Population Health and Integrated Care Quarterly Report

July 2022 – September 2022 (FY22 Q4)

Prepared by: Director of Utilization & Care Management

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Background & Purpose

Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better equity by utilizing informed population health and integrated care strategies. MSHN and its regional partners have a number of specific population health and integrated care initiatives underway during FY22 as detailed in the MSHN 2020-2022 Population Health and Integrated Care Plan (midstatehealthnetwork.org). The primary objectives of this quarterly report are as follows:

1. Monitor adherence to the MSHN Population Health & Integrated Care Plan
2. Report progress toward MDHHS-PIHP contractual integrated health performance requirements
3. Describe other current population health and integrated care initiatives that support MSHN Strategic Priorities of Better Health, Better Care, Better Provider Systems, Better Value, Better Equity
4. Provide additional recommendations as necessary regarding organizational needs in the areas of population health and integrated care

Michigan Department of Health and Human Services (MDHHS)-Prepaid Inpatient Health Plan (PIHP) Contractual Integrated Health Performance Requirements

FY22 PIHP-Only Pay for Performance Measure(s)

Note: Please refer to Attachment A: FY22 Performance Bonus Incentive Pool (PBIP) Contractual Requirements & Deliverables

A. Identification of beneficiaries who may be eligible for services through the Veteran's Administration

FY22 Q4 Progress: In Julyy 2022 MSHN submitted a narrative report to MDHHS comparing the total number of Veterans reported on BH-TEDS and the number of veterans reported on the Veteran's Service Navigator (VSN) report during FY22 Q1-Q2.

MSHN continues to perform at a high-level for the completion and accuracy of the Military Fields in the BH-TEDS data. The performance rate indicates that actions taken to improve the FY20 and FY21 quality and completeness of the BH-TEDS Military data have been effective. Veteran Navigator services were provided to 22% (50/231) of those who identified themselves as a veteran within the BH-TEDS. This is an increase from previous measurement period of 18%. Thirty-six percent (84/231) are or have been connected to VA related services during the measurement period, which is an increase from 32%.

MSHN in in the process of implementing additional efforts during FY23 to further improve the accuracy of data and ensure veterans are connected to appropriate services to meet their needs.

B. Increased data sharing with other providers (sending ADTs through Health Information Exchange)

FY22 Q4 Progress: To achieve compliance with this performance metric at least two CMHSPs within the PIHP region must submit Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) electronic data exchange daily by the end of FY22. *As of June 2022, all 12 CMHSPS in the region were fully functional and sending ADTs.*

C. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

FY22 Q4 Progress: MSHN performed required data analysis and validation activities on the IET measure during Q2 and submitted the final findings to MDHHS as required by March 31, 2022. MSHN had a match rate of 91.78%, demonstrating a high level of validity between MSHN internal data and data provided by MDHHS. MSHN had the second highest validity rate among PIHPs.

MSHN has developed provider-specific reports and began sharing IET performance data with SUD and CMH providers during FY22 to identify where disparities may exist and develop improvement strategies. This work will continue during FY23.

D. Increased Participation in Patient-Centered Medical Homes Narrative Report

FY22 Q4 Progress: Annually, MSHN must submit a narrative report to MDHHS by November 15th summarizing prior fiscal year efforts, activities, and achievements of the region. MSHN integrated health staff worked with Clinical Leadership Committee to collect CMHSP-specific information for inclusion in the FY22 report. A copy of the final report can be found on the MSHN website:
Population Health & Integrated Care - Mid-State Health Network (midstatehealthnetwork.org)

FY22 Medicaid Health Plan (MHP)/PIHP Joint Metrics

Note: Please refer to Attachment A of this report for a full copy of the FY22 Performance-Based Incentive Pool (PBIP) contract requirements and deliverables

