MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Evaluation Report FY2020

Prepared By: MSHN Quality Manager -December 2020
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SECTION ONE – FY2020 ANNUAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM PLAN

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 FY2021, 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

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.

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).

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

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, orsatisfaction.
> 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.

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.

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.

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.

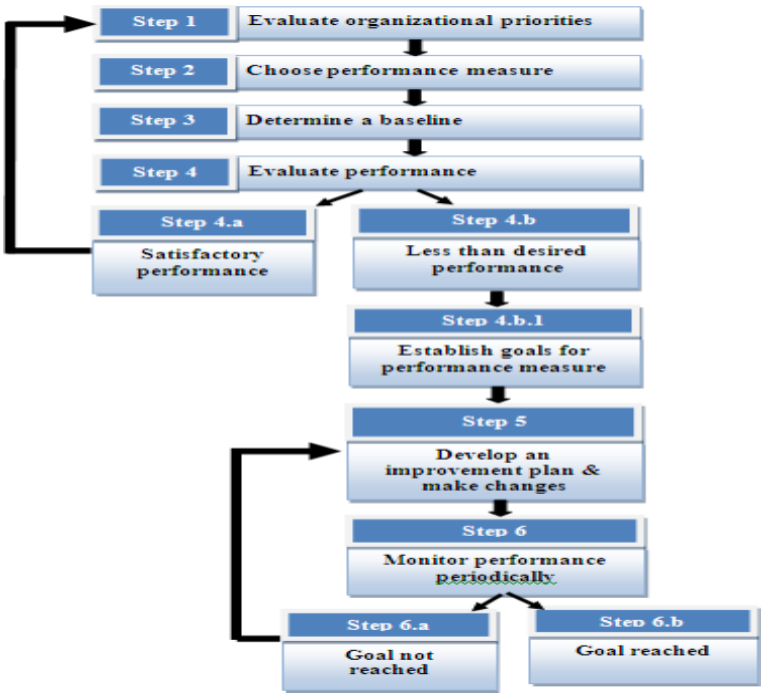
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement 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)



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 EXPERIENCE/ENGAGEMENT

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:

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, timelines, and strategies for measuring the effectiveness of the action.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events 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

Medicaid Event Verification

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 QUALITY STANDARDS

Utilization Management[1]

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 (Attachment UM Plan). 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.

[1] Annual Utilization Management Plan

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.

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.

Oversight Of "Vulnerable People"

MSHN assures the health and welfare of the region's service recipients through service delivery [2] by establishing standards of care for individuals served.[3][4][5] 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.

[2] Habilitation Supports Waiver Annual Recertification, initial
[3] Home and Community Based Services Monitoring Procedure
[4] Autism Benefit Compliance Monitoring
[5] Case Management Services

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.

Autism Benefit

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.

<u>Autism Benefit Review</u>

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.

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.

Trauma

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

Credentialing/Provider Qualifications and Selection

In compliance with MDHHS's Credentialing and Re-Credentialing Processes, 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, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of 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.

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.

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.

IX. 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.

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

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

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

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

(2020). Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program -Attachment P7.9.1

(2013). *Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans.*

(2004-2005). The Joint Commission. *Comprehensive Accreditation Manual for Behavioral Health Care.*

(May 13, 2011). *Michigan Department of Community Health (MDCH)/Prepaid Inpatient Health Plan (PIHP) Event Reporting v1.1, Data Exchange Workgroup-CIO-Forum.*

(2020). *Medicaid Managed Specialty Supports and Services Contract Link/Attachment-Standards for Behavioral Treatment Plan Review Committees, Revision FY'17.*

(November 2002). "Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience". *Harvard Review of Psychiatry*.

(1991). Scholtes, P. R. In *The Team Handbook* (pp. 5-31). Madison, WI: Joiner Associates, Inc.

SECTION TWO-ANNUAL REPORTS

I. MSHN Councils Annual Reports

TEAM NAME: Operations Council
TEAM LEADER: J. Sedlock, MSHN Chief Executive Officer
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

Purpose of the Operations Council:
The MSHN Board has created an OC to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[6]

Responsibilities and Duties[7]: The responsibilities and duties of the OC shall include the following:

- Advise the MSHN CEO in the development of the long-term plans of MSHN.
- Advise the MSHN CEO in establishing priorities for the Board's consideration.
- Make recommendations to the MSHN CEO on policy and fiscal matters.
- Review recommendations from Finance, Quality Improvement, and Information Services Councils other Councils/Committees asassigned.
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies[8];and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability[9]
The Operations Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Expanded service access (penetration rates),
- Fiscal accountability,
- Compliance, and
- Improved health outcomes/satisfaction.

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

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

[6] Article III, Section 3.2, MSHN/CMHSP Operating Agreement
[7] Ibid., unless otherwise footnoted
[8] Operations Council Charter, February 2014
[9] Ibid.

Annual Evaluation Process:

a. Past Year's (FY20) Accomplishments:
   - Adopted updates to the MSHN/CMHSP Operating Agreement
   - Monitored and advised MSHN on periodic financial reports including savings estimates and internal service fund balances, CMHSP revenue/spending estimates, MSHN revenue/spending estimates and overall fiscal health
   - Developed and implemented regionally standardized central registry check requirements and processes
   - Reviewed and developed regional implementation plan for changes to the MSHN/MDHHS contract
   - Reviewed and developed individualized work plans to address regional workforce survey results
   - Fully implemented parity requirements and related MCG software platform
   - Centralized Relias training platform administration under a single regional contract
   - Explored alternative managed care structures in anticipation of (and then in response to) MDHHS proposals for system redesign/reform
   - Approved regional SMI and SED level of care guidelines and related policies/procedures resulting in greater regional admission and benefit standardization
   - Established and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary services, specialized residential providers, and inpatient psychiatric units under contract to CMHSP Participants
   - Conducted two strategic planning sessions and created vision documents for the future of the PIHP and Public Behavioral Health System
   - Engaged in advocacy for addressing MSHN regional design elements in public system reforms
   - Implemented substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections via MSHN/MDHHS contract (rather than as a standalone contract directly between MSHN and MDOC)
   - Monitored and participated in Behavioral Health Fee Schedule discussions/meetings
   - Monitored CMHSP and regional performance under the regional Quality Assessment and Performance Improvement Plan, External Quality Reviews, MDHHS Oversight and Monitoring Reviews, audits and other quality assessment activities
   - Worked through many MDHHS/Milliman errors in initial rates and at least three subsequent rate certification processes
   - Addressed regional role in statewide training and provider performance monitoring reciprocity activities
   - Reviewed CMHSP performance on delegated managed care reviews
   - Revised MSHN performance on many performance metrics and SAPTR system oversight activities
   - Addressed impact of Healthy Michigan Plan work requirements
   - Considered then ruled out regional marketing/public relations campaign (specifically focused on CMHSP Participant integrated health activities)
   - Approved several new workgroup charters for regional implementation
   - Revised/updated many policies and related procedures

- Monitored and advised MSHN on matters relating to compliance with the HCBS rule transition
- Monitored and advised MSHN on MDHHS-initiated federal waivers
- Considered input from consumer satisfaction surveys and recommendations from consumer advisory and other peer/consumer structures to improve regional performance
- Recommended for approval several regional plans including Utilization Management Plan, Compliance Plan, Quality Assessment and Performance Improvement Plan, Population Health and Integrated Care Plan
- Established regionally standardized provider network application
- Committed to MSHN-led, regional approaches to standardize to the extent feasible responses to the COVID-19 pandemic
- Met weekly during most of the pandemic response period in this fiscal year to coordinate regional and local pandemic status/response
- Developed and adjusted plans to ensure delivery of behavioral health services in as safe a manner as possible during the COVID-19 pandemic response
- Developed stage-wise plans to engage services and supports at physical locations and to support physical plant safety for workforce members and beneficiaries/visitors
- Developed and implemented a regional plan for direct support professional (DCW) premium pay during the initial COVID-19 pandemic response; extended the regional plan for additional period into FY21
- Collaborated on implementation of telehealth services/supports
- Developed regional residential crisis support plans
- Collaborated to secure needed personal protection equipment in the region and to distribute to CMHSP participants and substance use disorder residential providers.
- Provided input on current year amended budget
- Provided input on proposed next fiscal year budget
- Reviewed Key Performance Indicators through Balanced Scorecard
- Reviewed Medicaid and Health Michigan Service Use Analysis
- Approved project for regional provider organizational online application
- Initiated work to understand statewide regional crisis line (MiCAL)
- Supported statewide PIHP-written proposal for complex care management for the unenrolled population

b. Upcoming Goals for Fiscal Year Ending, September 30, 2020:

- Assist MSHN with implementation of the FY 22-FY 23 Regional Strategic Plan (after approval in late FY 21)
- Support MSHN in establishing improved performance metrics for services and supports and for MDHHS incentive payment metrics (including follow-up after hospitalization for mental illnesses, follow-up to persons with an SUD diagnosis following contact with an Emergency Room; identification and follow up activities related to health disparities; increase in Patient Centered Medical Homes; better support for veterans and expanded population health and performance monitoring metrics

- Home and Community Based Services Waiver Transition implementation
- 1115 (and associated) Waiver implementation and workflow engineering changes
- Continue coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services
- Improve consistency, standardization, and cost-efficiency in retained and delegated managed care activities
- Increase efficiency through collective provider network management functions
- Continue advocacy for systemic improvement in access to inpatient care and identify and develop sub-inpatient regional crisis response systems/options
- Support MDHHS strategic planning efforts related to CCBHC, Behavioral Health Homes, State Innovation Models, etc.

TEAM NAME: Finance Council

TEAM LEADER: Leslie Thomas MSHN Chief Financial Officer

REPORT PERIOD COVERED: 10.1.19 - 9.30.20

Purpose of the Finance Council

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

Responsibilities and Duties:

Areas of responsibility:

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

Monitoring and reporting of the following delegated financial management functions:

- Tracking of Medicaid expenditures.
- Data compilation and cost determination for rate setting.
- FSR, Administrative Cost Report, MUNC and Sub-element preparation.
- Verification of the delivery of Medicaid services; and
- Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:

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

Defined Goals, Monitoring, Reporting and Accountability Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2019 and February 2020. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2020. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.

- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2019 Final Reports due to MDHHS February 28, 2020, are received from the CMHSPs to the PIHP. The goal for FY20 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Community Mental Health Administration to establish standard cost allocation methods. The goal is to reduce unit cost variances for each CPT or HCPCS. The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2020. MDHHS compiles PIHP reports and send an analysis to the PIHPs in June of 2020. Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. The PIHP CFO council developed definitions, grids, and guidelines for uniform administrative costing. Finance Council members agreed to follow the methodology guidance from MSHN. CMHSPs must show evidence of meeting MSHN's guidelines through its Administrative Cost Report (ACR) narrative.
- Monitor the impact on savings and reserves related to addition of Serious Emotional Disturbances (SED) Waiver and Children's Waiver funding now included in the PIHP's capitation. Both programs were previously funded directly to the CMHSPs on a fee- for-service basis.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

<u>Annual Evaluation Process</u>

Past Year's Accomplishments:

- FY 2019 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and all of the CMHSP audits rendered an unqualified opinion. Compliance Examinations were finalized for the PIHP and all CMHSPs. The PIHP's Compliance Examination is completed after the CMHSPs to ensure all adjustments to Medicaid and Healthy Michigan Plan are included. The PIHP received findings as a result of one issued to one CMHSPs. The other 11 CMHSPs had no findings and complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants.
- MSHN achieved a fully funded (7.5%) Internal Service Fund for FY 2019. In addition, the region boasted savings of more than $5.2 M which is approximately .89% of revenue for a total risk reserve of 8.39%.
- MDHHS and Milliman worked through FY 20 to develop a Standard Cost Allocation process. This work will be shared state-wide in December 2020 for implementation in FY22. A follow-up meeting will be conducted in early calendar year 2021 to address questions and concerns from CMHSPs as they work through implementation barriers.
- The SED and CW are incorporated into Medicaid funding for MDHHS reporting. MSHN also tracks each revenue source to ensure sufficiency for covering CMHSP expenses. In FY 20 revenues are sufficient to meet service needs.

