MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2021

Prepared By: MSHN Quality Manager -January 2022
Reviewed and Approved By: Quality Improvement Council – January 20, 2022
Reviewed By: MSHN Leadership – February 16, 2022
Reviewed By: MSHN Operations Council –
Reviewed and Approved By: MSHN Board –

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I. Introduction

The Mid State Health Network (MSHN) Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The review includes the components of the QAPIP, the performance measures, and improvement initiatives, as required based on the MDHHS PIHP contract and the BBA standards. In addition to ensuring the components continue to meet the requirements, each strategic initiative is reviewed to determine if the expected outcome has been achieved. Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan which includes a description of each activity and a work plan for the upcoming year. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for following year. The measurement period for this annual QAPIP Report is October 1, 2020, through September 30, 2021. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks.

II. Organizational Structure

a) Structure

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

b) Components

Recipients

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

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

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

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

Communication of Process and Outcomes

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

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

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

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

c) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including the priorities as identified in this plan. The QAPIP

Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors 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 Board of Directors, the QAPIP Report will include a list of the Board of Directors' and will be submitted to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the 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 MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP.

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

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services are represented 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 valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Having representation on organization-wide standing councils, committees, and work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the PIHP QIC and their local organization.

Councils and Committees

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional 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, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSP participants. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the majority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

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

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, 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 was charged with serving in an advisory capacity to MSHN to represent SUD providers offering input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, to support MSHN's focus on evidence-based, best practice service, delivery to persons served, and assist MSHN in establishing and pursuing state and federal legislative, policy and

regulatory goals. The broad-based SUD-PAC included every Level of Care (LOC) and recovery housing. In the four years since the SUD-PAC was established, engagement and membership declined. Due to lack of efficiency, it is recommended that the MSHN SUD provider network utilize workgroups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider workgroup is specific to a Level of Care (LOC) or recovery and functional areas including, Women's Specialty Services, Medication Assisted Treatment, Residential, as well as prevention and a broader recovery-oriented workgroup. The MSHN SUD provider workgroups will be used for advisory input around the functions that gave rise to the SUD-PAC's original intent.

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.

III. Annual Reports

a) MSHN Councils Annual Reports FY21

Team Name: Mid-State Health Network Operations Council

Team Leader: Joseph Sedlock, MSHN Chief Executive Officer

Report Period Covered: 10.1.20-9.30.21

Purpose of the Operations Council:

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

Responsibilities and Duties[2]:

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

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

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

[2] Ibid., unless otherwise footnoted

[3] Operations Council Charter, February 2014

Defined Goals, Monitoring, Reporting and Accountability[4]

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

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

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

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

Annual Evaluation Process:

a. Past Year's (FY 21) Accomplishments:

- Strong COVID-19 pandemic response coordination and regional collaboration.
  - Developed regional responses to provider questions and published definitive responses, published and updated pertinent regional pandemic-related guidance documents, published and updated COVID-related operational protocols.
  - Implemented regional direct care worker premium pay initiative with multiple extensions through the year.
  - Implemented regional provider support and stabilization initiatives.
  - Provided financial and in-kind supports to dozens of in-region providers.
  - Considered regional workforce recognition program (was not implemented regionally due to audit finding concerns).
  - Distributed personal protective equipment (PPE) to all regional CMHSPs and dozens of residential and ambulatory care providers, including substance use disorder network.
  - Pursued a formal request with MDHHS for a temporary moratorium on Specialized Residential Site Review activity for Providers struggling with Audits, HCBS oversight, MEV reviews, etc. to not have compliance issues if items are postponed.
  - 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.
    - Facilitated workforce and beneficiary engagement in vaccination activities.
  - Developed regional statement/communication regarding recommendation that all regional meetings be mandated "Video On".
- Monitored regional financial performance, including regional budget amendments for current year budget and provided input on FY 22 budget.
- Supported regional participation in the State's Bed Registry Pilot to collect inpatient denial data.
- Reviewed and approved changes and additions to the current year (FY 21) and next year (FY 22):
  - Delegated Managed Care Review Tools

[4] Ibid.

