MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2020

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SECTION ONE – ANNUAL PLAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2019-2020

I. OVERVIEW

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid- State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The FY2015 contract expanded to include administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention. For FY2020, MSHN continues to sub-contract with CMHSPs within the region to provide Medicaid funded behavioral health services as well as directly contracting with Substance Use Disorder Providers within the region for the provision of all public funded SUD services.

The mission of MSHN is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational

functions and aspects of care and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented retained, contracted and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

II. PHILOSOPHICAL FRAMEWORK

The program design is based on the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C. Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes;
- Quality problems can be seen as the result of defects in processes;
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams;
- Quality improvement work is grounded in measurement, statistical analysis and scientific method;
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, "the continuous study and adaptation of health care organization's functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services" (The Joint Commission, 2004-2005). MSHN employs the Plan-Do- Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R., 1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance;
- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established;
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and
- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its behavioral health contract providers through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and maximizing productivity and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated;
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success;
- An organizational culture that supports reporting errors and system failures, as the means to improvement, and is important and encouraged;
- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

III. ORGANIZATIONAL STRUCTURE AND LEADERSHIP (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020) (42 Code of Federal Regulations (CFR) 438.358, 2002)

a) Structure

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

b) Components

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

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate

Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures (Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans, 2013, p. 2.7.3).

c) Governance

Board of Directors

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

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives an Annual Quality Assessment and Performance Improvement Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review of the Annual Quality Assessment and Performance Improvement Report, through the MSHN CEO the Board of Directors submits the report to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Director of Compliance, Customer Service and Quality, is responsible for the development, review and evaluation of the Quality Assessment and

Performance Improvement Plan and Program in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of performance improvement plans as required.

Medical Director

The Regional Medical Directors Committee that includes membership of the MSHN Medical Director and the CMHSP Participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends. The MSHN Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

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

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services is represented on the Council by MSHN SUD Staff. CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in the data collection related to performance measures/indicators at the organizational or provider level;

- Identifying organization-wide opportunities for improvement;
- Having representation on organization-wide standing councils, committees and work groups, and
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers,
- Responsible for communication between the PIHP QIC and their local organization.

Councils and Committees

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

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

Regional Medical Directors

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

SUD Oversight Policy Board

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

SUD-Provider Advisory Council (PAC)

The PAC is charged with serving in an advisory capacity to MSHN to offer input regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Regional Consumer Advisory Council (RCAC)

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

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self-determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc.

In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; Consumer Advisory activities at the local, regional and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

IV. PERFORMANCE MEASUREMENT (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

a) Establishing Performance Measures:

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each established measure should align with MSHN's goals and priorities and needs to have clear expectations, promote transparency, and be accountable through ongoing monitoring.

Measures can be clinical and non-clinical. Desired performance ranges and/or external benchmarks are included when known. MSHN is responsible for the oversight and monitoring of the performance of the PIHP including data collection, documentation, and data reporting processes to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement. The measures established reflect the organizational priorities, have a baseline measurement when possible, have an established re-measurement frequency (at least annually) and should be actionable and likely to yield credible and reliable data over time.

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Prioritizing Measures

Measures are chosen based upon selection and prioritization of projects, data collection, and analysis of data, and will be based on the following three factors:

Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high-risk services; continuity and coordination of care), or Non- Clinical (availability, accessibility, cultural competency; interpersonal aspects of care; appeals, grievance, relevancy to stakeholders due to the prevalence of a condition, the need for a service, access to services, complaints, satisfaction, demographics, health risks or the interests of stakeholders as determined through qualitative and quantitative assessment.)

Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.

Compliance: Adherence to law, regulatory, accreditation requirement and/or clinical standards of cares.

Performance Indicators

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

When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. The form will be reviewed by the MSHN CO and the MSHN contractor to ensure sufficient corrective action planning. Regional trends will be identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per year. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is subject to validation by the external quality review (EQR) organization and requires the use of the EQR's form. The second or additional PI project(s) is chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. The QIC approves the performance improvement projects and presents to relevant committees and councils for collaboration.