In addition to the accomplishments listed above, MSHN's Region successfully implemented strategies to maintain provider fiscal stability during the COVID-19 pandemic. The goal was to ensure providers continued service delivery including implementing many changes such as audio only telehealth expansion and increased in-person safety measures. MSHN expended provider stability funds with existing FY 20 revenue as MDHHS did not disburse additional funds for this initiative.

Further, Direct Care Workers (DCW) were granted a $2 per hour premium pay increase for MDHHS identified services. MDHHS did increase FY 20 rates to cover DCW increases and will also continue this funding for the first quarter of FY 21.

Upcoming Goals for Fiscal Year Ending September 30, 2021 Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2020 and February 2021. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2021. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2020 Final Reports due to MDHHS February 28, 2021, are received from the CMHSPs to the PIHP. The goal for FY21 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Community Mental Health Association to establish standard cost allocation methods. The goal is to reduce unit cost variances for each CPT or HCPCS. For Fiscal Year-end 2020 reporting, MDHHS replaced the Medicaid Uniform Cost (MUNC) with the Encounter Quality Initiative (EQI) report. The change is being implemented in conjunction with mandated standardized allocation processes to provide MDHHS with more useful fiscal information from PIHPs. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. The Administrative Cost Report will be discontinued after FY 20 reporting due in February 2021. MDHHS and Milliman have embarked on a statewide Standard Cost Allocation methodology in an effort to reduce unit rate variability by ensure similar service cost inputs. The new Standard Cost Allocation tool will be implemented statewide beginning FY 22.
- Monitor the impact on savings and reserves related to addition of Serious Emotional Disturbances (SED) Waiver and Children's Waiver funding now included in the PIHP's capitation. Both programs were previously funded directly to the CMHSPs on a fee-for- service basis.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

TEAM NAME: Information Technology Council
TEAM LEADER: Forest Goodrich, MSHN CIO
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

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

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

Defined Goals, Monitoring, Reporting and Accountability:
The IT Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

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

Annual Evaluation Process:

1. Past Year Accomplishments

Representation from each CMHSP Participant at all meetings

- There was a 96% attendance rate during FY20 ITC meetings. 100% attendance occurred in 6 meetings. Several CMHSP participants have multiple staff attending for technical and content expertise.

Successfully submit MDHHS required data regarding quality, effectiveness and timeliness

- We reported above the 95% compliance standard for submitting BH-TEDS, and remain as one of the highest reporting regions according to MDHHS.
- MDHHS reported we were measured at 100% in encounter reporting timeliness and volume submissions. MSHN strives to report all required data to MDHHS and it shows when the reconciliation process reflects 100% match between MDHHS warehouse records and MSHN REMI records.
- MSHN met the requirements for MDHHS performance incentives that included evaluating and summarizing data quality improvement with Veterans and Military fields included in BH-TEDS reporting and developing a plan and status with submitting BH ADT records to a health exchange. (MiHIN)
- LOCUS data reporting improvements for rate setting.
- Performance indicator reporting changes to support MDHHS required reporting.

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

- Revised to the managed care information system (REMI) to be able to report telephonic and telehealth events as we transitioned our operations to work during pandemic.
- Implemented the SED and Child Waiver reporting through MSHN.
- Analysis and planning for EQI reporting.

Facilitate health information exchange processes

- Worked with MiHIN to integrate MIDIGATE (MI Gateway) and VIPR to support a single framework for HIE access.
- Establish pilot process for the Care Coordinators use case for MI Gateway with MiHIN.
- Pilot process with MDHHS and MiHIN for eConsent in MI Gateway.
- Finalized a standard template for mental health ADTs being sent to MiHIN.

Goals established by Operations Council

- Improvements with balanced scorecard reporting.
- Worked region-wide to develop COVID-19 statistical reports.
- Developed region-wide telehealth statistical reports.
- Supported the technical needs to install MCG Indicia and upgrade for Parity.

Meet external quality review requirements

- We had a successful review as conducted by Health Services Advisory Group for MDHHS. This was another good year in review for MSHN.

2. Goals for fiscal year ending September 30, 2021
   - Active participation by all CMHSP representatives at each monthly meeting.
   - Meet current reporting requirements as defined by MDHHS.
   - Review and improve telehealth reporting related to pandemic.
   - Improve Veterans and Military fields data quality in BH-TEDS reporting process.
   - Evaluate and plan for CC360 integration into EMRs.
   - Work to achieve balanced scorecard target values
   - Develop project plan outline for implementing BH ADT record submission to MiHIN for shared HIE processing.
   - Work toward achieving goals established by Operations Council.
   - Prepare for and pass audit requirements of the external quality review.

TEAM NAME: Quality Improvement Council
TEAM LEADER: Sandy Gettel, MSHN Quality Manager
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

Purpose of the Council or Committee: The Quality Improvement Council was established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the MSHN Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director and a MSHN SUD staff representing Substance Use Disorder services. The Quality Improvement Council is chaired by the MSHN Quality Manager. All Participants are equally represented on this council.

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

- Advising the MSHN Quality Manager and assisting with the development, implementation, operation, and distribution of the Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures.
- Reviewing and recommending changes/revisions to the QAPIP, related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the QAPIP.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Quality Assessment and Performance Improvement Program and supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had twelve (12) meetings during the reporting period and in that time completed the following tasks:
    - Reviewed and approved the FY19 Quality Assessment and Performance Improvement Report.
    - Reviewed, revised, and approved the FY20 Quality Assessment and Performance Improvement Plan.
    - Reviewed, revised, and developed current regional policies and procedures in areas of Quality Improvement.
    - Reviewed the annual Medicaid Event Verification Report.
    - Reviewed the Quality Assessment Performance Improvement (QAPI) Report which includes trends, strengths and growth areas from site reviews that occurred within the quarter.
    - Reviewed and approved the FY20 Delegated Managed Care Site Review Tools.
    - Reviewed key performance indicators (Diabetes Screening, Follow Up to Hospitalization, Diabetes Monitoring) identifying trends and action steps as needed.
    - Reviewed the Recovery Self-Assessment data (Administrator, Provider) identifying trends and growth areas.
    - Reviewed the data for the performance improvement project "Diabetes Monitoring for Schizophrenia Diagnosis" identifying barriers and interventions.
    - Reviewed the Critical Incident Data quarterly, developed a more in-depth analysis for identifying trends and growth areas for development of focused improvement efforts.
    - Reviewed the Michigan Mission Based Performance Indicator System (MMBPIS) data quarterly report identifying trends and actions steps for improvement.
    - Developed a process for collection and analysis of the new (Indicator 2, Indicator 2e and 2b, and Indicator 3) Michigan Mission Based Performance Indicator System (MMBPIS).
    - Reviewed the Behavior Treatment Review Data quarterly, identifying trends and growth areas, revising the definitions and process to be consistent with the MDHHS Behavioral Treatment Standards in coordination with the MSHN Behavioral Treatment Work Group.
    - Developed a new data collection process for streamlined efforts of analysis of behavior treatment data inclusive of all population groups within the required population for reporting and monitoring.

- Participated in the External Quality Reviews (Performance Improvement Project, Performance Measurement Validation, Compliance), completing and implanting required corrective action and recommendations.
- Completed satisfaction surveys for representative populations, identifying trends and growth areas for development of focused improvement efforts.
- Completed annual review and update of QIC charter.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2021

- Incorporate consumer representative in QIC Council and meetings.
- Report and complete a QAPIP report to assess the effectiveness of the QAPIP.
- Conduct ongoing bi- annual review of required policies, revising as needed to ensure compliance of MDHHS/MSHN requirements and processes.
- Continue implementation, monitoring and reporting of progress on the two (2) regional Performance Improvement Projects.
- Continue quarterly monitoring of quality and performance improvement related to the QAPIP, streamlining the reporting and improvement process in coordination with clinical committees/councils when relevant.
  - Behavior Treatment Review
  - Critical Incidents
  - Performance Improvement (MMBPIS)
  - Consumer Satisfaction
  - Follow Up to Hospitalization (FUH)
- Review available healthcare data for identification of trends and quality improvement opportunities.
- Incorporate Ethnic/Racial disparities into the relevant performance measures including but not limited to the FUH performance measure.
- Continue to measure stakeholder feedback and/satisfaction.
- Continue to develop a process to strengthen and to ensure training for Person-Centered Planning, Independent Facilitation and Self Determination implementation.
- Will perform at or above standard for identified performance measures.
- Monitor progress of site review corrective action plans.

II. Advisory Council FY20 Annual Reports

TEAM NAME: Regional Consumer Advisory Council
TEAM LEADER: Gordon Matrau, Chairperson
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.

Provide feedback for regional initiatives designed to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

- Past Year's Accomplishments: The Consumer Advisory Council had 5 meetings during the reporting period and in that time, they completed the following tasks:
    - Reviewed the 2019-2020 Annual Compliance Report
    - Reviewed changes to the FY20 MSHN Consumer Handbook
    - Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
    - Reviewed and provided feedback on the satisfaction survey results
    - Reviewed and provided feedback on the MSHN Compliance Plan
    - Reviewed and approved RCAC annual effectiveness report
    - Reviewed and provided feedback on Quality Assessment and Performance Improvement
    - Annual review of the MSHN RCAC policy for feedback
    - Education on Mental Health First Aid from CMHA-CEI staff
    - Education on Home and Community-Based Services (HCBS) Rule Transition from MSHN staff
    - Education on Utilization Management from MSHN staff
    - Education on Medicaid Fair Hearing Process from CMHA-CEI staff
    - Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews
    - Reviewed and revised council charter
    - Improved practices for ongoing communication between MSHN and local councils
    - Discussed ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation
    - Transitioned to online meetings through Zoom in response to a global pandemic

- Upcoming Goals for Fiscal Year 2021 Ending, September 30, 2021:
    - Provide input on regional educational opportunities for stakeholders
    - Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
    - Review regional survey results including SUD Satisfaction Survey and external quality reviews
    - Review annual compliance report
    - Annual review and feedback on QAPIP
    - Annual review and feedback on Compliance Plan
    - Annual review of the MSHN Consumer Handbook
    - Review and advise the MSHN Board relative to strategic planning and advocacy efforts
    - Provide group advocacy within the region for consumer related issues
    - Explore ways to improve Person Centered Planning, Independent Facilitation and Self Determination Implementation
    - Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
    - Explore ways to get more consumers involved in the RCAC and local consumer councils.

TEAM NAME: Provider Advisory Council
TEAM LEADER: Jill Worden
REPORT PERIOD COVERED: 10.1.2019-9.30.2020

Purpose of the Council or Committee: MSHN Leadership has created a Substance Use Disorder Provider Advisory Committee (SUD-PAC) to serve in an advisory capacity to MSHN 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.

