into consideration upon application for re-credentialing. The revised policy was added to the Region 10 website, distributed to PIHP staff, and sent to the PIHP Provider Network in May 2020. • Throughout fiscal year 2021, Region 10 Provider Network Management staff collaborated with PIHP Customer Services / Grievance & Appeals Department to develop a framework for the review of grievances, appeals, and quality issues when credentialing or recredentialing. • Region 10 PIHP's Credentialing and Privileging Policy was most recently revised in February 2021. • Region 10 PIHP's Credentialing and Privileging Policy defines the types of data and sources of provider quality issues included as part of the recredentialing review. These are minimally Medicare/Medicaid sanctions, State sanctions or limitations on licensure, registration, or certification, member concerns which include appeals and grievance (complaints) information, and PIHP Quality issues. Other organizational verification method(s) / clean application criteria standards include contract monitoring findings, grievance and appeal and recipient rights complaints, and demonstration of performance indicators meeting set standards or approved root cause analyses and plans of correction on file.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At the conclusion of fiscal year 2021, it was noted the improvement in documentation and procedures resulted in a smooth process for re-credentialing. • At the conclusion of the fiscal year 2021 contract monitoring process, all CMHs and SUD Providers scored 100% for the Credentialing domain. An area of strength for CMH and SUD Providers included improved Privileging & Credentialing adverse determination documentation and processes.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
c. Identify any barriers to implementing initiatives: • During the third and fourth quarters of fiscal year 2021, due to the COVID-19 pandemic, Region 10 PIHP staff capacity issues were a barrier to timely review and revision of the Region 10 PIHP Privileging and Credentialing Policy.
HSAG Assessment: HSAG determined that **Region 10 PIHP** addressed the prior year's recommendations. **Region 10 PIHP** implemented action plans to address ensuring a review of performance monitoring at the time of a provider's recredentialing, and **Region 10 PIHP** indicated that it has noted performance improvement as all CMHs and SUD providers scored 100 percent for the credentialing domain of **Region 10 PIHP**'s contract monitoring. HSAG will review **Region 10 PIHP**'s compliance in future compliance reviews.

5. Prepaid Inpatient Health Plan Comparative Information

In addition to performing a comprehensive assessment of each PIHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each PIHP to assess the Michigan Behavioral Health Managed Care program. Specifically, HSAG identifies any patterns and commonalities that exist across the 10 PIHPs and the Michigan Behavioral Health Managed Care program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

Prepaid Inpatient Health Plan External Quality Review Activity Results

This section provides the summarized results for the mandatory EQR activities across the PIHPs.

Validation of Performance Improvement Projects

For the SFY 2021 validation, the PIHPs submitted Remeasurement 2 data for their ongoing PIHP-specific PIP topic. Table 5-1 provides a comparison of the validation scores, by PIHP.

Table 5-1—Comparison of Validation, by PIHP

Overall PIP Validation Status, by PIHP		Design, Implementation, and Outcomes Scores		
		Met	Partially Met	Not Met
NorthCare	*Not Met*	*90%*	*0%*	*10%*
NMRE	*Not Met*	*70%*	*20%*	*10%*
LRE	*Not Met*	*90%*	*0%*	*10%*
SWMBH	*Not Met*	*80%*	*10%*	*10%*
MSHN	*Met*	*100%*	*0%*	*0%*
CMHPSM	*Not Met*	*90%*	*0%*	*10%*
DWIHN	*Not Met*	*80%*	*10%*	*10%*
OCHN	*Not Met*	*90%*	*0%*	*10%*
MCCMH	*Not Met*	*70%*	*20%*	*10%*
Region 10	*Met*	*100%*	*0%*	*0%*

The validation statuses for the PIHPs that received an overall *Not Met* validation score are related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. For the SFY 2021 PIP, achieving statistically significant improvement was an MDHHS-approved critical element; two of the 10 PIHPs achieved this high level of performance improvement.

Performance Measure Validation

Table 5-2 presents the PIHP-specific results for the SFY 2021 validated performance indicators. For each indicator, green font is used to denote the highest-performing PIHP(s), while red font is used to denote the lowest-performing PIHP(s).