Data collected through the performance improvement projects are aggregated, analyzed and reported at the QIC meeting. The population from which a sample is pulled, the data collection timeframe, the data collection tool, and the data source are defined for each measure, whether local or regional. A description of Project/Study is written for each measure which documents why the project was chosen and identifies the data that was used to determine there was a problem and who is affected by the problem. It incorporates the use of valid standardized data collection tools and consistent data collection techniques. Each data collection description delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Provisions for primary source verification of data and maintenance of documentation are also addressed in the description of the project/study. If sampling is used, appropriate sampling techniques are required to achieve a statistically reliable confidence level. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

b) Data Collection and Setting Performance Targets:

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

When a performance measure has an established performance target set through contract

requirements, then that target will be utilized to measure performance. If there is no set performance target, baseline data should be considered prior to setting a target. Baseline data is a snapshot of the performance of a process or outcome that is considered normal, average, or typical over a period. The baseline may already be established through historical data or may still need to be collected. If baseline data is not available for an established measure, then the measure should be implemented for a period (typically up to one year) prior to establishing performance targets. When collecting baseline data, it is important to establish a well-documented, standardized and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.)

Once the baseline has been established for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks, when available, and deemed within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should just continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks, when available, then a performance target should be established that is at, or greater than, the state and national average.

When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

a) *Minimum or Acceptable Level.* Performance standards can be considered "minimum" or "acceptable" levels of success.
b) *Challenge Level*. This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
c) *Better Than Before.* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

Targets may be defined in several ways including the following:

a) Defining a set target percentage for achievement - to meet the outcome being measured.
b) Defining a percentage increase/decrease change to be achieved.

c) Data Analysis and Reporting:

The data should be reviewed at the established intervals and analyzed for undesirable patterns, trends, or variations in performance. In some instances, further data collection and analysis may be necessary to isolate the causes of poor performance or excessive variability.

The appropriate council, committee, or workgroup, in collaboration with the QIC, will prepare a written analysis of the data, citing trends and patterns, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Region wide quality improvement efforts will be developed based on the patterns and trends identified and will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups, etc. In some instances, provider level corrective action may be necessary in addition to, or in lieu of, region wide improvement efforts.

d) Performance Improvement Action Steps:

Process improvements are achieved by taking action based upon data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to ensure any improvements achieved are truly associated with the action. Adhering to the following steps promotes process integrity:

- Develop a step by step action plan;
- Limit the number of variables impacted;
- Implement the action plan, preferably on a small or pilot scale initially, and
- Collect data to check for expected results.

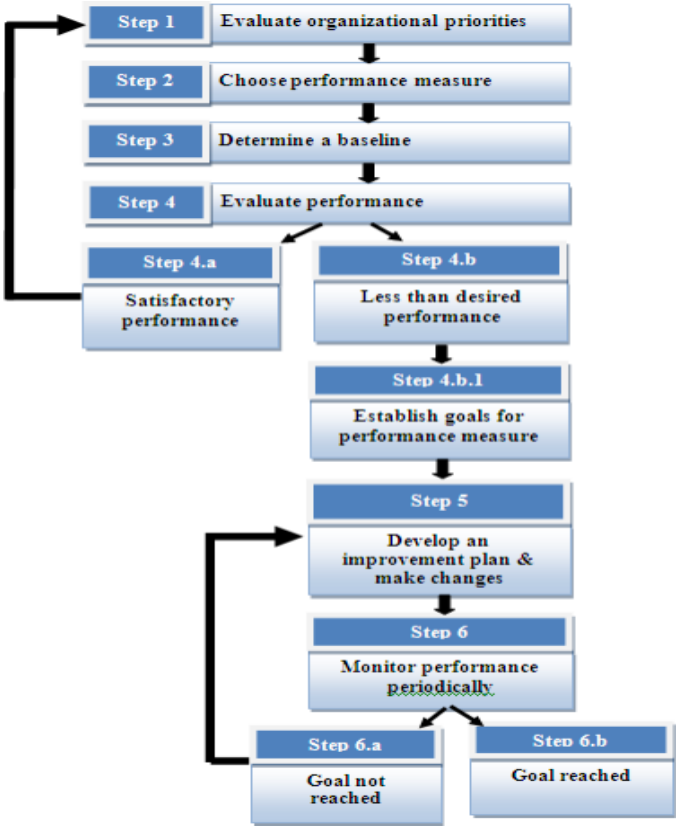
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to insure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

When the established minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a corrective action plan the includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the plans of correction. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Process Map of Performance Management Pathway (defined by HRSA)



e) Communication of Process and Outcomes: -

The MSHN Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements in collaborations with other committees and councils, and the CMHSP Participants and SUD Providers.