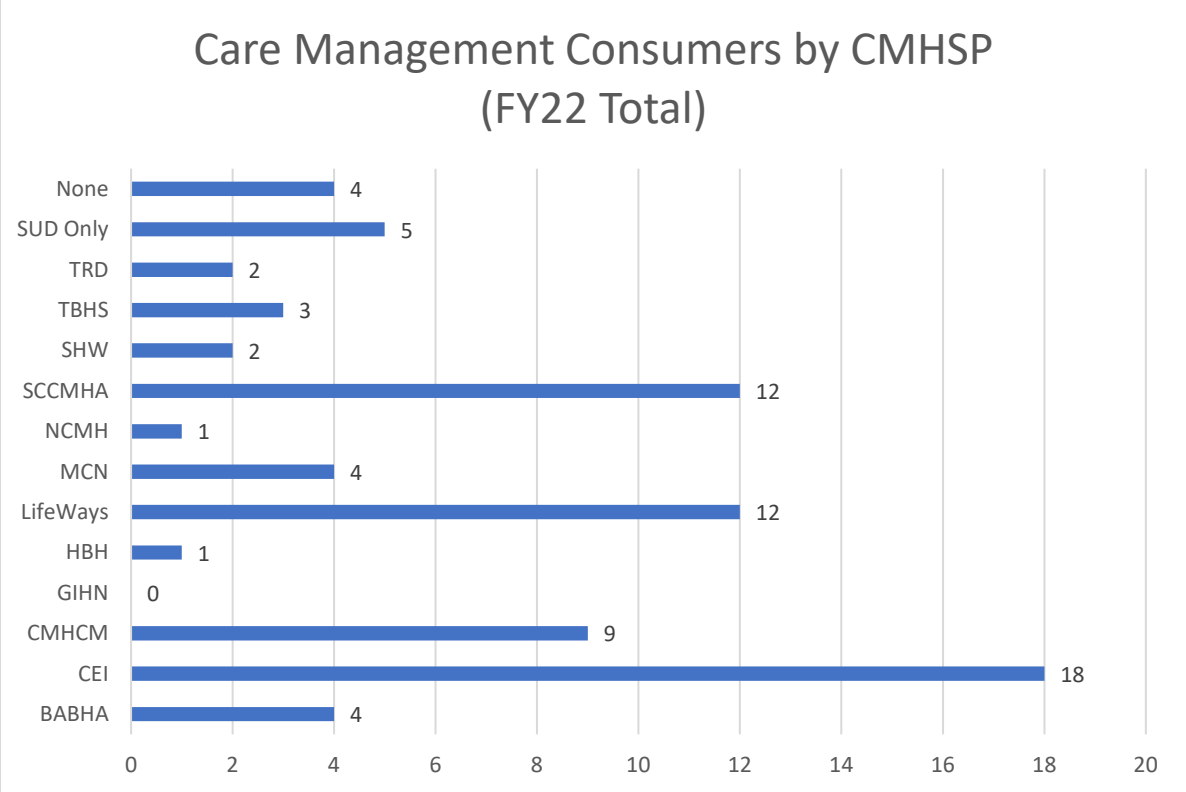
A. Implementation of Joint Care Management Processes

FY22 Q4 Performance: MSHN continues to participate in monthly care coordination meetings with each of the 8 Medicaid Health Plans (MHP) that operate within the PIHP's 21-county region. Joint care plans are developed to strengthen coordination between payors and providers in order to meet the needs of members with multiple chronic physical health and behavioral

health conditions. MSHN had open care plans for 77 individuals total during FY22. The distribution of individuals with open care plans among CMHSPs is represented in Figure 1 below.