Table 5-2—SFY 2021 PIHP-Specific Performance Measure Rate Percentages

Performance Indicator		Region 1 NorthCare	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#1	Children—Indicator #1a	100.00%	99.30%	97.02%	**DNR**	99.53%	98.58%	99.41%	98.80%	100.00%	100.00%
	Adults—Indicator #1b	100.00%	99.23%	97.68%	**DNR**	99.35%	98.05%	95.04%	95.60%	99.32%	99.81%
#2	MI–Children—Indicator #2a	70.00%	69.72%	51.45%	**DNR**	70.56%	68.27%	51.45%	64.29%	**DNR**	79.71%
	MI–Adults—Indicator #2b	65.57%	61.56%	82.11%	**DNR**	63.21%	64.74%	48.02%	60.89%	**DNR**	71.07%
	I/DD–Children—Indicator #2c	75.00%	81.82%	60.19%	**DNR**	64.88%	80.65%	63.18%	70.59%	**DNR**	81.90%
	I/DD–Adults—Indicator #2d	66.67%	80.77%	92.98%	**DNR**	70.27%	66.67%	42.59%	79.17%	**DNR**	83.02%
	Total—Indicator #2	67.39%	65.52%	79.52%	**DNR**	65.69%	67.35%	50.12%	62.52%	**DNR**	74.79%
#2e	Consumers[1]	62.34%	75.81%	71.52%	66.85%	86.28%	65.48%	68.43%	87.01%	94.45%	67.41%
#3	MI–Children—Indicator #3a	76.87%	71.81%	83.92%	**DNR**	68.30%	83.89%	82.70%	98.82%	59.09%	89.71%
	MI–Adults—Indicator #3b	76.44%	69.90%	78.71%	**DNR**	74.52%	77.73%	86.93%	99.53%	80.74%	87.61%

Performance Indicator		Region 1 NorthCare	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
	I/DD–Children—Indicator #3c	69.23%	86.89%	66.37%	**DNR**	73.94%	88.24%	78.38%	100.00%	87.76%	94.12%
	I/DD–Adults—Indicator #3d	86.36%	86.96%	90.00%	**DNR**	57.14%	80.00%	91.67%	100.00%	94.12%	87.50%
	Total—Indicator #3	76.92%	72.17%	80.33%	**DNR**	72.04%	81.25%	84.84%	99.38%	79.74%	88.92%
#4a	Children	100.00%	97.73%	98.78%	**DNR**	98.00%	100.00%	92.75%	96.43%	83.05%	98.88%
	Adults	94.87%	99.27%	92.60%	**DNR**	97.53%	95.52%	97.52%	95.15%	82.89%	98.33%
#4b	Consumers	66.67%	95.56%	97.56%	93.94%	98.31%	98.85%	100.00%	100.00%	94.75%	95.12%
#5	Medicaid Recipients	6.73%	7.73%	5.33%	6.74%	7.80%	6.42%	6.20%	7.11%	4.66%	6.90%
#6	HSW Enrollees	95.47%	94.95%	88.71%	95.18%	94.28%	89.98%	95.04%	97.57%	92.82%	98.76%
#8	MI–Adults—Indicator #8a	16.51%	19.27%	15.60%	17.05%	17.62%	15.75%	12.12%	17.24%	14.38%	11.76%
	I/DD–Adults—Indicator #8b	8.93%	11.52%	9.05%	9.36%	8.49%	9.42%	8.90%	13.25%	5.28%	6.28%
	MI & I/DD–Adults—Indicator #8c	9.63%	16.98%	8.70%	8.22%	9.46%	9.74%	6.05%	8.19%	5.16%	6.70%
#9	MI–Adults—Indicator #9a	96.60%	99.23%	98.43%	98.96%	98.41%	98.39%	99.39%	99.30%	99.49%	98.04%
	I/DD–Adults—Indicator #9b	47.10%	48.48%	69.68%	82.41%	56.49%	58.89%	53.87%	58.90%	27.05%	54.37%

Performance Indicator		Region 1 NorthCare	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
	MI & I/DD–Adults—Indicator #9c	58.62%	75.00%	70.78%	79.57%	57.91%	68.93%	50.91%	36.10%	30.59%	61.31%
#10	MI & I/DD–Children—Indicator #10a*	10.53%	9.62%	7.62%	5.00%	6.82%	7.14%	8.94%	6.25%	12.16%	11.67%
	MI & I/DD–Adults—Indicator #10b*	12.05%	11.27%	14.12%	12.32%	13.11%	10.29%	17.94%	10.16%	17.50%	10.94%
#13	I/DD–Adults	15.66%	21.89%	14.51%	21.32%	19.77%	25.85%	21.76%	19.34%	14.93%	16.89%
	MI & I/DD–Adults	23.57%	30.86%	22.00%	22.77%	25.86%	35.01%	27.65%	26.60%	25.08%	23.93%
#14	MI–Adults	52.41%	49.93%	45.55%	51.77%	48.73%	35.28%	37.49%	31.42%	43.28%	47.78%

DNR (Do Not Report) indicates that the rate was determined "materially biased."

* A lower rate indicates better performance.

Best performing PIHPs' rates are denoted in green font.