For any performance measure that falls below regulatory standards and/or established targets, plans of correction are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, and the Board of Directors and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated

by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

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

V. STAKEHOLDER FEEDBACK (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

The opinions of consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP, and organizations provider services to consumers are surveyed by MSHN at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs, and address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP Participants/SUD Providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services.

The aggregated results of the surveys and/or assessments are collected, analyzed and reported by MSHN in collaboration with the QI Council and Regional Consumer Advisory Council, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines appropriate action for improvements. The findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

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

VI. SAFETY AND RISK MONITORING: (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

a) Adverse Events

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

MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers. MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, time lines, and strategies for measuring the effectiveness of the action.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events as defined in the Medicaid Managed Specialty Supports and Service Concurrent 1915 (b)/(c) Waiver Program FY19 Attachment P7.9.1 and/or events requiring immediate notification to MDHHS. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future

b) Medicaid Event Verification (Medicaid Managed Specialty Supports and Services Program Contract and Medicaid Event Verification Technical Requirement-Attachment P.6.4.1)

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

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

Data collected through the Medicaid Event Verification process is aggregated, analyzed and reported for review at the QI Council meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report. All CMHSP Participants and MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

VII. CLINICAL STANDARDS (Medicaid Managed Specialty Supports and Services Program Contract)

a) Utilization Management -

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

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or

activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

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

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

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served;

information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) Practice Guidelines

MSHN supports CMHSP Participants local implementation of practice guidelines based on the Medicaid Provider Manual, the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program, and Evidence Based Practice models. The process for determining what practice guidelines were utilized is a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Practice guidelines as stated above are reviewed and updated annually or as needed and are disseminated to appropriate providers.

c) Oversight Of "Vulnerable People"

MSHN assures the health and welfare of the region's service recipients by establishing standards consistent with MDHHS contract requirements and reporting guidelines for all CMHSPs and subcontracted providers. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. MSHN monitors population health through data analytics software to identify adverse utilization patterns and to reduce health disparities.

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

d) Cultural Competence

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and

practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

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

e) Autism Benefit (Medicaid Managed Specialty Supports and Services Early and Periodic Screening, Diagnosis and treatment (EPSDT) State plan Home and Community-Based Services Administration and Operation)

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs the application of the policies, rules and regulations as established. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement Strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the EPSDT state plan and reviews this data monthly to quarterly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for reporting individual-level and systemic-level CMHSP quality improvement efforts.

Autism Benefit Review

Initial eligibility is managed through MSHN in a review of clinical content and then submitted to MDHHS for ABA service approval. Re-evaluations shall address the ongoing eligibility of the autism benefit participants and are updated annually. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

f) Behavior Treatment

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Only techniques approved by the Standards of Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered planning, and supported by current peer- reviewed psychological and psychiatric literature may be used. MSHN also receives CMHSP behavior treatment data regarding consumers on the habilitation supports waiver. This data has been piloted and tracked in the MSHN region and provides sub- assurances within participant safeguards that require additional oversight &

monitoring by the Michigan Department of Health and Human Services (MDHHS) for habilitation supports waiver enrollees around use of intrusive and/or restrictive techniques for behavioral control. By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data is analyzed on a quarterly basis by MSHN and is available to MHHS upon request. CMHSP data is reviewed as part of the CMHSP Quality Program and reported to the MSHN QIC at a defined frequency. MSHN analyzes the data on a quarterly basis to address any

trends and/or opportunities for quality improvements. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

e) <u>Trauma</u> (MDHHS Trauma Policy)

MSHN and its Provider Network shall adopt a trauma informed culture including the following: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization. In compliance with the MDHHS Trauma Policy MSHN has delegated the responsibility to the network providers to ensure development of a process for screening and assessing each population for trauma. Providers shall adopt approaches to address secondary trauma or staff and utilize evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment shall be completed to evaluate the extent to which the organizations policies are trauma informed. Organizational strengths and barriers, including an environmental scale to ensure the building and environment does not re-traumatize should occur every three years.

VIII. PROVIDER STANDARDS

a) <u>Credentialing/Qualification and Selection</u>

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY20 Attachment P7.1.1, FY20 Attachment PII.B.A), MSHN has established written policy and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs.