Of note, There were 4 individuals who were not open to CMHSP services or SUDSP services but whose pattern of hospital emergency department use indicated probable mental health and/or substance use treatment needs. Outreach efforts to these individuals were made by MSHN integrated health staff or Medicaid Health Plan care managers to provide education regarding services that were available through the PIHP provider system. *All 4 individuals were successfully connected to their local CMHSP or SUD provider of their choice to participate in an initial screening for services.*

Figure 1: Number of Consumers involved in Joint Care Management Process with Medicaid Health Plans by CMHSP

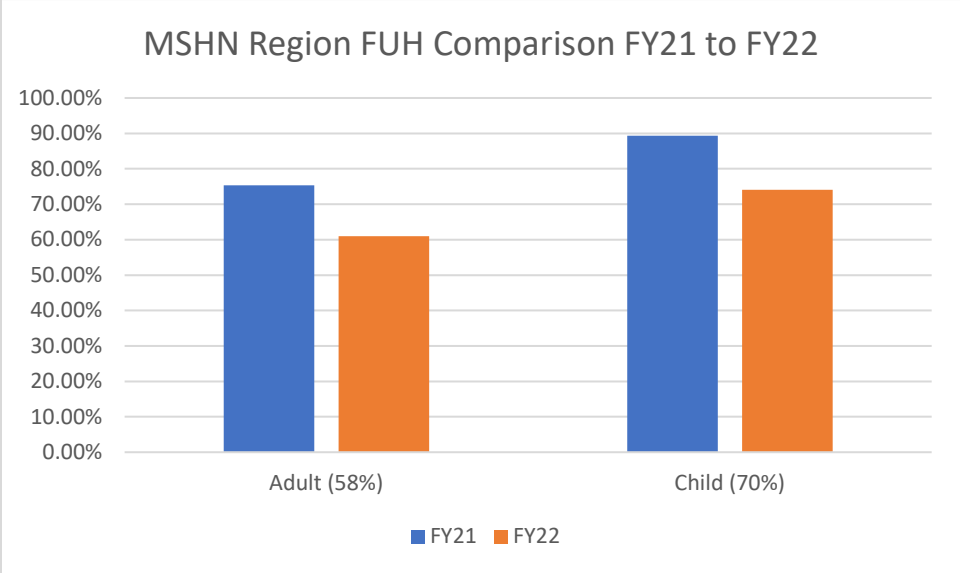


B. Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days

FY22 Q4 Performance: The MSHN Quality Improvement Council (QIC) provides a quarterly report on this performance measure and participates in quality improvement activities when adverse trends are identified. The following summary indicates performance during Q4:

- 10 out of 12 CMHSPs met or exceeded the 58% benchmark rate for adults
- 9 out of 12 CMHSPs met or exceeded the 70% benchmark rate for children
- There were no identified disparities between the white population or any racial/ethnic minority populations
- MSHN exceeded the benchmark rates for both adults and children as a total region, however overall performance for both adult and children measures has decreased considerably from FY21 to FY22 as shown below in Figure 2.

Figure 2: Comparison of overall regional performance rates on the FUH Adult and Child performance measures from FY21 to FY22



MSHN integrated health staff in partnership with the MSHN Quality Manager and regional Quality Improvement Committee (QIC) have identified potential causes for the decline in performance as well as improvement strategies. Recommendations for FY23 include:

- MSHN will provide refresher training for all CMHSP staff who complete the weekly inpatient data reporting process to ensure accuracy of data and consistency in reporting.
- Review the acceptable service codes and provider qualifications that are included in the FUH measure value set. Local CMHSP data analysis efforts have identified that most

individuals are receiving a follow-up service however sometimes the follow-up service or the credentials of the staff person who provided the service are not included in the FUH value set used by MDHHS, thus it does not "count" toward performance.

C. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

FY22 Q4 Performance: During FY22 MSHN and its CMHSP participants will work to reduce or eliminate disparities in the rates of follow-up after an emergency visit related to alcohol or substance use between White individuals and individuals belonging to racial/ethnic minority groups. The measurement period for FY22 is calendar year 2021 (January 1 – December 31, 2021). The baseline period is calendar year 2020 (January 1 – December 31, 2020).