Worst performing PIHPs' rates are denoted in red font.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

In comparing the PIHP-specific results for the SFY 2021 validated performance indicators, **Oakland Community Health Network** demonstrated the best PIHP performance overall, achieving the best rate on eight performance indicators, with 100 percent for both I/DD child and adult populations reported for Indicator #3 and for all members for Indicator #4b. **Macomb County Community Mental Health** demonstrated the worst PIHP performance overall, with the worst rate on nine performance indicators. **Lakeshore Regional Entity** also demonstrated poor PIHP performance overall, with the worst rate on seven performance indicators. **Southwest Michigan Behavioral Health** demonstrated opportunity for significant improvement as its performance was unable to be comparably assessed due to receiving a *DNR* designation for multiple indicators.

Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., for all 10 PIHPs, the total number of adults who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., for all 10 PIHPs, the total number of adults discharged from psychiatric inpatient facilities). These calculations excluded raw data from any PIHP that received a *Do Not Report (DNR)* audit designation.

Table 5-3 presents the SFY 2020 and SFY 2021 statewide results for the validated performance indicators with year-over-year comparative rates. MDHHS defined an MPS for seven performance indicators. For these performance indicators, the statewide rates that met or exceeded the MPS are denoted by green font, while those that did not meet the MPS are denoted by red font. Performance indicators in black font do not have an established MPS.

Table 5-3—SFY 2020 and SFY 2021 Statewide Performance Measure Rates

Performance Indicator	2020 Rate	2021 Rate
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *MPS = 95%*		
Children—Indicator #1a	98.63%	99.22%
Adults—Indicator #1b	97.64%	97.75%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *No standard for first year of implementation*		
MI–Children—Indicator #2a	NA	64.31%
MI–Adults—Indicator #2b	NA	61.57%
I/DD–Children—Indicator #2c	NA	69.19%
I/DD–Adults—Indicator #2d	NA	72.51%
Total—Indicator #2	NA	64.60%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.[1] *No standard for first year of implementation*		
Consumers	NA	74.88%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *No standard for first year of implementation*		
MI–Children—Indicator #3a	NA	78.59%
MI–Adults—Indicator #3b	NA	81.17%
I/DD–Children—Indicator #3c	NA	80.50%
I/DD–Adults—Indicator #3d	NA	82.85%
Total—Indicator #3	NA	80.38%

Performance Indicator	2020 Rate	2021 Rate
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *MPS = 95%*		
Children	95.17%	96.01%
Adults	93.41%	95.32%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. *MPS = 95%*		
Consumers	96.39%	97.59%
#5: The percent of Medicaid recipients having received PIHP managed services. *An MPS was not established.*		
The percentage of Medicaid recipients having received PIHP managed services.	7.11%	6.48%
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. *An MPS was not established.*		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.79%	94.51%
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively. *An MPS was not established.*		
MI–Adults—Indicator #8a	16.31%	15.17%
I/DD–Adults—Indicator #8b	10.01%	9.13%
MI and I/DD–Adults—Indicator #8c	8.73%	8.27%
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. *An MPS was not established.*		
MI–Adults—Indicator #9a	98.54%	98.81%
I/DD–Adults—Indicator #9b	53.64%	55.03%
MI and I/DD–Adults—Indicator #9c	56.95%	55.19%
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *MPS = 15%*		
MI and I/DD–Children—Indicator #10a	7.98%	8.57%
MI and I/DD–Adults—Indicator #10b	14.70%	14.40%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). *An MPS was not established.*		
I/DD–Adults	19.37%	19.48%
MI and I/DD–Adults	27.49	26.14%

Performance Indicator	2020 Rate	2021 Rate
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). *An MPS was not established.*		
MI–Adults	45.04%	43.31%

The statewide rates that met or exceeded the MPS are denoted in green font for performance indicators that have an MPS.

The statewide rates that did not meet the MPS are denoted in red font for performance indicators that have an MPS.

* A lower rate indicates better performance.

NA indicates that data were not available for the indicator for SFY 2020.

[1] Please note that the PIHP data for Indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

Compared to performance in the prior year, the statewide rates experienced a variety of changes. Indicator #4a showed the most improvement as it increased by 1.91 percentage points for Adults, followed by Indicator #9b with an improvement of 1.39 percentage points for I/DD Adults. The other indicators demonstrated less significant increases. Indicators #6, #8a, #9c, #13, and #14 demonstrated worse performance, with Indicator #6 declining the most (by 3.28 percentage points), followed by Indicator #9 declining by 1.76 percentage points for MI and I/DD Adult, Indicator #14 declining by 1.73 percentage points, Indicator #13 declining by 1.35 percentage points for MI and I/DD Adults, and Indicator #8a Adult declining by 1.14 percentage points. The other indicators demonstrated less significant decreases.