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

CMHSP Participant and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

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

b) Provider Monitoring and Follow-Up

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulates required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS. Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP Participant/SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. SUD Providers, however, must first obtain written authorization from MSHN in order to subcontract any portion of their agreement with MSHN. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies as necessary CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance are required to provide corrective action,

will be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

c) External Reviews

The PIHP is subject to external reviews through MDHHS or an external auditor to ensure compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external auditor to provide relevant evidence to support compliance. In accordance the Medicaid Managed Specialty Supports and Services Program FY20 7.0 Provider Network Services 7.9.1 External Quality Review. All findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives and activities in response to the findings. The improvement plan will be available to MDHHS upon request.

X. Quality Assessment and Performance Improvement Priorities (QAPIP) FY2020

The QAPIP priorities for FY20 are determined based on areas that have not demonstrated the desired performance for FY19. The QAPIP priorities shall guide quality efforts for FY20. Figure 1 demonstrates how MSHN will meet the contractual requirements for the elements of the QAPIP as required by MDHHS.

Figure 1. QAPIP Elements

Strategic Priority	Event Monitoring and Reporting	Indicator
MSHN will improve behavioral health services and supports and outcomes for all populations served	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports completed quarterly
	*Trends, patterns, strengths and opportunities for improvement identified.	Critical Incident Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	Oversight of CMHSP risk analysis and reduction	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.
Strategic Priority	**Behavior Treatment**	**Indicator**
MSHN will improve behavioral health services and supports and outcomes for all populations served	Quarterly Analysis of Data	BTR Performance Reports completed quarterly
	Trends, patterns, strengths and opportunities for improvement identified.	BTR Performance Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	Oversight of CMHSP risk analysis and reduction	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.
Strategic Priority	**Autism Waiver Monitoring**	**Indicator**
MSHN will improve access to services and supports	Quarterly Analysis of Data	Autism Performance Reports completed quarterly.
	Trends, patterns, strengths and opportunities for improvement identified.	Autism Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	*Oversight of CMHSP Autism benefit program requirements and corrective action related to the MDHHS site review	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.

Strategic Priority	Quantitative and Qualitative Assessment of Member Experiences	Indicator
Improve the Role of MSHN Consumers and Key Stakeholders	Opportunities for consumer feedback related to member experiences.	The Recovery Self-Assessment will be completed annually
		A Consumer Satisfaction Survey will be completed annually
MSHN will improve behavioral health services and supports and outcomes for all populations served	*Trends, patterns, strengths and opportunities for improvement identified.	Annual Report of Recovery Assessment will be completed annually
		Annual Report of Consumer Satisfaction Survey will be completed annually
Strategic Priority	**Practice Guidelines**	**Indicator**
Improve access to services and supports	MSHN Communication of practices guidelines	Utilization Management Plan and related policies/procedure will include a process for communicating practice guidelines.
	CMHSP Implementation of Practice Guidelines	MSHN desk review will verify local implementation of practice guidelines
Strategic Priority	**Credentialing, Provider Qualification and Selection**	**Indicator**
Enhance Regional Quality & Compliance	*Process to ensure CMHSP and SUD Providers adherence to MSHN credentialing policy	A process will be developed to increase compliance with the MDHHS/MSHN credentialing policy.
	CMHSP and SUD Providers adherence to MSHN credentialing policy	Delegated Managed Care Review will ensure credentialing is completed as required.
Strategic Priority	**Medicaid Event Verification**	**Indicator**
Public resources are used efficiently and effectively	Verifies delivery of services billed to Medicaid	The completion of the PIHP Medicaid Event Methodology Report
	Trends, patterns, strengths and opportunities for improvement identified.	The MEV Annual Methodology Report will be completed and reviewed with QIC and Compliance committee annually
	Reported annually to MDHHS	The annual MEV Methodology Report will be submitted to MDHHS as required