Figure 2: The following table summarizes the follow-up rates and existing disparities between the White population and racial/ethnic minority populations during calendar year 2020 and calendar year 2021

	Follow-Up Rate 2020	Disparity in 2020	Follow-Up Rate 2021	Disparity in 2021	Did Disparity Increase, Decrease, No Change
White	29.81%	N/A	28.78%	N/A	N/A
Black/African American	15.19%	YES	15.90%	YES	NO CHANGE
Hispanic	20.38%	YES	20.25%	YES	NO CHANGE
American Indian	27.12%	NO	21.43%	NO	NO CHANGE

One of the primary interventions MSHN has implemented to improve follow up care for individuals after they visit the ED for alcohol or substance-related issues is Project ASSERT. Project ASSERT is a model of early intervention, screening, and referral to treatment for individuals in hospital and primary care settings. MSHN-funded peer recovery coaches trained in Project ASSERT are currently located in hospital emergency departments in 13 counties in the MSHN region. Individuals who present to the hospital ED with substance-related concerns are offered the opportunity to speak with a Project ASSERT peer recovery coach who offers appropriate referrals and follow-up support. *789 individuals received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2022.*

Other Population Health and Integrated Care Initiatives

Population Health and Integrated Care Measurement Portfolio

With input from its regional councils and committees, MSHN developed a priority measure portfolio based on national healthcare industry standards. MSHN utilizes data analytics software to monitor and track these measures regionally as well as by individual performance of each CMHSP. Metrics are reviewed quarterly by regional MSHN councils and committees for ongoing input into performance improvement strategies. A priority measure data report is also published on the MSHN website and updated quarterly: Priority Measures - (midstatehealthnetwork.org)

As a region, MSHN continues to perform above State of Michigan average and benchmark rates on 11 of 13 priority measures.

Health Equity & Social Determinants of Health (SDOH)

During FY 22 MSHN endeavored in a number of tasks toward understanding and addressing issues related to health equity and social determinants of health:

- Analyzed regional service penetration rate data by county and race/ethnicity to identify areas of the PIHP region where increased outreach and engagement efforts might be needed for minority groups.
- Began to conduct focus groups and learn from people of color and other at-risk groups about their experiences with access to care and the healthcare system
- Built additional data analysis capability into all existing population health reports in order to monitor outcomes relative to race/ethnicity
- Began sharing health disparity data with CMH and SUD providers specific to their organizations in order to better inform patient-centered care for the individuals they serve
- Formed a Regional Equity Advisory Committee for Health (REACH) in January 2022 comprised of stakeholders and community partners from historically marginalized populations to provide guidance on issues related to Diversity, Equity, and Inclusion (DEI)
- Conducted an internal organizational DEI assessment facilitated by the Michigan Department of Civil Rights
- Formed a voluntary internal DEI workgroup to address the findings and recommendations from the organizational assessment
- MSHN leadership participated in an informational meeting with MDHHS contractors in September 2022 regarding regional efforts to identify and address SDOH. The regional Quality Improvement Committee (QIC) and IT Council began evaluating and planning related to collection of SDOH data

SUD Value Based Purchasing (VBP)

MSHN continued internal planning activities during FY22 to prepare for future implementation of 2 SUD VBP projects in FY23:

- Project ASSERT - MSHN seeks to increase both the total number of Project ASSERT encounters that occur in hospital EDs and the overall rate of follow-up contacts. The VBP pilot will explore

innovative payment strategies that incentivize Project ASSERT providers to increase the rate of follow-up care for individuals who have experienced an ED visit for alcohol or other drugs.

- Increasing Successful Discharges from Outpatient Treatment - MSHN seeks to increase the overall percentage of successful discharges from outpatient treatment. Providers were selected to participate in the current VBP based on significantly lower rates of successful discharges compared to regional averages during FY21. Providers will be incentivized to increase successful discharges by a certain percent (to be determined) over the baseline rate. MSHN will provide technical assistance and support to help providers identify barriers that may be contributing to undesirable discharge outcomes and implement processes for improvement.

  MSHN will evaluate feasibility to scale these pilot projects in future years so that all SUD providers may have an opportunity to earn bonus incentive payments based on meeting or exceeding established performance benchmarks for percentage of successful discharges by type of service provided.