Additionally, MDHHS has stated that Indicator #4b may have demonstrated inflated compliance due to the PIHPs' use of allowable exceptions. While HSAG determined that the PIHPs which achieved a *Reportable* designation for Indicator #4b did report the indicator in alignment with the MDHHS Codebook, HSAG agrees with MDHHS' assessment that PIHP reliance on exception criteria likely resulted in overall increased compliance with the Indicator #4b MPS.

Compliance Review

HSAG calculated the Michigan Behavioral Health Managed Care program overall performance in each of the six performance standards. Table 5-4 compares the Statewide average compliance score with the compliance score achieved by each PIHP for the standards reviewed in SFY 2021.

Table 5-4—PIHP and Statewide Compliance Review Scores for SFY 2021

Standard	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	84%	84%	89%	84%	84%	84%	84%	89%	84%	79%	**85%**
II	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
III	71%	100%	71%	86%	71%	71%	86%	71%	100%	86%	**81%**
IV	25%	50%	50%	25%	25%	25%	0%	50%	25%	25%	**30%**
V	93%	100%	79%	86%	93%	79%	79%	93%	79%	86%	**86%**
VI	82%	64%	73%	100%	91%	82%	64%	82%	73%	73%	**78%**
Total	**83%**	**86%**	**82%**	**86%**	**85%**	**80%**	**77%**	**86%**	**82%**	**80%**	**83%**

Standard I—Member Rights and Member Information
Standard II—Emergency and Poststabilization Services
Standard III—Availability of Services
Standard IV—Assurances of Adequate Capacity and Services
Standard V—Coordination and Continuity of Care
Standard VI—Coverage and Authorization of Services

Highest-performing PIHP(s) in each program area.

Lowest-performing PIHP(s) in each program area.

The findings from the compliance review activity identified moderate performance across all PIHPs, with overall compliance scores ranging from 77 percent to 86 percent. **Northern Michigan Regional Entity**, **Southwest Michigan Behavioral Health**, and **Oakland Community Health Network** demonstrated the highest overall performance across the 10 PIHPs, and **Detroit Wayne Integrated Health Network** demonstrated the lowest overall performance. As indicated by Statewide scores ranging from 30 percent to 86 percent (excluding Standard II), there are opportunities for improvement in all program areas. While achieving a Statewide score of 100 percent, Standard II results should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR.

6. Program-Wide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each PIHP and of the overall strengths and weaknesses of the Michigan Behavioral Health Managed Care program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the Behavioral Health Managed Care program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - Through the PIP activity, the Michigan Behavioral Health Managed Care Program is focusing its efforts on member engagement in appropriate care including medication management, screenings and testing, medication assistance for tobacco use cessation, and post-hospitalization care, which in turn should improve members' overall mental and physical health.
  - Through the MMBPIS, MDHHS is focused on driving continuous QI to increase timely access to services through established minimum performance standards that assist MDHHS in assessing PIHP compliance in several domains including access to care, adequacy and appropriateness of services provided, efficiency, and outcomes. As part of these continuous efforts, MDHHS and the Performance Indicator Workgroup determined the need for revisions to the MMBPIS measure indicators to identify program areas in need of improvement, including the need to remove exceptions, clearly document indicator specifications in order to remove variation in measurement across the PIHPs and CMHSPs, establish minimum performance standards after two years of measurement, and conduct performance improvement initiatives to address performance related to the new indicator specifications.
- **Timeliness** and **Access**
  - As demonstrated through performance indicator results in comparison to state-established MPSs, overall, the Michigan Behavioral Health Managed Care Program's PIHPs, CMHSPs, and contracted providers are conducting timely pre-admission screening for psychiatric inpatient care, seeing patients in a timely manner for follow-up care after psychiatric inpatient or substance abuse detox, and engaging with members to reduce inpatient psychiatric readmissions, suggesting members are able to access these providers in a timely manner for necessary follow-up care.