- MSHN/CMHSP Medicaid Sub-Contracting Agreement
- Regional training grid
- Regional Financial Management Services contract
- Regional Psychiatric Inpatient Hospital contract
- Regional ABA/Autism Services Contract

- Reviewed and approved changes to the:
  - FY21-22 Population Health and Integrated Care Plan
  - FY21 Consumer Handbook
  - FY 21 Regional Network Adequacy Assessment
  - MMBPIS Indicator and Performance Reports, including new indicators and changes to measurement methodology
  - QAPIP FY20 Annual Effectiveness report
  - FY21 QAPIP Plan and Workplan
  - Corporate Compliance Plan
- Approved the proposal to add consumer representation on MSHN councils and committees. Approved the charters for both QIC and Customer Service.
- Supported the Independent Facilitation (IF) regional contracting proposal to secure IF services.
- Discussed and supported current COFR policy.
- MSHN earning and distribution of FY 20 Performance Bonus Incentives.
- Strong engagement, collaboration, and regional commitment to strategic planning through multiple strategic planning meetings.
- Considered and supported a MSHN-held Crisis Residential Contract for the benefit of beneficiaries in the region.
- Presented the FY21 Balanced Scorecard with a new report including the CCBHC metrics in draft form until final CCBHC metrics have been determined along with the role of the PIHP.
- CCBHC – related planning and preparation.
- Approved MSHN to negotiate the RELIAS contract to determine best option for the region.
- Prepared for MiCAL expansion into MSHN region.
- Approved updated charters to Councils, Committees and Workgroups.
- Approved updated Policies and Procedures as presented for review.
- Reviewed multiple regional reports; Satisfaction Surveys, Denials & Grievances, Priority Measures, MMBPIS, Critical Incidents, Penetration Rates, Telehealth Utilization, Behavior Treatment, Acute Care Services.
- Reviewed External Regional Audit Results; HSAG Compliance, Performance Measure Validation, Performance Improvement Plan (PIP).

b. <u>Upcoming Goals for Fiscal Year Ending, September 30, 2022:</u>

- Continue provider support during COVID-19 pandemic response period:
  - Address workforce crisis regionally through continuation of Direct Care Worker Premium Pay initiative.
  - Continue regional provider stabilization initiative.
- Advocate for system reform changes that work for beneficiaries in the region while addressing, responding to, and planning for changes to the public behavioral health system as a result of legislative/other proposals for system redesign.
- Implement applicable portions of the MSHN Strategic Plan for FY 2022-2023.

Team Name: Finance Council
Team Leaders: Leslie Thomas MSHN Chief Financial Officer
Report Period Covered: 10.1.20-9.30.21

Purpose of the Finance Council

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

Responsibilities and Duties:

Areas of responsibility:

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

Monitoring and reporting of the following delegated financial management functions:

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

Monitoring and reporting of the following retained financial management functions:

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

Defined Goals, Monitoring, Reporting and Accountability

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 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 forpotential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

a. Past Year's Accomplishments
    - FY 2020 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and all CMHSP audits rendered an unqualified opinion. Compliance Examinations were finalized for the PIHP and all CMHSPs. The PIHP's Compliance Examination is completed after the CMHSPs to ensure all adjustments to Medicaid and Healthy Michigan Plan are included. The PIHP and its 12 CMHSPs complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants.
    - MSHN achieved a fully funded (7.5%) Internal Service Fund for FY 2020. In addition, the region boasted savings of more than $31.8 M which is approximately 5.2% of revenue for a total risk reserve of 12.7%.
    - MDHHS and Milliman worked through FY 21 to develop a Standard Cost Allocation (SCA) process. Throughout FY 21, Milliman has conducted SCA workgroup meetings and started statewide bi-weekly question and answer sessions. Although the implementation date of SCA is FY 22, only four MSHN's CMHSPs will meet this deadline (The Right Door, Lifeways, Saginaw, and Tuscola). The other eight CMHSPs received approval for an FY 23 implementation.
    - 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 21 revenues are sufficient to meet service needs.
    - MSHN successfully submitted FY 21 Encounter Quality Initiative (EQI) reports to MDHHS. EQI reporting replaced Utilization Cost Reports submitted in previous fiscal years.