Responsibilities and Duties: The responsibilities and duties of the SUD-PAC include the following:

- Serve as liaison between MSHN and SUD provider network
- Evaluate MSHN strategic plan as it relates to the SUD system and provide input into regional implementation of strategic action items
- Provide input on MSHN's Quality Assurance Reviews (review process, standards, QI enhancement);
- Evaluate annual provider satisfaction survey results and provide input into regional action
- Support implementation of evidence-based best practice service delivery to persons served
- Provide input and advocacy on prevention (PX), treatment (TX), and recovery network policies & procedures
- Support and provide input on MSHN and MDHHS performance improvement initiatives.
- Provide input on MSHN's Prevention, Treatment and Recovery annual plan processes
- Provide input on regional concerns that impact providers and/or clients (e.g. barriers to access);
- Support fulfilment of state and federal legislative, policy and regulatory goals

Defined SUD-PAC Goals:

- Enhance communication between MSHN and SUD Provider Network
- Strengthen SUD strategic objectives and implementation
- Assess MSHN's Quality Assurance Reviews for clarification
- Identify methods to encourage feedback to satisfaction surveys process
- Support delivery of evidence-based best practices
- Promote clarification of prevention, treatment, and recovery network policies/procedures
- Uphold MSHN and MDHHS performance improvement initiatives
- Identify methods to improve MSHN's Prevention, Treatment, and Recovery annual plan process
- Ensure regional concerns that impact providers and/or clients are identified
- Promote clarification of state and federal legislative, policy and regulatory goals

Past Accomplishments:
In the past year, the SUD-PAC has done the following:

- Reviewed and provided input to the Credentials-Claims Verification Process.
- Held group discussions on upcoming drug trends.
- Held group discussions on changes regarding LARA changes

- Held group discussions on State System proposed changes
- Held multiple discussions and provided input to MSHN on how pandemic was affecting treatment, prevention and recovery services and possible solutions.
- Continued to review and receive statewide assessment updates.
- Created method for provider feedback to PAC representative during quarterly SUD Provider Meetings.
- Offered input on SUD provider audit process and tools, including forming a sub-committee to review the treatment audit tool.
- Voted in a provider chair for the committee
- Reviewed the following:
- Required trainings
- Annual contract review procedure
- Provider network communication with PAC
- Recovery Self-Assessment implementation and report
- Revised performance indicators
- Provider satisfaction survey results
- Provider Workforce Attraction and Retention
- Proposed contract changes
- QAPI quarterly reports
- MMBPIS SUD Summary Report
- MSHN SUD Sentinel Events
- OROSC changes to the Youth Inspector for SYNAR Requirements, and processes for completing Synar and vendor education during a pandemic in a safe way.
- Assessment of Network Adequacy 2020 for anticipated policy changes that may impact the provider network
- PAC calendar
- OPB Updates
- Scheduled SUD Provider Meetings
- SUD Provider Manual
- 2021 Standards
- Provider Risk Assessments

Goals for Fiscal Year 2021; Ending September 30, 2021
In the coming fiscal year, the SUD-PAC will:

- Reassess SUD-PAC's efficacy and areas for improvement, utilizing a survey to members
- Serve as ongoing conduit for information between MSHN and provider network
- Review changes and updates to policies, procedures and regulations from MSHN, MDHHS and other state and federal bodies as they relate to SUD.
- Review Committee Provider Membership for additions
- Provide updates and input to Block Grant Reductions to MSHN

III. Oversight Policy Board FY20 Annual Report

TEAM NAME: Substance Use Disorder (SUD) Oversight Policy Board
TEAM LEADER: Chairman Deb Thalison, SUD Board Member
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

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

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments:
    - Received updates on the following:
        - MSHN SUD Strategic Plan
        - MSHN SUD Prevention & Treatment Services
    - Approval of Public Act 2 Funding for FY20 & related contracts
    - Approved use of PA2 funds for prevention and treatment services in each county
    - Received presentation on FY20 Budget Overview
    - Received PA2 Funding reports – receipts & expenditures by County
    - Received Quarterly Reports on Prevention and Treatment Goals and Progress
    - Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
    - Received updates on MDHHS proposed future of Behavioral Health
    - Received updates on MDHHS State Opioid Response Site Visit Results
    - Received updates on Michigan Department of Corrections Integration
    - Received information on the Mobile Care Unit
    - Received presentation on COVID-19 and Provider Status
    - Received information on MDHHS State Targeted Response Grants
    - Received information on Syringe Services Program
    - Received presentation on Achieving Equity in Opioid Use Disorder Treatment

b. Upcoming Goals for FY21 ending September 30, 2021:

- Approve use of PA2 funds for prevention and treatment services in each county
- Improve communications with MSHN Leadership, Board Members and local coalitions
- Orient new SUD OPB members as reappointments occur
- Share prevention and treatment strategies within region
- Provide advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Provide input into Community Block Grant reductions; and
- Monitor SUD spending to ensure it occurs consistent with PA 500.

IV. Committee & Workgroup FY20 Annual Reports

TEAM NAME: Regional Medical Directors Committee
TEAM LEADER: Dr. Zakia Alavi
REPORT PERIOD COVERED: 10.1.2019-9.30.2020

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

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

<u>MDC Annual Evaluation Process</u>

a. Past Year's Accomplishments
    - Case consult and documentation process begun.
    - Behavior Treatment Plan Review Committee feedback on medication guidelines.
    - Input into Population health and Integrated Care Plan and Quarterly Reports
    - MCG Indicia clinical support tool
    - Discussion on behavioral health system redesign.
    - Review of outlier analyses and use of CAFAS and LOCUS and related issues.
    - Review and input into data, including MSHN performance improvement projects, health equity analysis.
    - Establishment of bi-weekly RMD COVID calls to trouble shoot and establish protocols for response within the region. Very positive collaboration and learning regionwide.
    - Connection with health departments and regional healthcare coalitions and improved use of emergency planning steps actively implemented.
    - Guidance relating to Residential Safety, Agency Reopening, and Mask Wearing Guidance.
    - Increased regional cohesion as a regional group of medical directors.
    - Increased attendance and engagement as medical directors.
    - Improved communication.

b. Upcoming Goals

- Core service menus for LOCUS and CAFAS
- Assisted Outpatient Treatment
- COVID discussion for planning
- Continued input into behavior treatment processes
- Ongoing guidance and leadership into design of population health and integrated care
- Engagement of primary care physicians in team-based care and care management processes
- Ongoing input into data-related decisions
- Best practices for telehealth
- Focus on issues of diversity and inclusion training to address implicit bias and health disparities
- Focus on regionwide efforts toward immunization relative to the protection of vulnerable populations.

TEAM NAME: Clinical Leadership Committee
TEAM LEADER: Todd Lewicki MSHN CBHO and CLC Chair
REPORT PERIOD COVERED: 10.1.19 – 9.30.20

Purpose of the Council or Committee:

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

Responsibilities and Duties:

The responsibilities and duties of the CLC include the following:

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

Defined Goals, Monitoring, Reporting and Accountability:

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

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

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

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

Annual Evaluation Process:

FY20 Accomplishments:

- Medical Population health outcomes in collaboration with MSHN's ongoing work with the
- region's Medicaid Health Plans.
- Review and address opportunities for increasing integration with primary care,
- Partner with UMC around the implementation of regional consistency in use of LOCUS, CAFAS/PECFAS, SIS.
- Ongoing efforts to strengthen coordination of care between primary and behavioral health care services and seek to expand best practices.
- Ongoing HCBS Rule implementation.
- Ongoing Parity Rule implementation.
- Input into finalization of clinical protocols for support of regional consistency in access standards and delivery of services.
- Continued implementation of competencies in diagnosis and treatment of co-occurring conditions, trauma, gender competence and cultural competence (including military competency training).
- Continuing partnership opportunities with the Regional Medical Director's Committee.
- Building capacity in crisis residential psychiatric services.
- Address ongoing initiatives, including School Safety, Integrated Health, Staff Burnout, Telehealth, and other ongoing program requirements.
- Maintain consistent information, insight, and input into policy changes at MDHHS relating to the PIHP system of care and integration.
- Continue to leverage the partnership with MSHN Medical Director, Dr. Zakia Alavi, to address Medical Director perspectives and carry forward CLC content to the Regional Medical Director's Committee.
- Input into behavior treatment plan processes including guidance on use of medications for behavior control.
- Maintained committee output during COVID-19 pandemic.
- Regional response planning related to COVID pandemic.
- Review ACT team response to COVID-19.
- Begin discussions on issues relating to CLS and ABA and issues with IDEA during the pandemic,
- MCG/EMR integration for Parity.
- Input into the LOCUS benefit package ranges.
- Level of Care (LOC) system for SMI and SED populations.
- Region 5 Slot Allocation Notice to begin corrective work.
- Regional crisis residential feasibility study.
- Receive and review quarterly waiver, EPSDT, and HCBS reports.
- Regional review of case management models.
- Begin work on MI-SMART clearance form and process.
- Upcoming B3 changes and the 1115 Waiver.

Goals for Fiscal Year 2021; Ending September 30, 2021

The CLC will be involved in monitoring, developing and recommending improvements to:

- Continue exploring opportunities to maximize partnership role with the Regional Medical Directors
- Focus on 1915i service oversight transition to PIHP for annual eligibility authorizations
- Continued work relating to Parity for all CMHSP services
- Provide support to MCG Parity system
- Discuss, explore, and initiate program opportunities in psychiatric residential treatment facility implementation
- Continue to discuss options for difficult placement situations and create protocol as appropriate
- Continue to assess the impact of the COVID-19 pandemic and opportunities to enhance services for affected individuals related to PTSD, trauma-focused care, etc.
- Explore and recommend opportunities for innovative service models including telehealth and others as allowed by state rule.
- Continue oversight of regional HCBS compliance and related issues
- Complete work on crisis residential unit for adults in MSHN region

TEAM NAME: Utilization Management Committee
TEAM LEADER: Skye Pletcher, MSHN Director of Utilization and Care Management
REPORT PERIOD COVERED: 10.01.2019 – 9.30.2020

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

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

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

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

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific services or types of services, if not already addressed in policy.
- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies.

- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable).
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization.
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization); and
- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

<u>Annual Evaluation Process:</u>

a. Past Year's Accomplishments: The UMC had eleven meetings during the reporting period. In that time the following tasks were completed:
    - A thorough review of the UMC annual report schedule was conducted in order to evaluate the ongoing relevance and effectiveness of the data being reviewed by the committee. A number of recommendations were made related to eliminating areas of redundancy where similar data is being monitored by more than one regional committee or certain regional processes have become more automated and standardized over time resulting in there no longer being a need for data monitoring by the committee.
    - Ongoing review of data reports related to performance on regional UM and integrated health priority measures with CMH participants reporting on change strategies when performance is outside of established expected thresholds
    - Implemented and refined an exception-based review system of over/under utilization of services according to the common LOCUS benefit grid for adults with serious mental illness and CAFAS benefit grid for children with serious emotional disturbance.
    - Deployed new outlier data reports with TBD Solutions in order to monitor service variance between CMH organizations as well as individual consumer outliers
    - Ongoing cross-functional dialogue with QI Council, Clinical Leadership Committee (CLC), and Provider Network Management.