Weaknesses

HSAG's comprehensive assessment of the PIHPs and the Michigan Behavioral Health Managed Care program also identified areas of focus that represent significant opportunities for improvement within the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - As indicated through the PIP activity, six of 10 PIHPs experienced a decline in the SFY 2021 performance rate over the SFY 2019 baseline rate for at least one study indicator, indicating that the implemented interventions were not effective in increasing or sustaining QI.
  - Although the MMBPIS was identified as a strength of the program, not all performance indicators included as part of the MMBPIS had established performance benchmarks. Although MDHHS is collecting and analyzing performance measurement data for the new indicators, MPSs have not yet been determined. The lower-scoring rates for the new indicators confirm members are not always receiving timely services, suggesting the PIHPs may be prioritizing their efforts only on those indicators with an established MPS.
  - Through the compliance review activity, five of 10 PIHPs received scores below 75 percent in the Coverage and Authorization of Services standard primarily due to incomplete ABD notices. Although MDHHS has standardized ABD notice template language, PIHPs and/or their contracted providers sent notices with insufficient and/or inaccurate information about the denied service(s).
- **Timeliness** and **Access**
  - New PIHP members are not always able to receive a completed biopsychosocial assessment and access timely non-emergency services as evidenced by Indicator #2 and Indicator #2e rating below 75 percent for all individual populations, and Indicator #3 rating below 83 percent for all individual populations. Additionally, PIHP reliance on allowable exceptions for Indicator #4b likely causes inflated rates that may not reflect the true experience of the members served by the PIHPs in accessing timely follow-up care after discharge from a substance abuse detox unit.
  - All 10 PIHPs scored between 0 percent to 50 percent in Standard IV—Assurances of Adequate Capacity and Services, and five of 10 PIHPs scored below 75 percent in Standard III—Availability of Services, indicating significant opportunities at the program level for MDHHS and the PIHPs to enhance processes for monitoring timeliness and access to services and reporting to MDHHS network adequacy compliance in accordance with state-established network adequacy standards.

Quality Strategy Recommendations for the Behavioral Health Managed Care Program

The MDHHS CQS is designed to improve the health and welfare of the people of the State of Michigan and address the challenges facing the State. Through its CQS, MDHHS is focusing on population health improvement on behalf of all of the Medicaid members they serve, while accomplishing its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs. MDHHS uses three foundational principles to guide implementation of the CQS to improve the quality of care and services. The principles include:

- A focus on health equity and decreasing racial and ethnic disparities.
- Addressing social determinants of health.
- Using an integrated data-driven approach to identify opportunities and improve outcomes.

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following QI initiatives, which target the identified specific goals and objectives within MDHHS' CQS.

- **Goal 1:** Ensure high-quality and high levels of access to care
  - **Objective 1.2**: Assess and reduce identified racial disparities
  - **Objective 1.3**: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services
- **Goal 3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)
  - **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems
- **Goal 4:** Reduce racial and ethnic disparities in healthcare and health outcomes
  - **Objective 4.5**: Expand and share promising practices for reducing racial disparities
- **Goal 5:** Improve quality outcomes and disparity reduction through value-based initiatives and payment reform
  - **Objective 5.2**: Align value-based goals and objectives across programs

To improve program-wide performance in support of the objectives under **Goal 1**, **Goal 3,** and **Goal 4** and to enhance monitoring efforts and improve all members' access to timely care and services, HSAG recommends the following:

- **SFY 2022 PIP—**For SFY 2022, the PIHPs will be implementing a new PIP. MDHHS has elected to focus the statewide PIP topic on reducing racial or ethnic disparities. As part of the PIP process, and specifically when PIHPs are in the process of developing PIP interventions, MDHHS should consider the following:

  - To ensure interventions are actionable and will support performance improvement, MDHHS should review the PIHPs' planned interventions prior to PIHP implementation and provide feedback and/or approval on any planned interventions. MDHHS could consult with HSAG through this process.
  - Once interventions have been developed and implemented, MDHHS could consider assessing the PIHPs' processes to continuously measure and analyze intervention effectiveness through required quarterly status updates. These updates could include a summary of the PIHPs' intervention effectiveness, including any noted barriers, steps to mitigate those barriers, and any revisions that have been made to the interventions to support improvement. This is especially important through the COVID-19 pandemic as the PIHPs have continued to report COVID-19 as a barrier to successfully improving performance. MDHHS could leverage the HSAG-developed Intervention Progress Form to obtain feedback; however, this recommendation is specifically for MDHHS as MDHHS could provide valuable feedback to the PIHPs through its knowledge of the environment in Michigan.
  - MDHHS could also consider having the PIHPs, through a dedicated workgroup session, share promising practices (e.g., effective interventions) for reducing racial disparities and improving performance specifically through the PIP activity. This session could also be used to discuss how COVID-19 was considered when developing interventions that could be successful even through a pandemic.