b) 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 21 revenue as MDHHS did not disburse additional funds for this initiative.

c) Further, Direct Care Workers (DCW) were granted a $2 per hour premium pay increase for MDHHS identified services. In March 2021, the rate was increased to $2.25 per hour and all DCW payments include an additional 12% to cover the provider's associated administrative expenses. The State of Michigan's budget included continuation of the DCW premium pay and the effective October 1, 2021, boosted the hourly rate to $2.35.

Upcoming Goals for Fiscal Year Ending September 30, 2022, Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2021 and February 2022. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2022 and compliance exams by June 2022. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2021 Final Reports due to MDHHS March 31, 2022, 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 Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

TEAM NAME: Information Technology Council

TEAM LEADER: Forest Goodrich, MSHN Chief Information Officer

REPORT PERIOD COVERED: 10.1.20-9.30.21

Purpose of the Council or Committee:

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

Responsibilities and Duties:

The responsibilities and duties of the ITC include the following:

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

Defined Goals, Monitoring, Reporting and Accountability:

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

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

Annual Evaluation Process:

a. Past Year Accomplishments
   - Representation from each CMHSP Participant at all meetings
     - There was a 99% attendance rate during FY20 ITC meetings. 100% attendance occurred in 10 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
   - Successfully submit MDHHS required data regarding quality, effectiveness, and timeliness
     - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: mental health, substance use, and crisis records. (M, A, Q transactions)
     - MDHHS reported we were measured at 99.1% in encounter reporting timeliness and

volume submissions at quarterly intervals. MSHN reconciled 100% to MDHHS warehouse records at year-end.
    - MSHN met the requirements for MDHHS performance incentives that included evaluating Veterans Navigator quarterly reporting and Veteran's status in BH-TEDS reporting and submitting BH ADT records by two CMHSPs in the region to MiHIN. (CEI and Lifeways)
- Several initiatives that ITC assisted with during this fiscal year are:
    - Continued trending telehealth events during pandemic.
    - Assisted with encounter alignment to meet EQI reporting requirements.
- Facilitate health information exchange processes
    - Changed the active care relationship process (ACRS) to derive from CMHSP systems so that data exchange is timely.
    - Implemented COVID-19 response file exchange.
    - Transitioned LOCUS data exchange to HIE between CMHSP systems and MSHN.
    - Admission, Discharge and Transfer records are received directly into CMHSP EMR.
    - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway.
- Goals established by Operations Council
    - Improvements with balanced scorecard reporting.
    - Continue trending COVID-19 and telehealth reports.
    - Manage upgrades to MCG Indicia and guidelines.
- Meet external quality review requirements
    - Health Services Advisory Group conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved.

b. Goals for fiscal year ending September 30, 2022
- Active participation by all CMHSP representatives at each monthly meeting.
- Meet current reporting requirements as defined by MDHHS.
- Improve Employment and Minimum Wage field values in BH-TEDS reporting process.
- Pilot CC360 API integration in EMRs.
- Provide analysis with Medicaid disenrollment impact.
- Work to achieve balanced scorecard target values.
- Continue 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: 10.1.20 – 9.30.21

Purpose of the Council or Committee:

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

Responsibilities and Duties:

The responsibilities and duties of the QIC include the following:

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had twelve (12) meetings during the reporting period and in that time completed the following tasks:
   - Reviewed and approved the FY20 Quality Assessment and Performance Improvement Report.
   - Reviewed, revised, and approved the FY21 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 FY21 Delegated Managed Care Site Review Tools.
   - Reviewed key performance indicators (Diabetes Screening, Follow Up to Hospitalization, Diabetes Monitoring) quarterly identifying trends and action steps as needed.
   - Reviewed the Recovery Self-Assessment data (Administrator, Provider) identifying trends and growth areas.
   - Evaluated the effectiveness of the interventions and reviewed the data for the performance improvement project "Diabetes Monitoring for Schizophrenia Diagnosis" identifying barriers and interventions.
   - Identified a proposed new PIP topic for CY22
   - Reviewed the Critical Incident Data quarterly, developed a more in-depth analysis for identifying trends and growth areas for development of focused improvement efforts; developed a corrective action plan to address the timeliness of reporting incidents; developed a process to collect supplement data (drug related and COVID as a contributing factor) for death reporting.
   - Reviewed the Michigan Mission Based Performance Indicator System (MMBPIS) data quarterly report identifying trends and actions steps for improvement.
   - Monitored the 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
   - Participated in the External Quality Reviews (Performance Improvement Project, Performance Measurement Validation, Compliance Review), completing and implementing 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. Goals for Fiscal Year Ending, September 30, 2022
   - Incorporate consumer representatives 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 and evaluate the effectiveness of site review corrective action plans.

b) MSHN Advisory Councils FY21 Annual Reports

Team Name: Regional Consumer Advisory Council
Team Leader: Gordon Matrau, Chairperson
Report Period Covered: 10.1.20-9.30.21

Purpose of the Consumer Advisory Council:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The Consumer Advisory Council had 6 meetings during the reporting period and in that time, they completed the following tasks:
    - Reviewed the Annual Compliance Summary Report
    - Reviewed changes to the FY21 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 provided feedback on the MSHN Council/Committee Consumer Representative process
- Reviewed and provided feedback on 2022-2023 MSHN Strategic Plan
- Reviewed and provided feedback on Quality Assessment and Performance Improvement
- Partnered with MSHN to promote the Regional HCBS Final Rule Presentation
- Education on the Veteran Navigator program
- Education on and discussion on Veterans: Homelessness and Mental Health Support
- Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews
- Reviewed and revised council charter
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom in response to the global pandemic

b. Upcoming Goals for Fiscal Year 2022 Ending, September 30, 2022:
- 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 CMHSP consumer advisory groups
- Explore ways to get more consumers involved in the RCAC and local consumer councils
- Public Behavioral Health System Redesign Advocacy

TEAM NAME: Substance Use Disorder Provider Advisory Committee (SUD-PAC)
TEAM LEADERS: Shannon Myers, Treatment Specialist; Jill Worden, Prevention Lead; Melissa Davis, QAPI Manager; Kathrin Flavin, Utilization Management and Dani Meier, Chief Clinical Officer
REPORT PERIOD COVERED: 10.1.2020 – 9.30.2021

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:

- Held group discussions on staffing difficulties
- 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
- Held group discussions on LGBTQ+ inclusion and ideas to support increased penetration in services
- Held discussions on increasing diversity, equity, and inclusion in the MSHN region
- Continued to review and receive statewide ASAM Continuum assessment updates
- Offered input on SUD provider audit process and tools
- Discussed barriers to SUD PAC efficacy in meeting its defined purpose and role and considered alternatives.

Reviewed the following:

- Offered input on SUD provider audit process and tools
- Required trainings
- Reviewed the annual plan process
- Provider satisfaction survey results
- Provider workforce attraction, retention, and regional issues
- Proposed contract changes
- MMBPIS SUD Summary Report
- MSHN SUD Sentinel Events
- PAC calendar
- SUD Provider Manual
- 2022 QAPI Standards
- Provider Risk Assessment tool
- CAIT license questions and updates
- Reviewed financial changes related to reductions in Block Grant funds, provider stabilization, and COVID relief funds

Future Plans:

A consistent issue throughout the life of the SUD-PAC has been sustained engagement and ways that this has impacted its defining purpose, first and foremost, to provide advisory input on multiple levels of SUD regional issues and operations, and secondarily, to serve as liaison with the broader provider network. As noted above, this was raised and discussed with the group in FY21 and in previous years. Over time, changes were made to attempt greater engagement, for example, handing over meeting facilitation to a provider member of the SUD-PAC as Chair. These and other efforts didn't offer significant improvement even prior to the COVID pandemic and with the pandemic's impact on provider capacity and workforce issues, SUD-PAC engagement continued to decline in 2020 and 2021.