- Completed training and integration of MCG Indicia Software with individual CMH Electronic Medical Record (EMR) Systems
- Completed quarterly retrospective reviews for acute care services using the MCG Behavioral Health Guidelines and established a regional target of 95% or more correct application of medical necessity criteria. During FY20 the target was achieved for all quarters in which reviews were conducted.
- Ongoing UMC discussion relative to prospective, concurrent, and retrospective UM processes. UMC members share best practices in order to promote efficiency and consistency throughout region.
- Ongoing work on project to develop regional standard clinical service protocols
- Developed short-term Case Management/Supports Coordination Workgroup to develop regional best practice guidance for those services
- Reviewed data relative to quarterly Balanced Scorecard

b. Upcoming Goals for Fiscal Year Ending, September 30, 2021
   - Follow utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
   - Recommend policy and practices for access and authorization standards that are consistent with requirements and represent best practices.
   - Evaluate opportunities for improvement in 24/7/365 Access to SUD Services; consider availability of after-hours acute services (withdrawal management, residential)
   - Ensure representative SUD presence on UMC.
   - Implementation of an exception-based review system of over/under utilization of services according to the common SIS benefit grid for individuals with intellectual and/or developmental disabilities.
   - Completion of regional standard clinical service protocols project
   - Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
   - Recommend improvement strategies where adverse utilization trends are detected.
   - Recommend opportunities for replication where best practice is identified.
   - Continue to focus on population health measures related to care coordination.
   - Ongoing integration of substance use disorder (SUD) into utilization management practices.
   - Ensure there is synchronized (as able) content matter expert input into processes shared by UM (i.e. QI, Finance, Clinical, etc.).
   - Address succession planning for UMC members relative to skill set needed by committee members.
   - Input into HCBS data, findings, and system improvements, as appropriate.

TEAM NAME: Provider Network Management Committee
TEAM LEADER: MSHN Director of Provider Network Management
REPORT PERIOD: 10.1.2019-9.30.2020

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

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

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

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

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

OC Annual Evaluation Process

a) Past Year's Accomplishments (FY20):

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

b) Upcoming Goals (FY21):

- Address recommendations from the 2020 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs.
- Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems.
- Establish relevant key performance indicators for the PNMC scorecard.
- Monitor and implement Electronic Visit Verification as required by MDHHS.
- Initiatives to support reciprocity:

- Contracting:
  - Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational
- Procurement:
  - Fully implement the use of a regional web-based provider application.
  - Publish provider selection processes on MSHN web.
- Monitoring:
  - Fully implement specialized residential reciprocity provider monitoring plan.
- Training:
  - All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan.
  - Advocate for direct support professionals to support provider retention (e.g. wage increase, recognition)

TEAM NAME: Compliance Committee
TEAM MEMBER: Kim Zimmerman
REPORT PERIOD COVERED: 10.1.2019-9.30.2020

Purpose of the Compliance Committee:
The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

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

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

Defined Goals, Monitoring, Reporting and Accountability
The Compliance Committee shall establish metrics and monitoring criteria to evaluate progress:
As defined in the Compliance Plan

Annual Evaluation Process
Past Year's Accomplishments

- Revised and approved MSHN Compliance Plan
- Reviewed and updated Committee Charter
- Reviewed trends in the OIG Quarterly Reports and recommended quality improvements
- Reviewed updates to the MDHHS standard consent to ensure regional and local compliance

- Revised the disqualified provider policy to include a chart to clearly identify requirements and legal references and clarified language around Recipient Rights reporting
- Reviewed Medicaid Policy Bulletins and Medicaid Manual and implemented changes
  regionally and locally as needed
- Reviewed changes/revisions to state and federal policies and regulations, including but not limited to:
  - Department of Justice Compliance Program Guidelines
  - Office Guidance of Civil Rights Protections
  - Summary of 42 CFR Part 2 Final Rule
  - COVID-19
- Reviewed information provided at PIHP/OIG triannual meetings
- Reviewed information provided at the PIHP Compliance Officers meetings
- Provided feedback and approval for the annual Compliance Summary Report
- Reviewed outcomes from external site reviews for necessary changes and compliance related issues
- Provided consultation on local compliance related matters
- Revised the committee agenda and meeting minutes to be standardized for consistency, timeliness and to clearly identify action items
- Developed, implemented, reviewed and made necessary corrections for quarterly data mining activities
  - Death to encounter data report
  - Overlapping residential services
  - CLS in wrong location
  - Multiple case managers
- Provided feedback on MSHN practices to include but not limited to:
  - Regional Training Grid
  - Ownership and Control forms and practices
  - Delegated Managed Care Review tools

Upcoming Goals for Fiscal Year Ending, September 30, 2021

- Complete revisions to the Compliance Plan, policies and procedures and reporting as needed and as identified by the OIG
- Review changes to state and federal regulations/guidelines and develop and implement changes regional and locally as needed
- Review data identified as part of the quarterly reports, delegated managed care reports and external site reviews for any trends, areas of non-compliance and develop processes to address
- Monitoring orders, guidelines and policies related to COVID-19, to include monitoring of data related to use of telehealth
- Identify region wide opportunities for data mining activities
- Identify compliance related educational opportunities including those aimed at training compliance officers

TEAM NAME: Customer Service Committee
TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist
REPORT PERIOD COVERED: 10.1.19 – 09.30.20

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The CSC had six committee bi-monthly meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY20 Consumer Handbook
   - Facilitated publication and electronic regional distribution of the MSHN FY20 Consumer Handbook: Spanish language version for each of the 12 CMHSPs
   - Reviewed and revised regional policies and procedures in areas of Customer Service/Customer Handbook, Customer/Consumer Service Policy, Regional Consumer Advisory Council, Information Accessibility/Limited English Proficiency (LEP), Medicaid Beneficiary Appeals/Grievances, Advance Directives, Customer Service/Confidentiality & Privacy, and Reporting Medicaid Beneficiary Appeals, Grievances, Recipient Rights and Administrative Hearings
   - Reviewed and approved a new Customer Service policy for Enrollee Rights
   - Reviewed, analyzed and reported regional customer service information for:
     - Denials
     - Grievances
     - Appeals
     - Second Opinions
     - Medicaid Fair Hearings
     - Recipient Rights
   - Developed, reviewed, and approved regional standardized templates for the extension of Grievances, Appeals, and Service Authorization Requests
   - Developed, reviewed, and approved a regional standardized template and process for Appeal written confirmations in response to oral Appeal requests
   - Recommended and facilitated implementation for the review of Adverse Benefit Determinations during MSHN Delegated Managed Care reviews
b. Upcoming Goals for Fiscal Year 2021 Ending, September 30, 2021
   - Conduct annual review and revisions to the MSHN Consumer Handbook to reflect contract updates and regional changes
   - Continue to develop, where applicable, MSHN standardized regional forms
   - Continue reporting and monitoring customer service information
   - Evaluate oversight & monitoring of regional grievances & appeals, in accordance with customer service standards
   - Increase the percentage met for the MSHN Denial, Appeal, Grievance, and Second Opinion Report
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region

- Continue to explore regional Customer Service process improvement

TEAM NAME: Behavior Treatment Review Work Group

TEAM LEADER: Sandy Gettel, MSHN Quality Manager

REPORT PERIOD: 10.01.2019 – 9.30.2020

Purpose of the Council or Committee:

The Behavior Treatment Plan Review Workgroup was established to ensure compliance and oversight of the delegated function of Behavior Treatment Plan (BTP) Committees to the CMHSP Participants in accordance with the Michigan Department of Community Mental Health Medicaid Managed Specialty Supports and Services Contract, P.1.4.1 Behavioral Treatment Review Standards. The BTR Workgroup is comprised of the MSHN Quality Manager and the CMHSP Behavior Treatment Review staff appointed by the respective CMHSP Chief Executive Officer/Executive Director, and other subject matter experts as relevant. The BTR Workgroup is chaired by the MSHN Quality Manager.

Defined Goals, Monitoring, Reporting, and Accountability

- Maintain knowledge and implement the MDHHS Behavioral Treatment Standards.
- Demonstrate consistent use of physical interventions, restrictive and intrusive interventions as interpreted by MSHN and MDHHS for consistency of reporting.
- Develop guidelines for restrictions requiring Behavior Treatment Plan approval.
- Develop regional training for use of initial and ongoing education related to behavior treatment assessment, plan development and restrictive and intrusive intervention identification.
- Report and review quarterly data as required for improvement efforts, interventions and modifications to data collection as needed to ensure value.

Annual Evaluation Process:

a. Past Year's Accomplishments: The BTRC had five (5) meetings during the reporting period and in that time, they completed the following tasks:
    - The data review and topic discussions were transitioned to CLC. CLC tasked the BTPR work group with training and competency development.
    - Continued development of the guidelines for medications for behavioral control with the Medical Directors.
    - Development and utilization of the Frequently Asked Questions document to assist with interpretations has been completed and will be ongoing; this has been updated based on the MDHHS Behavior Work Group.
    - A streamlined data collection process for restrictive and intrusive interventions, emergency physical interventions, and 911 calls has been completed. The new data collection began April 1st to allow for analysis by program and streamline/combine two data collection processes to increase efficiencies. The first submission was July 31st. Modifications have been recommended and made to the data collection sheet to further clarify and provide valid information pertaining to number of plans and programs.

- Training for development of Behavior Treatment Plan and Person-Centered Plan development including restrictions. Development work continues for formalized regional training.
- Received and reviewed regional BTPR quarterly reports, identified trends and areas of improvement.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2021
   - Continue to gain knowledge of the Behavior Treatment Standards as interpreted by MDHHS.
   - Continue to finalize guidelines related to Medication for behavioral control in collaboration with the Regional Medical Directors.
   - Evaluate and monitor the development of the streamlined data collection process for restrictive and intrusive interventions, emergency physical interventions, and 911 calls.
   - Continue development of training plan for Behavior Treatment Plan and Person-Centered Plan development including restrictions.
   - Develop process to ensure restrictions are reviewed through BTPRC and PCP development.
   - Identify Standards or supported documentation related to BTPRC Processes and regional consensus decisions.
   - Develop competencies for BTP development.
   - Identify best practice guideline for BTPR committee meetings.

TEAM NAME: Habilitation Supports Waiver (HSW) Workgroup

TEAM LEADER: Tera Harris

REPORT PERIOD COVERED: 10.1.2019-9.30.2020

Purpose of the HSW Workgroup:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

- Monitoring and oversight of slot allocation utilization and achieving and maintaining 95% utilization.
- Identifying potential candidates for enrollment in the HSW.
- Monitoring and oversight of the annual re-certification process, including overdue re-certifications.
- Monitoring and oversight of overdue Individual plans of service (IPOS);
- Monitoring and oversight of overdue consents.
- Implementation of the agreed upon corrective actions related to the Michigan Department of Health and Human Services (MDHHS) HSW site review findings.