- **MMBPIS New Indicators—**To enhance processes to monitor, track, and trend the quality, timeliness, and availability of care and services, MDHHS should consider establishing quality metrics (e.g., MPS) and performance improvement initiatives for the new performance indicators. To support this effort, MDHHS could consider the following:
  - Using the aggregated statewide SFY 2021 performance indicator rates, MDHHS could informally establish a benchmark for the PIHPs to work toward in SFY 2022 to ensure a prioritized focus on the indicators that do not already have an established MPS. The performance data results should then be shared through public forums to promote accountability.
  - For SFY 2022, MDHHS should also require the PIHPs to develop and implement a performance improvement initiative that focuses on Indicator #2, Indicator #2e, and/or Indicator #3. This initiative must be included as part of the PIHP's QAPIP for SFY 2022.
    - The QAPIP should include, at a minimum, a description of the initiative, workplan goals and objectives, and data collection and analysis methods.
    - At least annually, or as determined by MDHHS, the PIHP's QAPIP evaluation should contain the outcomes of the initiative, including any barriers identified and modifications made to the initiative to support performance improvement in the associated rates. MDHHS should review this information through the next annual QAPIP submission.
  - For SFY 2023, MDHHS should then use the performance measure data collected in both SFY 2021 and SFY 2022 to establish a formal MPS to hold the PIHPs accountable to performance improvement.

- **MDHHS Codebook Revisions—**To ensure the PIHP rates accurately reflect the true member experience with accessing timely follow-up care after discharge from a substance abuse detox unit, MDHHS should modify the allowable exceptions for Indicator #4b within the MDHHS Codebook, removing exceptions that artificially inflate PIHP rates. While it is reasonable to allow exceptions in some situations, the current exception methodology allows the PIHPs to document exceptions for a wide variety of cases. Limiting exceptions to only extraordinary cases will ensure the member experience is accurately portrayed in rates. If the MDHHS Codebook is updated to modify or remove exception criteria, HSAG further recommends that MDHHS revisit the MPS for Indicator #4b since the PIHPs achieved 95 percent using the exception methodology. The PIHPs are therefore unlikely to achieve a 95 percent or higher rate without using the current exception methodology.
- **Network Adequacy Monitoring—**To support ongoing PIHP monitoring of the MDHHS-established network adequacy standards identified through MDHHS' PIHP Network Adequacy Standard Procedural Document and to identify gaps in network adequacy that may impact members' timely access to care, MDHHS should consider the following:
  - MDHHS should identify specifications to uniformly calculate member/provider ratios and time/distance standards to ensure network adequacy standards are reported consistently across all PIHPs.
    - MDHHS should host a meeting with the PIHPs to discuss the network adequacy specifications to ensure consistent application of the network adequacy requirements.
  - MDHHS should establish a due date for the PIHPs to annually submit their assurances and supporting documentation to demonstrate their capacity in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document. MDHHS should update the SFY 2022 contract to include this date in the Schedule E Contractor Reporting Requirements and develop a standardized template for the annual submission.
  - MDHHS should use the PIHPs' network adequacy submissions to identify gaps in specific provider types and/or specific regions that may have a negative impact on member access to care. MDHHS could implement corrective action or other interventions, as appropriate, to improve network capacity.
  - After the annual network adequacy submissions, MDHHS should host a meeting with the PIHPs to discuss the network adequacy results and any required next steps to improve network capacity.

To improve performance in support of Objective 5.2 under **Goal 5** to align value-based goals and objectives across programs, HSAG recommends the following:

- **MDHHS Collaborative—**MDHHS is responsible for several separate Medicaid managed care programs. These programs are managed separately by multiple teams within MDHHS with minimal program alignment. To support the sharing of best practices and potentially reduce duplicative efforts, HSAG recommends the following:
  - MDHHS should establish a collaborative workgroup whose membership consists of representation from all Medicaid managed care programs. As part of this workgroup, MDHHS

should implement a communication channel and protocol for ongoing collaboration between the managed care programs. Through the workgroup, MDHHS could:

- Determine processes within the programs that could be streamlined to reduce efforts.
- Team members from each program area could report regularly on program-level activities, including successes and challenges, and solicit feedback from other program team members, when necessary, to identify potential opportunities for improvement and program enhancements.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), PIHPs are required to have a comprehensive QAPIP, which includes PIPs that focus on both clinical and non-clinical areas. Each PIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve QI.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The primary objective of PIP validation is to determine the PIHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the QI process:

1. Evaluates the technical structure of the PIP to ensure that the PIHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. Evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PIHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related and can be logically linked to the QI strategies and activities conducted by the PIHP during the PIP.

MDHHS requires that each PIHP conduct at least one PIP subject to validation by HSAG. In SFY 2021, the PIHPs submitted Remeasurement 2 data on one of the 10 state-recommended PIP topics. HSAG conducted the validation on the PIP study Design (Steps I through VI), Implementation (Step VII through VIII), and Outcomes (Steps IX and X) stages of the selected PIP topic for each PIHP. The PIP topics chosen by PIHPs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services.