A common theme was that with the diversity in SUD-PAC membership—inclusive of prevention, treatment at every level of care, and recovery providers—there were frequent gaps in what was

relevant or useful as topics or foci of the group. By contrast, MSHN's provider workgroup groups that are more focused around functional areas—Women's Specialty Services (WSS), Medication-Assisted Treatment (MAT), and Recovery providers, for example, have been meeting for years with solid engagement and a high sense of relevance and utility for provider members. A recently developed Residential Treatment workgroup has had similar engagement and appreciation from members for what the group has to offer in terms of targeted and focused problem-solving and information-sharing.

It was determined therefore that in FY22, MSHN would use these more targeted provider groups organized around functional and operational domains as a venue for provider input and engagement with MSHN. While not formally disbanded, the SUD-PAC will suspend its activity in FY22 as MSHN explores the impact of these other provider groups.

MSHN is grateful to those providers whose staff have served on the SUD-PAC and have contributed their time and labor to increasing and improving collaboration and communication between the provider network and MSHN.

c) MSHN Oversight Policy Board FY21 Annual Report

Team Name: Substance Use Disorder Oversight Policy Board
Team Leader: Chairman John Hunter, SUD Board Member
Report Period Covered: 10.1.20-9.30.21

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments:
   - Received updates and presentations on the following:
     - MSHN SUD Strategic Plan
     - MSHN SUD Prevention & Treatment Services
   - Approval of Public Act 2 Funding for FY20 & related contracts
   - Approved use of PA2 funds for prevention and treatment services in each county
   - Received presentation on FY21 Budget Overview
   - Received PA2 Funding reports – receipts & expenditures by County
   - Received Quarterly Reports on Prevention and Treatment Goals and Progress
   - Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
   - Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
   - Executed new three-year SUD Intergovernmental Agreement
   - Received new written updates from Deputy Director including state and federal activities related to SUD
   - Received updates on MDHHS proposed future of Behavioral Health
   - Provided input and received information/updates on Block Grand Reduction Strategies
   - Received updates on MDHHS State Opioid Response Site Visit Results
   - Received information on COVID-19 and Provider Status
   - Shared prevention and treatment strategies within region

b. Upcoming Goals for FY22 ending, September 30, 2022:
   - Approve use of PA2 funds for prevention and treatment services in each county
   - Improve communications with MSHN Leadership, Board Members and local coalitions
   - Orient new SUD OPB members as reappointments occur
   - Receive information and education on opioid settlement and strategies
   - Provide input into COVID related funding specific to Substance Use Disorder Treatment and prevention
   - Monitor SUD spending to ensure it occurs consistent with PA 500

d) MSHN Committee FY21 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, Chief Behavioral Health Officer
Report Period Reviewed: 10.1.20-9.30.21

Purpose of the Clinical Leadership Committee (CLC):

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

Responsibilities and Duties

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

- Improved health outcomes.
- Increased use of 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

a. Past Year's Accomplishments

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

b. Upcoming Goals (FY2022) (CF=carry forward from FY2021)

- Carry forward some goals from previous year
- Address workforce shortage
- Address crisis resources uniformly across the region
- Stabilize CLS and residential systems of care, including staffing and provider stability (CLS and spec. res.). Include planning relating to serving persons with behavioral issues.
- Deal with crisis response to meth and substance induced psychosis.
- (CF) Continue exploring opportunities to maximize partnership role with the Regional Medical Directors
- (CF) Focus on 1915i service oversight transition to PIHP for annual eligibility authorizations
- (CF) Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation.

Team Name: Regional Medical Director's Committee
Team Leaders: Dr. Zakia Alavi
Report Period Covered: 10.1.20-9.30.21

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.