- Compliance and oversight of the above identified areas.
- Monitoring and guidance related to Behavior Treatment standards for HSW enrollees with such interventions.
- Implementation, monitoring and guidance with the Home and Community Based Services (HCBS) rule change

MSHN HSW Workgroup Annual Evaluation Process

a. Past Year's Accomplishments
   - Separation of HCBS and HSW workgroups
   - Developed corrective action plan related to underutilization of HSW slot allocation
   - Implemented process for identifying potential HSW candidates for enrollment
   - Conducted region-wide training on the HSW process
   - Increased slot utilization to reach the 95% utilization standard set by MDHHS
   - Implemented updated recertification process that was effective 10/1/2019
   - Developed process for reviewing and monitoring initial applications and recertifications for restrictive and intrusive techniques and/or Behavior Treatment Plans
   - Complied with MDHHS issued "Clarification of the Licensed Residential bed size in the HSW Renewal"
   - Regional preparation for MDHHS HSW site review
   - Adjusted processes related to service delivery and administrative tasks due to COVID-19 pandemic

b. Upcoming Goals
   - Work to develop a corrective action plan related to MDHHS HSW findings
   - Implementation of corrective action plan related to MDHHS HSW findings
   - Continue to ensure 95% slot allocation utilization is maintained
   - Continue to identify potential HSW candidates for enrollment
   - Emphasize the importance of and encourage participation in regional HSW meetings and trainings

TEAM NAME: Children's Waiver Program Workgroup
TEAM LEADER: Tera Harris
REPORT PERIOD COVERED: 10.1.2019-9.30.2020

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

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

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

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

- Assess eligibility for the CWP
- Carry out administrative tasks for CWP
    - Initial Pre-Screen Eligibility, Application, and Service Start,
    - Annual Recertification,
    - Disenrollments,
    - Age-Offs,
    - CWP Slot Transfer (as appropriate), and
    - CWP Financial Monitoring

- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the CWP,
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to Michigan Department of Health and Human Services (MDHHS) CWP site review findings
- Support compliance and oversight of the above identified areas

MSHN CWP Workgroup Annual Evaluation Process

a. Past Year's Accomplishments
   - Reviewed and approved draft CWP policies and procedures
   - Development and distribution of monthly CWP reports
   - Development and distribution of monthly overdue and coming due reports for each CMHSP
   - Development and approval of CMHSP and PIHP forms for Prior Review and Approval Requests (PRARs)
   - Development and approval of transfer form for intra-regional and inter-regional case transfers
   - Regional preparation for MDHHS CWP site review
   - Completion of first year of delegated site reviews for CWP program specific standards
   - Adjusted processes related to service delivery and administrative tasks due to COVID-19 pandemic

b. Upcoming Goals
   - Work to develop a corrective action plan related to MDHHS CWP findings
   - Implementation of corrective action plan related to MDHHS CWP findings
   - Support the process to provide delegated site reviews based on MDHHS finding for FY21
   - Continue to work to ensure the entire region is prepared to support individuals needing the supports of the CWP
   - Emphasize the importance of and encourage participation in regional CWP meetings and trainings.

TEAM NAME: Serious and Emotionally Disturbed (SED)Waiver Workgroup
TEAM LEADER: Barb Groom
REPORT PERIOD COVERED: 10.1.2019-9.30.2020

Purpose of the SEDW Workgroup:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

- Assess eligibility for the SEDW
- Carry out administrative tasks for SEDW
    - Initial Eligibility, Application, and Service Start,
    - Annual Recertification,
    - 3rd year Recertifications
    - Dis-enrollments
    - SEDW transfers, and
    - SEDW Financial Monitoring

- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the SEDW;
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to Michigan Department of Health and Human Services (MDHHS) SEDW site review findings
- Provide support to ensure appropriate payments rendered for SEDW enrollees receiving services
- Support compliance and oversight of the above identified areas

MSHN SEDW Workgroup Annual Evaluation Process

Past Year's Accomplishments:

- Regional preparation for MDHHS SEDW site review.
- Significant increase in overall enrollments of SEDW participants (over 60% during FY20);
- Regional preparation of SEDW standards for each CMHSP.
- Completion of first year of delegated site reviews for SEDW program specific standards.
- Development and distribution of monthly SEDW reports.
- Development and distribution of monthly overdue and coming due SEDW certifications.
- Reviewed and approved draft SEDW policies and procedures.
- Adjusted processes related to service delivery due to COVID-19 pandemic

Upcoming Goals:

- Work to develop a corrective action plan related to MDHHS SEDW findings.
- Continue to work to increase overall regional enrollments of SEDW.
- Continue to work to ensure the entire network is prepared to support an individual needing the supports tied to the SEDW.
- Support the process to provide delegated site reviews based on MDHHS findings for FY21.
- Emphasize the importance of and encourage participation in regional SEDW based trainings

TEAM NAME: Autism Benefit Workgroup

TEAM LEADER: Barb Groom

REPORT PERIOD COVERED: 10.1.2019-9.30.2020

Purpose of the Autism Workgroup:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

- Reduction and elimination of overdue re-evaluations
- Reduction and elimination of overdue Individual plans of service (IPOS);
- Reduction and elimination of individuals with an overdue service start date (90 days or more);
- Reduction and elimination of WSA Cases whose hours of ABA are not within the IPOS range for the intensity of service plus or minus a variance of 25%.
- Tracking of pending cases (only referred and awaiting an evaluation).
- Implementation of the agreed upon correction actions related to the Michigan Department of Health and Human Services (MDHHS) Autism Benefit site review findings.

- Assist CMHSPs with continuous monitoring to assure hours of behavioral observation and direction are within MDHHS' recommended range.
- Increase frequency and quality of Family Training encounters for those enrolled.
- Compliance and oversight of the above identified areas.
- Continuous efforts to support and encourage recruitment, training and retention of qualified autism staff.

MSHN Autism Benefit Workgroup Annual Evaluation Process

a. Last Year's Accomplishments:
    - Regional response to changes in MDHHS AUT Section leadership and practices.
    - Regional response and compliance with changes to QBHP credentialing requirements.
    - Regional response and compliance with changes to BCBA licensure requirements as of 1.1.20.
    - Regional participation and leadership around the MSU Family Guidance project.
    - Collaboration with Autism Operations Workgroup on development of a standardized regional contract for autism services.
    - Coordination of ABA provider audits and credentialing reciprocity
    - Regional response and coordination of modifications to service delivery during the COVID-19 pandemic

b. Upcoming Goals
    - Continue to monitor and modify processes related to COVID-19 service delivery.
    - Distribute information on the results of the Family Guidance project to the network, including families.
    - Work to prepare for the MDHHS on-site autism review in 2021.
    - Continue to work to improve quality provider network capacity.
    - Continue efforts to reduce instances of individuals experiencing an overdue service start date for ABA.

SECTION THREE-EVALUATION AND PRIORITIES

The QAPIP is reviewed annually for effectiveness. The review includes the components of the QAPIP, the performance measures, and improvement initiatives, as required based on the MDHHS PIHP contract, and the BBA standards. In addition to ensuring the components continue to meet the requirements each strategic initiative priority is reviewed to determine if the expected outcome has been achieved. Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for following year. The measurement period for this annual QAPIP Report is October 1, 2019 through September 30, 2020. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks.

I. ANNUAL EFFECTIVENESS REVIEW OF QAPIP PRIORITIES-FY20

MSHN evaluates the process for which each element of the QAPIP requirements are implemented throughout the PIHP. Those indicators with an * indicate improvement efforts were required as a result of an external review. A status of completed/continue indicate the process has been completed and will be ongoing for monitoring purposes or requirements set forth by an external regulatory body. A status of "In Progress" indicates continued development work or monitoring is needed to ensure effectiveness is occurring prior to receiving a status designation of "Completed". Goal statements are included for areas resulting in a corrective action plan from an external review. Recommendations are based on feedback from external reviews and/or based on the evaluation of the QAPIP Plan from FY20.

Strategic Goal	Organizational Structure and Leadership	Evaluation Method	Status/Recommendations/Goals
Enhance Regional Quality & Compliance	MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	• The annual QAPIP Plan Description • The annual QAPIP Report	• Completed/Continue Recommendation: Development of MSHN process to monitor progress of the quality workplan quarterly, inclusive of other departments.
	Board of Directors will approve the QAPIP Plan and Report	• The Final QAPIP Report • The Final QAPIP Plan • Board of Directors Meeting Minutes	• Completed/Continue Recommendation: Evaluate and modify time frames to ensure Board approval is received before 1.31.2022.
	Board of Directors review QAPIP Progress Reports	• Balanced Score Card. *Attachment 16 FY2020 Balanced Scorecard.*	• Completed/Continue Recommendation: Utilize Compliance, Quality, Customer Services Department Report for Board review.
	Include the role of recipients of service	• The QAPIP Plan Description • The Annual Member Experience Surveys	• Completed/Continue • Completed

Strategic Priority	Communication of Process and Outcome Improvements	Evaluation Method	Status/Recommendations/Goals
Enhance Regional Quality & Compliance	*The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	• Completed Board approved QAPIP Evaluation/Report posted to the MSHN Website, distributed through committee/councils, MSHN Constant Contact, and email distribution. Evidence of CMHSP providers receiving the QAPIP is obtained during the DMC Reviews.	• Completed/Continue
Strategic Priority	**Quantitative/Qualitative Assessment of Member Experiences**	**Evaluation Method**	**Status/Recommendations/Goals**
Improve the Role of MSHN Consumers and Key Stakeholders	MSHN will provide annual opportunities for consumer feedback related to member experiences.	• Annual Assessment of Recovery completed annually. *Attachment 3. RSA -PIP* • Annual Consumer Satisfaction Survey completed annually (MHSIP, YSS, SUD Satisfaction Survey, NCI Summary). • Provider Survey will be completed. *Attachment 15. Strategic Workforce Summary*	• Completed/Continue • Completed/Continue • Completed.
MSHN will improve behavioral health services and supports and outcomes for all populations served	*Trends, patterns, strengths and opportunities for improvement identified.	• Report of Consumer Satisfaction Survey will be completed annually. *Attachment 5. MSHN Annual Satisfaction Survey Report* *Attachment 6. NCI Summary*	• Completed/Continue Goal: MSHN will distribute survey/assessments for each representative population served, inclusive of LTSS, with development of action plan to address areas of dissatisfaction biennially. MSHN will demonstrate an 80% rate of satisfaction for each representative population.

Strategic Priority	Safety and Risk Monitoring (Event Monitoring and Reporting)	Evaluation Method	Status/Recommendations/Goals
MSHN will improve behavioral health services and supports and outcomes for all populations served	MSHN will adhere to Critical Incident Reporting requirements to MDHHS	• Monthly submissions to Critical Incident Reporting System. • Sentinel Event Reporting to MDHHS as required.	• Completed/Continue • Completed/Continue
	*MSHN will identify trends, patterns, strengths and opportunities for improvement.	• Critical Incident/Sentinel Event Performance Reports completed quarterly. *Attachment 8. MSHN Critical Incident Performance Summary CMHSP* *Attachment 7. MSHN Critical Incident Performance Summary SUDP*	• Completed/Continue Goal: Will demonstrate a 100% completion rate of Critical Incident/Event Performance Summaries each quarter for CMHSP Participants and SUD Providers. Recommendation: Develop electronic process for sentinel event submissions.
	MSHN will conduct annual oversight of CMHSP.	• 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.	• Completed/Continue • Completed/Continue
Strategic Priority	**Medicaid Event Verification**	**Evaluation Method**	**Status/Recommendations/Goals**
Public resources are used efficiently and effectively	MSHN will verify delivery of services billed to Medicaid	• The completion of the PIHP Medicaid Event verification reviews of CMHSPs and SUD Providers.	• Completed/Continue
	MSHN will annually identify trends, patterns, strengths and opportunities for improvement.	• The MEV Annual Methodology Report will be completed and reviewed with QIC and Compliance committee annually. *Attachment 9. MEV Methodology Report*	• Completed/Continue
	MSHN will submit report annually to MDHHS as required.	• The annual MEV Methodology Report will be submitted to MDHHS as required.	• Completed/Continue