Environmental Scan:

There are several initiatives occurring simultaneously throughout Michigan with broad goals of improving integrated behavioral health and physical health care experiences and health outcomes for Medicaid/Healthy Michigan Plan beneficiaries. The following table provides a summary of key initiatives (not meant to be an exhaustive list), MSHN level of involvement, and planning considerations.

INITIATIVE	DESCRIPTION	MSHN INVOLVEMENT	CURRENT STATUS
SAMHSA Certified Community Behavioral Health Clinic (CCBHC) "EXPANSION GRANTS"	Planning grants awarded to CEI CMH, Saginaw CMH, and LifeWays CMH for infrastructure development to meet requirements as a CCBHC	There is no formal PIHP role in Expansion grants, however CCBHC sites must coordinate with PIHPs as the payer for SUD services.	MSHN will provide support as needed/requested by CCBHC sites in the areas of population health and care coordination (especially as it relates to coordination with SUD service providers)

INITIATIVE	DESCRIPTION	MSHN INVOLVEMENT	CURRENT STATUS
State of Michigan Center for Medicare/Medicaid Services (CMS) CCBHC Demonstration Project	Limited to organizations certified by MDHHS during the 2016 CCBHC planning grant. CCBHC demonstration project sites within MSHN region include CEI CMH, Saginaw CMH, The Right Door	The MDHHS CCBHC handbook identifies responsibilities for PIHP including quality reporting, pass-through payments and reconciliation, beneficiary enrollment in the Waiver Support Application (WSA), and care coordination	MSHN continues to meet on a monthly basis with the 3 CMHSP CCBHC sites to identify and address operational challenges. *8,059 Medicaid beneficiaries and 347 non-Medicaid beneficiaries received CCBHC services in the MSHN region during FY22.*
Opioid Health Home	Expansion of MDHHS Opioid Health Home initiative to MSHN Region 5 beginning in FY23 (10/1/2022) MSHN has partnered with Victory Clinical Services in Saginaw County for initial rollout	MSHN developed internal planning and implementation team to ensure necessary components are in place by 10/1/2022. OHH responsibilities for PIHP including quality reporting, pass-through payments and reconciliation, beneficiary enrollment in the Waiver Support Application (WSA), and care coordination	MSHN hired a full-time Integrated Health Coordinator in August 2022 who will serve as the OHH lead for the region. MSHN continues to meet on a monthly basis with Victory Clinic to ensure all components are in place for 10/1/2022 rollout. MSHN staff and VCS staff completed training for the MDHHS Waiver Support Application (WSA) in September 2022.

INITIATIVE	DESCRIPTION	MSHN INVOLVEMENT	CURRENT STATUS
Behavioral Health Home (NEW)	Expansion of MDHHS Behavioral Health Home initiative to MSHN Region 5 beginning in FY23 (Anticipated 4/1/2023)	BHH responsibilities for PIHP including quality reporting, pass-through payments and reconciliation, beneficiary enrollment in the Waiver Support Application (WSA), and care coordination	MSHN met with MDHHS during FY22 Q4 to begin planning for BHH implementation. MSHN identified 5 BHH partners: Montcalm Care Network, Saginaw CMH, Newaygo CMH, Shiawassee Health & Wellness, CMH for Central MI The PIHP is required to have 0.5 FTE Health Home Coordinator staff per 100 beneficiaries enrolled in the BHH. MSHN currently posted for one Integrated Health Coordinator position to serve as lead for BHH, however MSHN will continue to evaluate staffing needs to ensure adequate support for BHH during FY23.

Summary & Next Quarter Focus:

MSHN and its CMHSP participants are currently involved in several population health and integrated care initiatives including MDHHS contractual requirements, PIHP strategic priorities, and innovative pilot projects. Activities during FY23 will focus on the following:

- Quarterly health equity data analysis for PIHP/MHP joint performance metrics; results of data analysis will be shared with CMHSP participants and MHPs
- Continue regular project implementation meetings for CCBHC, OHH, and BHH demonstration projects in collaboration with regional partners

ii. Assessment and Distribution
PBIP funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system. The 0.75% PBIP withhold will be distributed as follows:
a. Contractor-only Pay for Performance Measure(s): 45%
b. Contractor Narrative Reports: 25%
c. MHP/Contractor Joint Metrics: 30%
d. The State will distribute earned funds by April 30 of each year.