Annual Evaluation Process

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.
    - Guidance relating to Residential Safety, Agency Reopening, and Mask Wearing Guidance.

b. Upcoming Goals
    - Core service menus for LOCUS and CAFAS
    - Assisted Outpatient Treatment
    - COVID discussion for planning
    - Continued input into behavior treatment processes
    - Ongoing input into population health and integrated care
    - Ongoing input into data-related decisions
    - Maintaining/improving staffing at all levels.
    - Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with Clinical Leadership Committee. Protect time to ensure that there is medical director input and address with Operations Council.
    - Create a description of the minimum functions/roles expected of a medical director.
    - Improve relationship with MDHHS around processes related to CMH functions (i.e., determination of hospitalization). Address improving collaboration in the authorities that exist in the CMH and MDHHS.
    - Address MI-SMART at a regional level, to also include adequate coverage at the hospital. Include medical issues the individual is experiencing and hospital capability to address.

TEAM NAME: Utilization Management Committee
TEAM LEADER: Skye Pletcher**,** MSHN Director of Utilization and Care Management
REPORT PERIOD: 10.01.2020 – 9.30.2021

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

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

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

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

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

across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization).

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The UMC had eleven meetings during the reporting period. In that time the following tasks were completed:
    - A thorough review of the UMC annual report schedule was conducted in order to evaluate the ongoing relevance and effectiveness of the data being reviewed by the committee. A number of recommendations were made related to eliminating areas of redundancy where similar data is being monitored by more than one regional committee or certain regional processes have become more automated and standardized over time resulting in there no longer being a need for data monitoring by the committee.
    - Ongoing review of data reports related to performance on regional UM and integrated health priority measures with CMH participants reporting on change strategies when performance is outside of established expected thresholds
    - 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 CMHSP organizations as well as individual consumer outliers, however, there have been challenges with providing CMHSPs access to their own data without exposing underlying data for the region. This will continue to be addressed as a goal in FY22
    - Ongoing cross-functional dialogue with QI Council, Clinical Leadership Committee (CLC), and Provider Network Management.
    - Completed training and deployed the Interrater Reliability training module for MCG Behavioral Health Guidelines
    - Completed quarterly retrospective reviews for acute care services using the MCG Behavioral Health Guidelines and established a regional target of 95% or more correct application of medical necessity criteria. During FY21 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.
    - Reviewed data relative to quarterly Balanced Scorecard
    - Implemented improved tracking capabilities as a region to ensure authorization determinations are made within established timeframes (14 Days for Standard Requests, 72 Hours for Expedited Requests)
    - Began monitoring quarterly ACT utilization data to evaluate if services are being delivered consistent with evidence-based practice guidelines for average hours of service per individual per week
    - Implemented new quarterly MDHHS Service Authorization Denials Report and deployed an automated process for gathering and reporting data to ensure regional consistency
    - Began monitoring quarterly telehealth utilization data and overall impact on service delivery and engagement

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

- 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 and/or practice guidelines 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: Regional Compliance Committee

TEAM LEADER: Kim Zimmerman, Chief Compliance and Quality Officer

REPORT PERIOD REVIEWED: 10.1.20-9.30.21

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 Federaland 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 Committeeshall include the following:

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

Defined Goals, Monitoring, Reporting and Accountability

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

- As defined in the Compliance Plan

Annual Evaluation Process

a. Past Year's Accomplishments
   - Revised and approved the MSHN Compliance Plan
   - Provided feedback and approval for the Annual Compliance Summary Report
   - Reviewed and updated the Committee Charter
   - Provided feedback on the MSHN FY22-23 Strategic Plan
   - Provided opinion on Preponderance Rule (H2015 Memo)
   - Reviewed FY20-21 Contract Comparison for Compliance and Quality
   - Review of 21st Century Cures Act for compliance with standards
   - Review of new Mediation requirements (House Rule 5043)
   - Reviewed CMH Patient Access Rule and InterOp Station for compliance with standards
   - Reviewed trends in the OIG Quarterly Reports
   - Reviewed Medicaid Policy Bulletins and Medicaid Manual and implementedchanges