Technical Methods of Data Collection and Analysis

Since these PIPs were initiated in SFY 2018, the methodology used to validate PIPs was based on CMS guidelines as outlined in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-1] When the PIHPs implement new PIPs, HSAG will use the CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-2]

Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each PIHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The CMS protocols identify 10 steps that should be validated for each PIP. For the SFY 2021 submissions, the PIHPs reported Remeasurement 2 data and were validated for Steps I through X in the PIP Validation Tool.

The 10 steps included in the PIP Validation Tool are listed below:

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Question(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)
Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate/Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 10, 2020.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 6, 2021.

HSAG used the following methodology to evaluate PIPs conducted by the PIHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The PIHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Not Met*.

The PIHPs had the opportunity to receive initial PIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to MDHHS and the PIHPs.

Description of Data Obtained and Related Time Period

For SFY 2021, the PIHPs submitted Remeasurement 2 data. The study indicator measurement period dates for the PIP are listed below.

Table A-1—Measurement Period Dates

Data Obtained	Reporting Year (Measurement Period)
Baseline	HEDIS 2019 (calendar year 2018)
Remeasurement 1	HEDIS 2020 (calendar year 2019)
Remeasurement 2	HEDIS 2021 (calendar year 2020)

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the PIHP provided to members, HSAG validated the PIPs to ensure the PIHP used a sound methodology in its design, implementation, analysis, and reporting of the study's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, or *Not Met*. HSAG further analyzed the quantitative results (e.g., study indicator results compared to baseline, prior remeasurement period results, and study goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Performance Measure Validation

Activity Objectives

As set forth in 42 CFR §438.350(a), the validation of performance measures calculated by the PIHPs and/or the State during the preceding 12 months was one of the mandatory EQR activities. The primary objectives of the performance measure validation activities were to:

- Evaluate the accuracy of the performance measure data calculated and/or reported by the PIHP.
- Determine the extent to which the specific performance measures calculated and/or reported by the PIHP (or on behalf of the PIHP) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure reporting and calculation process.

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS.

Table A-3 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of SFY 2021, which began October 1, 2020, and ended December 31, 2020. Table A-4 lists the performance indicators calculated by the PIHPs and MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook.

Technical Methods of Data Collection and Analysis

The CMS EQR PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The type of data collected and how HSAG conducted an analysis of the data included:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs and CMHSPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs/CMHSPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2020 performance indicator reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

PMV Activities

HSAG conducted PMV virtually with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors

were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

Description of Data Obtained and Related Time Period

As identified in the CMS EQR PMV protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool—**HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDHHS' and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each PIHP (if applicable) and from MDHHS (for the indicators calculated by MDHHS). If the PIHP did not produce source code to generate the performance indicators, the PIHP submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by MDHHS.
- **Previous Performance Measure Results Reports—**HSAG obtained these reports from MDHHS and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results—**HSAG obtained the calculated results from MDHHS and each PIHP.
- **Virtual On-Site Interviews and Demonstrations—**HSAG also obtained information through interaction, discussion, and formal interviews with key PIHP and MDHHS staff members as well as through virtual on-site systems demonstrations.

Table A-2 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-2—Data Sources and Time Frame

Data Sources	Period to Which Data Applied
ISCAT (from PIHPs)	SFY 2020
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2020
Previous performance measure results reports (from MDHHS)	SFY 2020
Performance measure results (from PIHPs and MDHHS)	1st Quarter SFY 2021
Supporting documentation (from PIHPs and MDHHS)	SFY 2020
Virtual interviews and systems demonstrations (from PIHPs)	During Virtual Review

Table A-3 displays the performance indicators calculated by the PIHPs and Table A-4 displays the performance indicators calculated by MDHHS that were included in the validation of performance measures, the subpopulations, the validation review period to which the data applied, and the agency responsible for calculating the indicator.

Table A-3—Performance Indicators Calculated by PIHPs

Indicator		Sub-Populations	Measurement Period
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	1st Quarter SFY 2021
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	1st Quarter SFY 2021
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	1st Quarter SFY 2021
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults	1st Quarter SFY 2021

Indicator		Sub-Populations	Measurement Period
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers	1st Quarter SFY 2021
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI & I/DD–Adults • MI & I/DD–Children	1st Quarter SFY 2021

Table A-4—Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders (SUDs).	• Consumers	1st Quarter SFY 2021
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2021
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	• HSW Enrollees	1st Quarter SFY 2021
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2020
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2020

Indicator		Sub-Populations	Measurement Period
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• I/DD–Adults • MI & I/DD–Adults	SFY 2020
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	• MI–Adults	SFY 2020

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the PIHP provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to the MPSs) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Compliance Review

Activity Objectives

The objective of the SFY 2021 Compliance Review was to assess each PIHP's compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements.