21. Schedule A, Statement of Work
Section 8. Payment Terms, D. Contractor Performance Bonus, letter c. OHH Benefit, the following statement is hereby added:

OHH Pay for Performance funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

22. Schedule A, Statement of Work
Section 8. Payment Terms, D. Contractor Performance Bonus, letter d. BHH Benefit, the following statements are hereby added:

BHH Pay for Performance funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

23. Schedule A, Statement of Work
Section 8. Payment Terms, D. Contractor Performance Bonus, letter e. is hereby added:
e. Certified Community Behavioral Health Center (CCBHC) Benefit
The State will provide a Quality Based Payment (QBP) to CCBHCs through a 5% withhold of the total CCBHC annual costs based on federally defined metrics to be disseminated in FY22. These payments are outside of the PPS-1 actuarial equivalent rate.

24. Schedule A, Statement of Work
Section 8. Payment Terms, D. Contractor Performance Bonus, 2. Contractor-only Pay for Performance Measures is hereby deleted and replaced in its entirety with the following:

2. Contractor-only Pay for Performance Measures

Measure	Description	Deliverables
P.1. PA 107 of 2013 Sec. 105d (18): Identification of beneficiaries who may be	a. Improve and maintain data quality on BH-TEDS military and veteran fields.	a. Due January 2022: • a resubmission of October 1 through March 31 of FY21 **comparison** of the total number

Measure	Description	Deliverables
eligible for services through the Veteran's Administration (25 points). The State acknowledges that not all Veterans interacted with by the Veteran Navigator and on the VSN will have a CMHSP contact and thus will not have a BH-TEDS file.	b. Monitor and analyze data discrepancies between VSN and BH-TEDS data.	of individual veterans reported on BHTEDS and the VSN form. • submission of April 1 through September 30 of FY21 comparison of the total number of individual veterans reported on BHTEDS and the VSN form. • Narrative comparison of the above time periods, identifying any areas needing improvement and actions to be taken to improve data quality. b. The contractor must compare the total number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality. Timely submission constitutes metric achievement number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality. Timely submission constitutes metric achievement
P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers (25 points)	Send ADT messages for purposes of care coordination through health information exchange.	For multi-county PIHPs, two or more CMHSPs within a Contractor's service area, or the Contractor, will be submitting Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY22. By July 31, the Contractor must submit, to the State, a report no longer than two pages listing CMHSPs sending ADT messages,

Measure	Description	Deliverables
		and barriers for those who are not, along with remediation efforts and plans. In the event that MiHIN cannot accept or process Contractor's ADT submissions this will not constitute failure on Contractor's part.
P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (50 points)	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. -Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.	1. The points will be awarded based on contractor participation in IET measure data validation work with MDHHS. Contractor will submit an IET data validation response file by March 31 in accordance with instruction provided by MDHHS. Note: The State recognizes the Contractor does not have a full data set for analyses.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (20% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

3. MHP/Contractor Joint Metrics (30% of total withhold)

Joint Metrics for the Integration of Behavioral Health and Physical Health Services

To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Contractor, the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

Category	Description	Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the Contractor-MHP Collaboration Work Group in consultation with the State.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be calendar year 2021. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with Calendar year 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

J3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	1. The Contractor must meet set standards for follow-up within 30 Days. The Contractor will be measured against a minimum standard of 27%. Measurement period will be calendar year 2021. 2. Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with calendar year 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

25. Local Funding Source Obligation FY22 Schedule G is hereby added, and SFY2021 March, 2021 to September, 2021 Behavioral Health Rate Certification and SFY2022 Behavioral Health Capitated Rate Certification are hereby added to Schedule H as follows.