regionally and locally as needed

- Reviewed changes/revisions to state and federal policies and regulations, includingbut not limited to:
    - Department of Justice Compliance Program Guidelines
    - COVID-19 requirements and technical guidance
    - Anti-Kickback Law
    - Stark Law
    - Medicaid Final Rule
- Reviewed information provided at the PIHP Compliance Officers meetings
- Reviewed outcomes from external site reviews for necessary changes andcompliance related issues
- Provided consultation on local compliance related matters
- Developed, implemented, reviewed and made necessary corrections for quarterlydata mining activities
    - Death to encounter data report
- Provided feedback on MSHN practices to include but not limited to:
    - Delegated Managed Care Review tools
- Review and revise compliance policies and procedures

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

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

TEAM NAME: Provider Network Management Committee
TEAM LEADER: Kyle Jaskulka, MSHN Contract Manager
REPORT PERIOD REVIEWED: 10.1.20-9.30.21

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

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

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

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

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

Annual Evaluation Process

a. Past Year's Accomplishments (FY21):
    - Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures

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

b. Upcoming Goals (FY22):
- Address recommendations from the 2021 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
- Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
- Establish relevant key performance indicators for the PNMC scorecard;
- Monitor and implement Electronic Visit Verification as required by MDHHS;
- Initiatives to support reciprocity:
    - Contracting:
        - Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation
    - Procurement:
        - Fully implement the use of a regional web-based provider application;
        - Publish provider selection processes on MSHN web;
    - Monitoring:
        - Fully implement specialized residential reciprocity provider monitoring plan;
    - Training:
        - All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
- Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
- Develop and implement regionally approved process for credentialing/re-credentialing reciprocity

TEAM NAME: Customer Service Committee
TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist
REPORT PERIOD COVERED: 10.1.20 – 09.30.21

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments: The CSC had six committee bi-monthly meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY21 Consumer Handbook
   - Facilitated publication and electronic regional distribution of the MSHN FY21 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
   - Reviewed, analyzed and reported regional customer service information for:
     - Denials
     - Grievances
     - Appeals
     - Medicaid Fair Hearings
     - Recipient Rights
   - Updated, reviewed, and approved language updates for the MDHHS standardized templates
   - Implemented the MDHHS quarterly Grievance and Appeals data reporting
   - Electronic Health Record process improvements to better capture MDHHS Grievance and Appeals data reporting

b. Upcoming Goals for Fiscal Year 2021 Ending, September 30, 2022
   - Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
   - Determine oversight & monitoring of regional Appeals and Grievances using the MDHHS data reporting, in accordance with customer service standards
   - Advocate for improvements to the MDHHS Notices to improve consumer friendly language
   - Develop a standardized training for the Adverse Benefit Determination process
   - Continue reporting and monitoring customer service information
   - Continue to explore regional Customer Service process improvements
   - Continue to develop, where applicable, MSHN standardized regional forms
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region

e) MSHN Workgroups FY21 Annual Reports

Team Name: Autism Benefit Workgroup

Team Leader: Kara Hart

Report Period Reviewed: 10.1.20-9.30.21

Purpose of the Autism Workgroup:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

Annual Evaluation Process

a. Past Year's Accomplishments:
    - Communicated about autism provider workgroup and provider audit process
    - Preparation and implementation of autism policy updates (effective 9.1.2021)
    - Served as a conduit of information from MDHHS which included sharing state plan, appendix K, return to school guidance, billing and code chart updates, telehealth, and any updated COVID-19 pandemic changes
    - Significant enrollment growth in the program (October 2020- 1371 enrolled and July 2021-1639 enrolled. As of July, a 20% increase
    - Shared and discussed Behavior Treatment FAQ
    - Regional response to changes in MDHHS AUT Section leadership and practices
    - Regional participation and leadership around the MSU Family Guidance project, including publications from the project
    - Collaboration with Autism Operations Workgroup on updating of standardized regional contract for autism services as needed
    - Coordination of ABA provider audits and credentialing reciprocity
    - Regional response and coordination of modifications to service delivery during the COVID-19 pandemic

b. Upcoming Goals:
    - Continue to monitor and modify processes related to COVID-19 service delivery
    - Adjust to code changes and new policy language
    - Update policies in contracts based on new benefit language
    - Continue to work to improve quality provider network capacity
    - Continue efforts to ensure individuals are receiving services within 90 days of enrollment.