Strategic Priority	Utilization Management Plan	Evaluation Method	Status/Recommendations/Goals
Public resources are used efficiently and effectively	MSHN UM Committee develops standards for utilization management annually.	• The MSHN Utilization Management Plan is reviewed annually. *Attachment 13. UM Plan*	• Completed/Continue
	MSHN identifies trends, patterns of under / over utilization, strengths and opportunities for improvement are identified.	• MSHN Utilization Management Plan. MCG Reports; LOCUS/CAFAS Outlier Reports. *Attachment 13. UM Plan*	• Completed/Continue
	*MSHN will have a process to monitor and ensure that, for service authorization decisions not reached within required time frames Adverse Benefit Determinations (ABD) notices will be completed.	• Delegated Managed Care Review (DMC) review. ABD Policies and Procedures. Primary Source Verification	• Completed/Continue <u>Goal:</u> MSHN will demonstrate an improvement in in the compliance rate with the ABD notice requirements.
Strategic Priority	**Utilization Management Plan**	**Evaluation Method**	**Status/Recommendations/Goals**
MSHN will improve access to supports and services.	*MSHN will have a documented process for extending service authorization timeframes as for select circumstances.	• DMC Review. Policies and Procedures	• Completed/Continue. <u>Goal:</u> MSHN's Provider Network will demonstrate improvement in the compliance rate with the required timeframes for service authorizations.
	MSHN will utilize uniform screening tools and admission criteria	• *Attachment 13. Utilization Management Plan*	• Completed/Continue
Strategic Priority	**Practice Guidelines**	**Evaluation Method**	**Status/Recommendations/Goals**
Improve access to services and supports	*MSHN Communication of practices guidelines	• QAPIP and related policies/procedure will include a process for communicating practice guidelines.	• Completed/Continue <u>Goal:</u> MSHN will demonstrate full compliance with communication of practice guidelines.
	CMHSP Implementation of Practice Guidelines	• MSHN desk review will verify local implementation of practice guidelines.	• Completed/Continue

Strategic Priority	Oversight of "Vulnerable People"	Evaluation Method	Status/Recommendations/Goals
MSHN will improve its population health and integrated health activities	CMHSPs monitor health, safety and welfare of individuals served	• Biennial DMC site reviews-clinical record reviews. • Performance Measures.	• Completed/Continue • Completed/Continue
	Trends, patterns, strengths and opportunities for improvement identified.	• Individual corrective action plans will be completed for areas out of compliance. • Annual/quarterly reports will be completed to identify regional action for improvement. *Attachment 2. Diabetes Monitoring* *Attachment 4. Priority Measures* *Attachment 6. NCI Summary* *Attachment 7, 8. Critical/Sentinel Event,* *Attachment 10. Behavior Treatment Summary* *Attachment 11. Population Integrated Care Report/Plan*	• Completed/Continue • Completed/Continue
Strategic Priority	**Autism Waiver Monitoring**	**Evaluation Method**	**Status/Recommendations/Goals**
MSHN will improve access to services and supports MSHN will improve access to services and supports	MSHN will complete quarterly analysis of data to include trends, patterns, strengths and opportunities for improvement.	• Autism Performance Reports completed quarterly. *Attachment 12. Behavioral Health Quarterly Report*	• Completed/Continue
	*MSHN will monitor and conduct oversight of CMHSP Autism Benefit program requirements and corrective action related to the MDHHS site review	• DMC Review. Will conduct primary source verification and ensure a process exists for follow up related to recommendations and ensuring improvement plans are completed.	• Completed/Continue

Strategic Priority	Behavior Treatment	Evaluation Method	Status/Recommendations/Goals
MSHN will improve behavioral health services and supports and outcomes for all populations served	MSHN will complete quarterly analysis of data to include trends, patterns, strengths and opportunities for improvement.	• BTR Performance Reports completed quarterly. *Attachment 10.*	• Completed/Continue Recommendations: Modify goals to address restrictive and intrusive interventions in IPOS's.
	MSHN will conduct oversight of CMHSP.	• DMC Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and improvement plans are completed.	• Completed/Continue
Strategic Priority	**Credentialing, Provider Qualification and Selection**	**Evaluation Method**	**Status/Recommendations/Goals**
Enhance Regional Quality & Compliance	*MSHN will develop process to ensure CMHSP and SUD Providers adhere to MSHN credentialing policy	Delegated Managed Care Review will ensure credentialing is completed as required.	• Completed/Continue Monitoring of the effectiveness of the new process is in progress.
	*CMHSP and SUD Providers adherence to MSHN credentialing policy	Delegated Managed Care Review will ensure credentialing is completed as required. Monitoring of the effectiveness of the new process is in progress	• Completed/Continue Goal: MSHN's Provider Network will demonstrate an increase in compliance with the MDHHS/MSHN staff qualification and credentialing/recredentialing requirements.
Strategic Priority	**Provider Monitoring**	**Evaluation Method**	• **Status/Recommendations/Goals**
Enhance organizational quality & compliance	CMHSP annual monitoring of provider subcontractors	Full review of DMC standards is completed biennially. New standards and required corrective action are completed in the interim year.	• Completed/Continue
	MSHN monitoring of CMHSPs and SUD Provider Network compliance		

Strategic Priority	External Reviews/Monitoring	Evaluation Method	Status/Recommendations/Goals
Enhance organizational quality & compliance	Will coordinate external reviews with the CMHSPs and SUDP Providers.	• HSAG PMV Final Report • HSAG Compliance Review Final Report • MDHHS SUD Final Report • MDHHS Waiver Review Final Report • MDHHS Autism Final Report *Attachment 14 R5 MSHN EQR TR Follow up*	• Completed Recommendation: Develop process for improved BH-TEDS Data Quality Recommendation: Add improvement plans resulting from partial compliance to the QAPIP Work Plan.
	Will develop an improvement plan to address the findings and incorporate into the QAPIP workplan.	• HSAG Compliance Review Final CAP • MDHHS Waiver Review Final CAP • MDHHS Autism Final CAP *Attachment 15 R5 MSHN EQR TR Follow up*	• Completed

II. Annual Strategic Plan Priorities Review

The strategic plan includes objectives and tasks related to each priority and goal. The evaluation method includes examples of evidence supporting the status. A status of completed/continue indicate the process has been completed and will be ongoing for monitoring purposes or requirements set forth by an external regulatory body. A status of "In Progress" indicates continued development work or monitoring is needed to ensure effectiveness is occurring prior to receiving a status designation of "Completed". Any recommendations will be included within the quality work plan.

Better Health			
Improve Population and Integrated Health Activities			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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.	Examples of Data Exchange completed • MMBPIS Affiliate Upload and aggregation • Critical Incident reporting system • COVID Response File • BH-ADT records • Provider Directory Upload	• Completed/Continue
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	• Completed/Continue

Better Care			
Improve Access to Care			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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	• Completed/Continue
	1. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	• Development of access and authorization guidelines	• Completed
	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 CMHSP participants	• Completed
	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 CMHSP participants	• Completed
Improve the Role of MSHN Consumers and Key Stakeholders			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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 • Provider Satisfaction Survey • Regional Committee /Council Survey	• Completed • In Progress • Completed
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	• In progress
	2. Evaluate feasibility of survey consolidation and streamlining.	• Provider Survey • Consumer Experience Report	• In Progress • Completed/Continue

Enhance Regional Quality and Compliance			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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	• In progress
	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	• In progress
Better Value			
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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/PIHP.	• BTPRC, MMBPIS, RSA, Critical Incidents, Satisfaction Survey	• Completed/Continue
	2. MSHN evaluates penetration rate, cost and other metrics and addresses undesirable variation through its councils and committees to promote standardized, consistent, and cost-effective operations across the region.	• See performance measurement data	• Completed/Continue
MSHN's Provider Network Management Systems are effective and efficient.	1. MSHN publishes provider performance data to consumers and the public.	• Available on Website	• Completed/Continue

Better Provider System			
MSHN ensures that it engages a provider network with adequate capacity and competency			
Strategic Objective	**Task/Activity**	**Evaluation Method**	**Status**
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	• In Progress
	2. MSHN will strengthen regional performance improvement systems in the SAPT provider network.	• Reporting has been completed for performance measures as identified.	• Complete/Continue
	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.	• Completed/Ongoing
	4. MSHN will integrate fiscal information and performance results into its quality assessment and performance improvement systems.	• Incorporate Financial oversight into the DMC Process for improvement.	• Completed/Continue
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.	• Currently an efficiency review is occurring to specifically identify areas of overlap and recommend additional collaboration and streamlined processes.	• In Progress

III. Annual Performance Measurement Review

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

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 its CMHSP Participants and Substance Use Disorder Providers are measuring performance through The Michigan Mission Based Performance Indicator System in addition to key performance indicators established by MSHN. Performance is monitored quarterly. When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. A status of "met" indicates MSHN met the standard for all four quarter of FY20. A status of "not met"' indicates 1 or more quarter did not meet the identified standard.

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

MSHN did not meet the goal as indicated in Attachment 2 for indicator 10a: The percentage of children who had a re-admission to psychiatric unit within 30 days.

Indicator	Assigned Committee	Status
Michigan Mission Based Performance Indicator System		
Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	Met
Indicator 2: (Discontinued March 31, 2020) Initial Assessment within 14 Days - Children/Adults (Standard is 95% or above)	QIC	Met
Indicator 2a: (Effective April 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. MI-adults, MI-children, IDD-adults, IDD-children. (No standard the first year)	QIC	NA

Michigan Mission Based Performance Indicator System	Assigned Committee	Status
Indicator 2e: (Effective April 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.(No standard the first year)	QIC	NA
Indicator 3: (Discontinued March 31, 2020) Start of Service within 14 Days (Standard is 95% or above)	QIC	Not Met
Indicator 3: (Effective April 1, 2020) The percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. MI-adults, MI-children, IDD-adults, and IDD-children). (No standard the first year)	QIC	NA
Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above)	QIC	Met
Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	QIC	Met
Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less)	QIC	Not Met

Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per year. Data collected through the performance improvement projects are aggregated, analyzed and reported through QIC meeting, regional Medical Directors, and/or other relevant committees/councils. MSHN participated in two performance improvement projects during FY20.

Recovery Self- Assessment

Goal: To increase the degree to which CMHSP participants and SUD Providers implement recovery-oriented practices.
MSHN met the goal as indicated in Attachment 3 The MSHN Recovery Self-Assessment-Performance Improvement Project.

Diabetes Monitoring

Goal: 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).

MSHN met the goal of 7% increase as indicated in Attachment 4 The MSHN Diabetes Monitoring – Performance Improvement Project Diabetes Monitoring. MSHN did not achieve a status of "Met" on the External Quality Review Performance Improvement Validation Report. The percent increase did not demonstrate statistically significant improvement.

Performance Improvement Projects	Assigned Committee	Status
PIP – The degree to which programs implement recovery-oriented practices. (Annual Standard is >=3.50)	QIC	Met
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	QIC	Met (not validated)

Key Priority Measures

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

MSHN met the standard for nine of the eleven measures used to monitor the health, safety and welfare of individuals served as indicated in the table below and the following attachments:

Attachment 16 Behavioral Health Quarterly Report

Attachment 15 Integrated Population Health Integrated Care Report

Key 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%)	QIC	Met
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%)	QIC	Met
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 (Perform higher than Michigan)	QIC	Met
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)	CLC	Not Met
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	CLC	Met
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	CLC	Not Met
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%)	UM	Met
The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%)	UM	Met
The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%)	UM	Met
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)	CLC	Met

Event Reporting (Safety and Risk Monitoring)

Goal: MSHN will submit critical incidents as required by MDHHS, analyzing the data quarterly, identifying trends, patterns, strengths and opportunities for improvement.

Goal: MSHN will complete oversight for delegated activities related to critical incidents.
MSHN has submitted all reported critical incidents and completed oversight of the delegated activities of the CMHSPs.

Attachment 10 MSHN SUDTP Critical Incident Performance Summary

Safety and Risk Monitoring (Adverse Events)		
The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year.	QIC	Not Met
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.	QIC	Met
The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.	QIC	Met
The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year.	QIC	Not Met
The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year.	QIC	Not Met
The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year.	QIC	Not Met

Behavior Treatment Review Data

Goal: MSHN will collect data as required by MDHHS, analyzing the data quarterly, identifying trends, patterns, strengths and opportunities for improvement.