SFY 2021 began a new three-year review cycle, in which HSAG reviewed six standards for compliance. The remaining seven standards will be reviewed in SFY 2022. In SFY 2023, HSAG will perform a comprehensive review of the PIHPs' implementation of corrective actions taken to remediate any elements that received a *Not Met* score during SFYs 2021 and 2022. As demonstrated in Table A-5, HSAG will complete a comprehensive review of compliance with all applicable federal requirements as stipulated in 42 CFR §438.358.

Table A-5—Division of Standards Over Review Periods

Compliance Review Standards	Federal Standards and Associated Citations[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Mandatory Standards				
Standard I—Member Rights and Member Information	§438.100	✓		Review of PIHP implementation of Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan Medicaid health plans. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.
[2]The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).
[3]The Health Information Systems standard includes an assessment of each PIHP's information system.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review findings. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between MDHHS and the PIHPs. HSAG conducted the following activities as part of the compliance review:

Pre-review activities included:

- Scheduling the review.
- Developing the compliance review tools.
- Preparing and forwarding to each PIHP a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Conducting a technical assistance session to assist the PIHP in preparing for the compliance review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each PIHP to facilitate preparation for HSAG's review.
- Generating a list of 10 sample records for service authorization denials from the universe file submitted to HSAG from the PIHP.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from MDHHS and of documents that each PIHP submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each PIHP's operations, identify areas needing clarification, and begin compiling information before the site review.

Site review activities included:[A-3]

- An opening conference with introductions and a review of the agenda and logistics for HSAG's review activities.
- A review of the data systems that each PIHP used in its operations, which included, but was not limited to, utilization management, and care management systems.
- Interviews conducted with each PIHP's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection tool (compliance standards), which serves as a comprehensive record of HSAG's findings; performance scores assigned to each requirement; and actions required to bring each PIHP's performance into compliance for those requirements that HSAG assessed as less than fully compliant. HSAG also provided relevant recommendations to enhance program performance.

[A-3] Due to COVID-19, the on-site review was conducted virtually through a Webex session.

Post-review activities: HSAG reviewers aggregated findings to produce a comprehensive compliance review report. HSAG used scores of *Met* and *Not Met* to indicate the degree to which each PIHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a PIHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-4] The protocol describes the scoring as follows:

Table A-6—Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews. • Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice. • No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 6, 2021.

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by adding the score for each requirement in the standard receiving a score of *Met* (value: 1 point) or *Not Met* (0 points), then dividing the summed scores by the total number of applicable requirements for that standard. Elements *Not Applicable* to the PIHP were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the review areas by following the same method used to calculate the scores for each standard (i.e., by summing the values of the scores, then dividing the result by the total number of applicable requirements).

Additionally, HSAG created a CAP template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to MDHHS and HSAG, the PIHP must use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s). The CAP process included the following activities:

- PIHPs completed the CAP template describing the action plans to be implemented to remediate each deficient element.
- HSAG and MDHHS reviewed the PIHPs' action plans for each deficient element and assigned each element a designation of *Accepted*, *Accepted With Recommendations*, or *Not Accepted*.
- For any deficient element that received a designation of *Not Accepted*, the PIHPs were required to revise the CAP until HSAG and MDHHS determined the action plan is sufficient to ensure compliance with the requirements of the element.

Aggregating the Scores

HSAG aggregated and analyzed the data resulting from desk and site review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the PIHP's performance in complying with each standard requirement.
- Scores assigned to the PIHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to MDHHS staff members for their review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess each PIHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the PIHPs, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Member informational materials such as the member handbook and provider directory.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to, utilization management, care management, and network adequacy.
- PIHP-maintained records for service authorization denials.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with each PIHP's key staff members. Table A-7 lists the major data sources HSAG used to determine the PIHP's performance in complying with requirements and the time period to which the data applied.

Table A-7—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	October 1, 2020–March 31, 2021
Information obtained through interviews	July 12, 2021–July 26, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding concurrent reviews) between October 1, 2020–March 31, 2021

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each PIHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated for each standard. As any standard or program area not achieving 100 percent compliance required a formal CAP, HSAG determined each PIHP's substantial strengths and weaknesses as follows:

- Strength—Any program area that achieved 100 percent compliance.[A-5]
- Weakness—Any program area that received less than 75 percent compliance.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality and timeliness of, and access to care and services that the PIHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

[A-5] For Standard II—Emergency and Poststabilization Services, there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR, and the PIHPs' progress in implementing HSAG's recommendations in this program area will be further assessed for continued compliance in future reviews.