Strategic Priority	Utilization Management Plan	Indicator
Public resources are used efficiently and effectively	UM Committee develops standards for utilization	The MSHN Utilization Management Plan will be completed/reviewed annually.
	Trends, patterns of under / over utilization, strengths and opportunities for improvement are identified.	MSHN Utilization Management Reports will be completed quarterly/annually.
	*MSHN will have a process to ensure that, for service authorization decisions not reached within required timeframes ABD notices will be completed.	Delegated Managed Care Review (DMC) review
Strategic Priority	**Utilization Management Plan**	**Indicator**
MSHN will improve access to supports and services.	*MSHN will have a documented process for extending service authorization timeframes in certain circumstances.	DMC Review
	Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS
Strategic Priority	**Provider Monitoring**	**Indicator**
Enhance organizational quality & compliance	CMHSP annual monitoring of provider subcontractors	Annual Delegated Managed Care (DMC) Site Review are completed bi-annually. New standards and required corrective action is completed in the interim year.
	MSHN monitoring of CMHSPs and SUD Provider Network compliance	
Strategic Priority	**Oversight of "Vulnerable People"**	**Indicator**
MSHN will improve its population health and integrated health activities	CMHSPs monitor health, safety and welfare of individuals served	Annual DMC site reviews-clinical record reviews. Key priorities measures
	Trends, patterns, strengths and opportunities for improvement identified.	Individual corrective action plans will be completed for areas out of compliance. An annual report will be completed to identify regional action for improvement.

*Identifies required corrective action from external reviews.

QAPIP activities as exhibited in Figure 2 are aligned with the MSHN Strategic Plan Priorities contributing to Better Health, Better Care, and Better Provider Systems for the individual we serve.

Figure 2. Strategic Plan Priorities

Better Health		
Improve Population and Integrated Health Activities		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will expand the use and adoption of the Regional Electronic Medical Information (REMI) System and other applicable software platforms in use across the region to support improved population health outcomes, coordinated and integrated care activities, effectiveness and efficiency.	1. MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. MSHN and SAPT Providers and will facilitate CMHSP-to-CMHSP data exchange in order to reduce duplication when gathering needed information for reporting.	MMBPIS Affiliate Upload and aggregation in REMI; Critical Incident reporting system developed in REMI
MSHN will work with CMHSPs to MONITOR key indicators, supported by MSHN data analysis tools and analytics, such that these metrics inform both regional and county contractual performance targets, and are value added for decision making at councils, committees and board governance levels at MSHN and at all CMHSPs.	1. MSHN will continue to monitor and increase performance related to selected priority measures, key performance indicators and MDHHS's required metrics.	See performance measurement data

Better Care		
Improve Access to Care		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN and participating CMHSPs establish processes to assist individuals served in maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	1. MSHN will monitor CMHSP and SAPT provider consumer verification practices through its site review process and Medicaid event verification audit.	Medicaid Event Verification Site Review Process
	1. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	Admissions and Benefits workgroup developed access and authorization guidelines
	2. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.	Development within the appropriate committee in collaboration with the CMHSPs.
	3. MSHN will ensure there are uniform access and utilization management criteria in place and will monitor admissions and denials for conformity with the established criteria.	Development within the appropriate committee in collaboration with the CMHSPs.
Improve the Role of MSHN Consumers and Key Stakeholders		
Stakeholder feedback demonstrates effective, efficient and collaborative operations.	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications.	Work Force Survey
MSHN will improve and integrate stakeholder and consumer input and utilize compiled input to improve system performance and provide feedback to stakeholders on systems improvements made.	1. Improve communications linkages between provider input forums, executive leadership and governance.	In development
	2. Evaluate feasibility of survey consolidation and streamlining.	Obtaining information

Enhance Regional Quality and Compliance		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination and independent facilitation in the region.	1. MSHN will strengthen MSHN QAPI reviews of person-centered planning, independent facilitation and self-determination implementation in its provider network oversight activities.	Improvements to the DMC Site Review Process
	2. MSHN will use data gathered in its provider network oversight activities to develop specific training and/or learning communities to strengthen person-centered planning, independent facilitation and self-determination implementation.	Improvements to the DMC Site Review Process
Better Value		
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure.	1. MSHN ensures full implementation of agreed upon regionally standardized processes at all CMHSPs and the PIHP.	BTPRC, MMBPIS, RSA, Critical Incidents, Satisfaction Survey
	2. MSHN evaluates penetration rate, cost and other metrics and addresses undesirable variation through its councils and committees in order to promote standardized, consistent and cost-effective operations across the region.	See performance measurement data
MSHN's Provider Network Management Systems are effective and efficient.	1. MSHN publishes provider performance data to consumers and the public.	Available on Website