Goal: MSHN will complete oversight for delegated activities related to Behavior Treatment.
MSHN met the goals as indicated in Attachment 11 Behavioral Treatment Performance Summary. MSHN has completed oversight to ensure compliance with MDHHS Behavioral Standards, all CMHSP participants did not receive full compliance with the MDHHS Behavioral Standards as indicated in the MDHHS 1915 HCBS Waiver Review.

Attachment 11 Behavior Treatment Performance Summary

Behavior Treatment Review Data		
The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.	QIC	Not Met
The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC	Met
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.	QIC	Met

Assessment of Member Experiences and Stakeholder Feedback

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

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

MSHN met the goal based on the comprehensive score of each survey. Performance as it relates to individual subscales can be found in the following attachments:

Attachment 7 The Annual Satisfaction Survey Report
Attachment 8 The National Core Indicator Summary
Attachment 18 The MSHN Strategic Work Force Summary
Attachment 4 The Recovery Self-Assessment

Stakeholder Feedback		
I am involved in my community and organization (RSA-Involvement) (>=3.5)	QIC	Met
Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services) (>=3.5)	QIC	Met
I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment) (>=3.5)	QIC	Met
I am given choices about my treatment and care that I receive (RSA-Choice) (>=3.5)	QIC	Met
Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals) (>=3.5)	QIC	Met
I am satisfied with the services I receive. (MHSIP/YSS/SUD Satisfaction Survey-Comprehensive Score (>=3.5)	QIC	Met

Medicaid Event Verification

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

MSHN met the goal as indicated in Attachment 12 MSHN FY2020 Medicaid Event Verification Methodology Report

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).	QIC	Met
Medicaid Event Verification review demonstrates improvement of previous year results with the service being included in the persons individualized plan of service (SUD results).	QIC	Met

External Reviews

The following external reviews were completed for FY20:

- MDHHS 1915 c Waiver Review-Partial Compliance
- MDHHS SUD Review-Full Compliance
- HSAG Performance Measure Validation Review-Full Compliance
- HSAG Compliance Review-Partial Compliance
- HSAG Performance Improvement Project-Not Met

Based on the external reviews the following areas have been identified for corrective action by MDHHS or HSAG for MSHN in coordination with the CMHSP participants.

- Individual Plan of Service (IPOS) development and implementation (includes coordination with ABA providers, amount scope and duration, measurable goals, authorization of services)
- Credentialing and staff qualification requirements (ABA and waiver programs)
- Qualitative and quantitative assessments for each representative population served annually with development of action plan to address findings.
- Adverse Benefit Determinations time frames
- Appeal Resolution Notice content requirements
- PIP-Obtain statistical improvement from previous reporting period.

Recommendations:
Goal: MSHN will demonstrate an increase in compliance for IPOS development and implementation. (includes coordination with ABA providers)
Goal: MSHN inclusive of CMHSP participants and SUD Network Providers will demonstrate an increase in compliance with the MDHHS/MSHN staff qualifications and credentialing and recredentialing requirements.
Goal: MSHN will achieve full compliance for completion of assessments for each representative population served.
Goal: MSHN will demonstrate an increase in compliance with Adverse Benefit Determinations in accordance with MDHHS requirements.
Goal: MSHN will achieve a status of "Met" for the Performance Improvement Project Validation Review.

Refer to the specific site review report for complete details.
Refer to QAPIP priorities/work plan for action steps.

Autism Review		
Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (standard-95%)	CLC	Not Met

IV. Quality Assessment and Performance Improvement Priorities (QAPIP) FY2021

The QAPIP priorities shall guide quality efforts for FY21. Figure 1 provides recommendations of priorities for FY21. The FY21 QAPIP Priorities include completion of required elements of the QAPIP, growth areas based on external site reviews and the on the review of effectiveness.

Figure 1. QAPIP Priorities and Work Plan FY21

Organizational Structure and Leadership	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.18.2021
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP (UM, PNM, CC, Clinical-SUD and CMHSP, IT).	Quality Manager	9.30.2021
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	Deputy Director/Director of Compliance, Quality, Customer Services	1.1.2022
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board via quarterly QAPIP Report.	Deputy Director/Director of Compliance, Quality, Customer Services	6.1.2021
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site) Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	Quality Manager/QIC CEO	1.31.2022 10.1.2021
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	Quality Manager/QIC	1.31.2022

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	*To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	Quality Manager	1.31.2022 Annually
*The Practice Guidelines MSHN will communicate practice guidelines to the providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact. Upload clinical practice guidelines, including MDHHS specified guidelines to the MSHN website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	Quality Manager- QIC, CLC, UM, CLC, ITC, CSC, SUDP, FC, OC	As needed, minimum annually
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Recovery Survey Assessments, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC and PAC quarterly for feedback.	Customer Services Specialist; Quality Manager; Director of Compliance, Customer Services, Quality, MEV; Director of Utilization and Care Management	December, February, April, June, August, October
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Director of Compliance, Customer Services, Quality, MEV; CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly

MMBPIS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	CMHSPs to upload detail data utilizing MSHN template quarterly through REMI.	CMHSP Participants	Q1-3.15.2021; Q2-6.15.2021; Q3-9.15.2021; Q4-12.15.2021
	MSHN submit MMBPIS to MDHHS quarterly.	Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021
	MSHN to complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations), and present/ provide to relevant committees/councils and providers quarterly.	Quality Manager QIC, Medical Directors, Tx/UM, PAC, RCAC, SUDP.	Q1 April; Q2 July; Q3 October; Q4 January
	CMHSPs to develop and submit improvement plans quarterly.	CMHSP Participants	Q1 April; Q2 July; Q3 October; Q4 January
	SUD Providers to develop improvements quarterly	SUDPs	FY21 Q3
	MSHN will develop or have available documentation for education and training of performance indicator requirements.	Quality Manager	Annually through QIC/PAC/SUD Provider Meeting
	MSHN to complete primary source verification of submitted records during the DMC review.	QAPI	Biennially with follows ups based on findings

BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will improve the quality of BH-TEDS data.	1. MSHN will identify areas of discrepancy for the BH-TEDS data for FY21Q1. Veterans data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	CIO-ITC	2.28.21
	2. Causal factors will be determined based on review BH-TEDS data.	Quality Manager- QIC; IT Project Manager- CMHSP participants	3.31.21
	3. Narrative completed comparing BH-TEDS (veteran's military fields) and VSN Report for FY21 Q1Q2 data.	CIO, Quality Manager- QIC; IT Project Manager- ITC	6.30.21
	4. Action steps developed to address incomplete data, discrepancies. Veterans data (military fields), Employment data-minimum wage, Living arrangements.	CIO, Quality Manager- QIC; IT Project Manager- ITC	7.31.21
	5. MSHN QIC will monitor progress through quarterly performance reports.	Quality Manager- QIC; IT Project Manager- ITC	FY21 Q4, FY22 Q1
Performance Improvement Projects	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
Will engage in two performance improvement projects during the waiver renewal period.	To complete the Annual Recovery Self-Assessment-Provider/Administrator Summary Report	Quality Manager/QIC/CLC/RCAC	Annually/May
	To complete the Diabetes Monitoring Performance Report quarterly and complete the Annual Submission to HSAG.	Quality Manager/Data Coordinator, QIC, Regional Medical Directors	Quarterly-December, March, June, September

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*MSHN will demonstrate an 80% or above for assess consumer experience and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, communicating results. *Member assessment of experiences will represent all served (including LTSS), and address the issues of the quality, availability, and accessibility of care.	MSHN in collaboration with CMHSPs and SUDPs will identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction)	Quality Manager-QIC/SUDP	March, April
	MSHN to complete an Annual Member Experience Report to include trends, causal sources of dissatisfaction, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July
MSHN will assess the recovery environment	MSHN to complete the Annual RAS Report to include trends, causal factors, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
MSHN will ensure Events (Sentinel/Critical/Risk) as specified in the PIHP Contract, are monitored, and submitted to MDHHS.	To submit Critical Events to MSHN monthly	CMHSPs	26th of each month
	To submit Critical Events to MDHHS monthly	Quality Manager	The last day of each month
	To submit Critical Events to MSHN Quarterly	SUDPs	January 15, April 15, July 15, October 14
	To submit Sentinel Events to MSHN Quarterly or sooner based on event notification requirements	CMHSPs / SUDP	January 15, April 15, July 15, October 15
	To submit Sentinel Events to MDHHS 2x annually	Quality Manager	Q1-Q2 April 30, Q3-Q4 October 30
MSHN Will complete oversight through primary source verification of critical incidents and sentinel events; review of the process for follow up of recommendations and consistency with MSHN/MDHHS requirements.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will ensure appropriate follow up will occur for all events dependent on the type and severity of the event and may including a root cause analysis, mortality review, immediate notification to MDHHS.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed
MSHN will ensure Individuals will have the appropriate credentials for review of scope of care.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed
CMHSP Participants and SUD Treatment Providers will achieve established targets as applicable. Trends, patterns, strengths, and opportunities for improvement identified. The PIHP must analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. *MSHN will demonstrate a 100% completion rate of the Critical Incident Review System performance reports quarterly.	To complete the CIRS Performance Reports (including standards, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. To distribute the Performance Reports to relevant committees/councils/providers for review and follow up.	Quality Manager (QIC relevant committees	Quarterly (Q4 January, Q3 April, Q2 July, Q3 October)

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
Will verify delivery of services billed to Medicaid	To complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	See annual schedule for each provider
MSHN will identify trends, patterns, strengths and opportunities for improvement.	To complete The MEV Annual Methodology Report and review with QIC and Compliance Committee annually.	Director of Compliance/Quality/ Customer Services, MEV auditor	1.31.2022
The MEV Methodology Report will be submitted to MDHHS annually as required.	To submit the Annual MEV Methodology Report to MDHHS.	Director of Compliance/ Quality/Customer Services,	12.31.2021
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	To complete/review the MSHN Utilization Management Plan annually.	Director of Utilization and Care Management	12.1.2021
MSHN will identify trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services.	MSHN to complete performance summary quarterly reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations), identifying CMHSPs/SUDSPs requiring improvement and present/provide to relevant committees/councils.	Director of Utilization and Care Management	Quarterly/annually See UM Reporting Schedule
MSHN will utilize uniform screening tools and admission criteria	To utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	Director of Utilization and Care Management	Quarterly/Annually
*MSHN will achieve full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews. Development of new timeliness standard to be reviewed quarterly.	QAPI Customer Service Specialist	Biennial Full Review with follow up annually as needed. Quarterly
*MSHN will achieve full compliance with the appeal resolution notice contact as required by MDHHS.	Refresher training will be conducted Oversight of compliance during Delegated Managed Care Reviews.	Customer Service Specialist QAPI	1.25.2020 Biennial Full Review with follow up annually as needed.

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN adopts practice guidelines that are nationally, or mutually accepted by MDHHS and MSHN.	The QAPIP Plan and related policies/procedure will include a process for adoption, evaluating and communicating practice guidelines.	Chief Behavioral Health Officer-CLC and RMD	Annually
MSHN will communicate and disseminate practice guidelines to providers and members upon request. *MSHN will communicate the practice guidelines to providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact. Upload clinical practice guidelines, including MDHHS specified guidelines to the MSHN website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually
CMHSPs will adhere to the standards within the accepted practice guidelines.	To provide oversight during DMC Review to ensure providers adhere to practice guidelines as appropriate to the population served.	QAPI	Biennially with follows ups based on findings
*MSHN will meet the standards for PCP/IPOS development for those receiving services, specifically the Autism Benefit, SEDW Waiver, CWP Waiver, and HSW	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. The following elements will be incorporated into the planning process and document: • Choice voucher/self-determination arrangements offered • Assessed needs in IPOS • Strategies adequately address health and safety and primary care coordination • Goals are measurable and include amount, scope and duration • Prior authorization of services corresponds to services in IPOS • IPOS is reviewed and updated no less than annually • Include guardian in PCP process • Category/intensity of Care (CWP)	Director of Compliance, Quality and Customer Services; Waiver Manager, Waiver Coordinator	2.17.2021

Oversight of "Vulnerable People"	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
Will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes. This includes members with special health care needs, members with long-term services and supports. This will include assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.	MSHN will analyze performance measures-Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	Director of Utilization Management, Chief Behavioral Health Officer, HCBS Manager, Autism Coordinator	Annually/Quarterly
	To complete clinical record reviews during the delegated managed care review.	QAPI, Autism Coordinator, HCBS Manager	Biennial Full Review with follow up annually as needed.
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. Behavior Treatment Data to include intrusive or restrictive techniques, and/or emergency physical intervention and 911 call to law enforcement, will be reviewed quarterly. Oversight will occur during Delegated Managed Care Site Reviews. *MSHN will demonstrate an increase in fidelity to the MDHHS Behavioral Treatment Standards for all IPOSs reviewed during the reporting period.	To develop/update the BTPR regional template, project description, policy and procedure.	BTPR Work Group, QIC, CLC, Quality Manager, Autism Coordinator	Annually
	To complete Behavior Treatment Performance Reports (including barriers, improvement efforts, recommendations, and status) quarterly.	Quality Manager/BTPR Work Group/CLC/QIC	Q1-February Q2- May Q3- August Q4-November
	CMHSPs to upload BTPR Regional Template for CMHSP data submissions	CMHSP	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021
	CMHSPs to develop action steps based on performance.	CMHSP Participants	Quarterly
	MSHN to develop/provide education and training in coordination with the CMHSP.	HCBS Manager, Autism and Waiver Coordinators	Annually
	MSHN to complete primary source verification of reported events during the DMC Review.	Autism Coordinator/HCBS Manager	Biennial Full Review with annual follow up as needed

Autism Waiver Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will ensure CMHSP participants are in compliance with the Autism Benefit.	To complete performance reports. To identify patterns, trends, and identification of improvement recommendations and actions steps as needed.	Autism Coordinator	Quarterly
*MSHN will have oversight of the Autism Benefit program requirements and corrective action related to the MDHHS Site Review.	To complete the DMC Site Review Report, ensuring ABA Treatment plans are developed in coordination with the IPOS goals and best practice standards.	Autism Coordinator	Biennial Full Review with follow up to occur in the off year.
Credentialing, Provider Qualification and Selection	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
*The PIHP shall have written credentialing policies/ procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.	To provide communication, training, and technical assistance on policy and procedures. Resources developed to support compliance with requirements and made available on MSHN website. Revised process to include additional monitoring and reporting based on repeat non-compliance with credentialing and recredentialing requirements. Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review. REMI Provider Portal implemented to assist with document management for SUD Organizational provider qualifications.	QAPI Managers Provider Network Management Committee Contract Specialist Director of Provider Network Autism Coordinator Waiver Manager	Biennial Full Review with follow up to occur in the off year. Regional results reported quarterly via Provider Network Report.
*The PIHP complies (ensures all delegates performing credentialing functions comply) with all initial (including provisional) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool.			
*Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.			
*All providers (non-licensed and licensed) will demonstrate an increase in compliance with staff qualifications, training, credentialing and recredentialing requirements.			

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
CMHSP will ensure subcontractors are in compliance with MSHN standards and requirements.	To complete annual Delegated Managed Care (DMC) Site Review Reports and Corrective Action Plans.	CMHSP (as delegate) Contract Specialist QAPI	Biennially. Interim year review includes review of new standards and evaluation of required corrective action implementation.-
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards and regulations.	To complete annual DMC Site Review Reports and Corrective Action Plans.	QAPI-Subject Matter Experts	
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards related to Financial Management regulations.	CMHSP participants are not subject to additional fiscal oversight by MSHN as they are required to obtain a Certified Public Accounting Firm Financial Audit and Compliance Examination. In addition, CMHSPs receiving Federal Funds meeting the 2 Code of Federal Regulations (CFR) 200 threshold must also obtain a Single Audit. MSHN does however review the CMHSP audits to identify adverse opinions. CMHSP Compliance Examination results are included in MSHN's Compliance Examination report. Any findings must be addressed by the PIHP and remedied. SUD Providers are subject to Fiscal Monitoring and Oversight by MSHN Finance Staff to ensure Sub-recipient requirements are met	Financial Specialist	

External Reviews	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will coordinate external site reviews between external body and the provider network. MSHN will receive full compliance on external site reviews.	Completion of the MDHHS Waiver Review Follow Up MDHHS Autism Review Completion of Health Services Advisory Group (HSAG) Compliance Review, Performance Measure Validation Review, Performance Improvement Project Validation Review.	Quality Manager-QIC; Directors of Utilization and Care Management UMC, Customer Services-Compliance-Quality CCC, Provider Network PNMC, Customer Services Specialist-CSC; Waiver Manager, Waiver Coordinators; CBHO; CIO	Annually
MSHN will coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Completion of Corrective Action Plan for each review below: MDHHS Waiver Review MDHHS Autism Review HSAG Compliance Review	Quality Manager-QIC; HCBS Waiver Manager, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services- Compliance- Quality; CIO	Annually
MSHN will monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	Completion of DMC reviews and follow up reviews	Quality Manager-QIC; Waiver Managers, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services- Compliance- Quality, Customer Services Specialist; CIO	Biennial Full Review with follow up to occur in the off year.

An effective performance measurement system allows an organization to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, outcomes, and an evaluation of satisfaction of the services in which an individual receives. MSHN utilizes a balanced score card and performance summaries to monitor organizational performance. Those areas that perform below the standard are included in the annual QAPIP. Figure 2 demonstrates indicators used to monitor the performance of MSHN.

Figure 2. Performance Measures FY21

Indicator	Committee / Council Review
Michigan Mission Based Performance Indicator System	
MSHN will meet or exceed the standard for indicator 1: Percentage of Children/Adults who receive a Prescreen within 3 hours of request (standard is 95% or above)	QIC
Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC
Indicator 2 b. Effective April 16, 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. (No Standard)	QIC/SUD
Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC
MSHN will meet or exceed the standard for indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above)	QIC
MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above)	QIC/SUD
*MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less)	QIC
BH-TEDS Data	
MSHN will demonstrate an improvement with the quality of data for the BH-TEDS data. (military fields, living arrangements and employment, LOCUS, Medicaid ID)	QIC/ITC
Performance Improvement Projects	
PIP – The degree to which programs implement recovery-oriented practices will demonstrate a 3.50 or above annually. (standard is >=3.50) (annually)	QIC
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 will demonstrate a statistically significant increase from previous reporting period. (target- 38.6%)	QIC

Assessment of Member Experiences	
*MSHN will demonstrate a 100% completion rate of assessments for each representative population served (SUD, MI/SED, IDD inclusive of LTSS) with development of action plan to address findings annually.	QIC
MSHN will demonstrate an 80% rate of satisfaction for each representative population.	QIC
I am involved in my community and organization (RSA-Involvement) (>=3.5)	QIC
Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services) (>=3.5)	QIC
I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment) (>=3.5)	QIC
I am given choices about my treatment and care that I receive (RSA-Choice) (>=3.5)	QIC
Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals) (>=3.5)	QIC
The rate of satisfaction with SUD services and treatment received will meet or exceed 80%.	QIC
The rate of satisfaction with services and treatment received for a mental illness (including LTSS) will meet or exceed 80%.	QIC
The rate of satisfaction with services and treatment received for a Severe Emotional Disturbance will meet or exceed 80%.	QIC
Safety and Risk Monitoring (Event Monitoring and Reporting)	
*MSHN will demonstrate a 100% completion rate of Critical Incident/Event performance summary quarterly.	QIC
The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year. (CMHSP)	QIC
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. (CMHSP)	QIC
The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.	QIC
The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC
The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year. (CMHSP)	QIC
The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year. (CMHSP)	QIC
The rate of deaths per 1000 persons served will demonstrate a decrease from previous reporting period. (SUD)	SUD
The rate of accidents requiring emergency medical treatment and/or hospitalization per 1000 persons served will demonstrate a decrease from previous reporting period.(SUD)	SUD
The rate of physical illness requiring admissions to hospitals per 1000 persons served will demonstrate a decrease from previous reporting period. (SUD)	SUD
The rate of arrest or convictions per 1000 persons served will demonstrate a decrease from previous reporting period. (SUD)	SUD
The rate of serious challenging behaviors per 1000 persons, served will demonstrate a decrease from previous reporting period. (SUD)	SUD
The rate of medication errors, per 1000 persons, served will demonstrate a decrease from previous reporting period. (SUD)	SUD
Medicaid Event Verification	
MSHN will demonstrate a 90% performance rate in verification of the required elements during the Medicaid Event Verification Reviews.	CCC
Medicaid Event Verification review demonstrates improvement of previous year results (94.05%) with the documentation of the service date and time matching the claim date and time of the service. SUD	CCC

Joint Metrics	
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%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences)	QIC
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%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences)	QIC
Implementation of Joint Care Management Processes	UMC
Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence	UMC
Performance Based Incentive Payments	
Identification of enrollees who may be eligible for services through the Veteran's Administration. (Narrative Report BH-TEDS and Veteran Services Navigator Data)	ITC/QIC
Increased data sharing with providers (narrative report)	ITC
MSHN will demonstrate an increase over previous reporting period of Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (2018 level Intitation-36.81%; Engagement 22.30%) (informational only)	TX/UM
Increased participation in patient centered medical homes (narrative)	UMC
Priority Measures-	
*MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report	QIC
*MSHN will demonstrate an increase from previous measurement period (78.5%) in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening	CLC
*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	CLC
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	CLC
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%)	UMC
The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%)	UMC
The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%)	UMC

Member Appeals and Grievance Performance Summary	
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%)	CSC
The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (standard-95%)	CSC
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%)	CSC
The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)	CSC
Behavior Treatment	
The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.	QIC
The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC
The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC
External Reviews	
MSHN will achieve a 95% percent for individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (standard-95%)	CLC
The QAPIP Plan and Report will be provided to network providers and members upon request.	QIC
MSHN will demonstrate an increase in compliance with the Adverse Benefit Determination notice requirements.	CSC
MSHN will communicate practice guidelines to the providers annually.	CLC
MSHN providers will demonstrate increase compliance with the MDHHS/MSHN credentialing and staff qualification requirements. (DMC Standard 8)	PNM
MSHN will achieve a status of “Met” on the Performance Improvement Validation Review.	QIC

V. Attachments

Attachment 1 MSHN MMBPIS Performance Report

Attachment 2 MSHN Diabetes Monitoring PIP

Attachment 3 MSHN Recovery Self-Assessment Summary PIP

Attachment 4 MSHN Priority Measures

Attachment 5 Satisfaction Survey Report

Attachment 6 National Core Indicator Summary

Attachment 7 MSHN Critical Incident Performance Report SUDTP

Attachment 8 MSHN Critical Incident Performance Report CMHSP

Attachment 9 MSHN FY2020 MEV Methodology Report

Attachment 10 MSHN Behavior Treatment Performance Report

Attachment 11 FY21_22_Pop_Health Integrated Care Plan Final

Attachment 12 MSHN Behavioral Health Department QTR. Report

Attachment 13 MSHN UM Plan FY20-21

Attachment 14 R5_MSHN 2020 EQR TR Follow Up

Attachment 15 Strategic Workforce Summary

Attachment 16 MSHN Balanced Scorecard