Better Provider System		
MSHN ensures that it engages a provider network with adequate capacity and competency		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN enhances existing quality assessment and performance improvement systems that promote continuous improvement and enhanced accountability for clinical and fiscal performance.	1. MSHN will develop and begin reporting on the provider scorecard.	MMBPIS, Adverse Event Reporting, Satisfaction Survey
	2. MSHN will strengthen regional performance improvement systems in the SAPT provider network.	MMBPIS, Adverse Event Reporting, Recovery Assessment, Satisfaction Survey
	3. MSHN will provide training and education related to data integrity, reporting standards, use of data in decision making and provider development.	Documentation and training completed during committee/council/work group meetings.
	4. MSHN will integrate fiscal information and performance results into its quality assessment and performance improvement systems.	Priority Measures, MMBPIS, Adverse Events, Recovery Assessment, Satisfaction Survey
MSHN engages in activities to simplify administrative complexity and enhance provider satisfaction.	2. MSHN will develop internal functional area annual plans (inclusive of provider responsibilities related to strategic projects/initiatives, and operational requirements such as audits, annual plans, reporting requirements, etc.) To identify overlap/redundancy and opportunities for cross functional collaboration to streamline processes.	In development

An effective performance measurement system allows MSHN to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, and outcomes of the services provided. An effective performance measurement system also allows for an evaluation of satisfaction of the services in which an individual receives. Figure 3 demonstrates performance measurements used to monitor the performance of MSHN.

Figure 3. Performance Measurement

Performance Measurement	Indicator
Performance Indicators (Michigan Mission Based Performance Indicator System-MMBPIS)	Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above)
	Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) Indicator 2. a. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.
	Indicator 2 b. Effective on and after January 1, 2020, 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.
	Indicator 3: Start of Service within 14 Days (standard is 95% or above) Indicator 3: Effective on and after January 1, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).
	Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above)
	Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above)
	Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less)
Performance Improvement Projects	PIP – The degree to which programs implement recovery-oriented practices. (standard is >=3.50)
	PIP - The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. (standard is 7% increase from baseline) HEDIS Diabetes Monitoring Report

Priority Measures	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (standard-58%)
	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (standard-70%)
	The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. (standard is 7% increase from baseline) HEDIS Diabetes Monitoring Report.
	The percentage of patients `8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Increase from previous measurement period)
	The percentage of individual 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (increase from previous measurement period)
	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. FU Children ADHD Med Initiation Phase
	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. FU Children ADHD Med Continuation & Monitoring (C&M) Phase
	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%)
	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%)
	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%)

	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within (34)30 days of the initiation visit (Initiation of Alcohol and Other Drug (AOD) Treatment,(above national numbers)
	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within (34)30 days of the initiation visit (Initiation of Alcohol and Other Drug (AOD) Treatment, (above national numbers)
Contract Requirement	Identification of enrollees who may be eligible for services through the Veteran's Administration (baseline).
Contract Requirement	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (standard-95%)
Contract Requirement	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid second opinion requests regarding inpatient psychiatric hospitalization denials which are resolved in compliance with state and federal timeliness standards, including receiving a written provision of disposition (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)

Performance Measurement	Indicator
Event Monitoring and Reporting	The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year.
Performance Measurement	**Indicator**
Behavior Treatment	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.
	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.
	The percent of incidents per consumer served requiring phone calls made by staff to police for behavioral assistance during the reporting period will decrease from previous year.
Performance Measurement	**Indicator**
Quantitative and Qualitative Assessment of Member Experiences	I am involved in my community and organization (RSA-Involvement) (>=3.5)
	Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services) (>=3.5)
	I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment) (>=3.5)
	I am given choices about my treatment and care that I receive (RSA-Choice) (>=3.5)
	Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals) (>=3.5)
Performance Measurement	**Indicator**
Medicaid Event Verification	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the services provided falling within the scope of the service code billed (CMHSP results).
	Medicaid Event Verification review demonstrates improvement of previous year results with the service being included in the persons individualized plan of service (SUD results).

XI. DEFINITIONS

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

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

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

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

MMBPIS: Michigan Mission Based Performance Indicator System

MSHN: Mid-State Health Network

MDHHS: Michigan Department of Health and Human Services

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

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

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

purposes. For example, some demonstration and service programs may include research activities.

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

SUD Providers: Refers to Substance Use Disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.

(2020). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.*

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