Team Name: Child Waiver Program (CWP) Workgroup
Tam Leader: Tera Harris
Report Period Reviewed: 10.1.2020-9.30.2021

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 CMHSP participants 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,
    - Disenrollment's
    - Age-Offs,
    - CWP Slot Transfer (as appropriate), and
    - CWP Financial Monitoring
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the CWP,
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to Michigan Department of Health and Human Services

(MDHHS) CWP site review findings
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Regional monitoring of CWP standards for each CMHSP
   - Completion of second year of delegated site reviews for CWP program specific standards as well as CWP clinical charts
   - Development and distribution of monthly CWP reports
   - Development and distribution of monthly overdue and coming due CWP certifications
   - Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, and any updated COVID-19 pandemic changes
   - Created and shared Behavior Treatment FAQ
   - Reviewed and approved draft CWP policies and procedures
   - Adjusted processes related to service delivery due to COVID-19 pandemic
   - Shared MSHN strategic plan
   - Created form for Prior Review and Approval Requests (PRARs)

b. Upcoming Goals
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN CWP findings
   - 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: Home and Community Based Services (HCBS) Workgroup
Team Leader: Katy Hammack
Time Period Reviewed: 10.1.20-9.30.21

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

    - Field questions
    - Gain Workgroup feedback
    - HCBS-pandemic updates
    - HCBS FAQ updates
    - BTPRC FAQ updates
    - WSA/Optum updates
- Monitoring and reporting of current survey projects
    - Trends, themes
    - Documentation issues
    - Progress & Deadlines
- Heightened Scrutiny Updates
- REMI Audit Module Updates and discussion and training (as appropriate)
- Dissemination of conferences and trainings

Annual Evaluation Process

a. Past Year's Accomplishments

- Full Remediation of all original and "exit ramp" C waiver and b3 (1915i-SPA) out of compliance cases
- Full Compliance Validation of all providers with Compliant survey results conflicting with participant survey results
- Establishment of Remi Audit Module and streamlined remediation process including the incorporation of utilizing a virtual review process
- Regional monitoring of HCBS standards through Delegated Managed Care reviews
- Completed Bi-Annual MDHHS and HSAG audits

b. Upcoming Goals

- Complete Heightened Scrutiny-Out of Compliance remediation before July 2022
- Survey, assess, and remediate, if necessary, individuals identified on the non-Responder survey list
- Identification and surveying of providers who have received provisional approval status between June 2020 through October 2021.
- Establish a region-wide transition plan for individuals in lieu of providers unable/willing to come into HCBS Compliance

Team Name: Habilitation Supports Waiver (HSW) Workgroup
Team Leader: Tera Harris
Report Period Reviewed: 10.1.20-9.30.21

Purpose of the HSW Workgroup:

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

Annual Evaluation Process

a. Past Year's Accomplishments
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Continued corrective action measures related to underutilization of HSW slot allocation
   - Distribution of monthly HSW reports and monthly overdue/coming due data
   - Regional monitoring of HSW standards for each CMHSP
   - Completion of delegated site reviews for HSW program specific standards and clinical charts
   - Implemented process for reviewing and monitoring initial applications and recertifications for restrictive and intrusive techniques and/or Behavior Treatment Plans
   - Served as conduit of information from MDHHS – sharing trainings, updated policies, billing and code changes, and any updated COVID-19 pandemic changes.
   - Adjusted processes related to service delivery and administrative tasks due to COVID-19 pandemic
   - Shared MSHN strategic plan
b. Upcoming Goals
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN 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: Severe Emotional Disturbance (SED) Waiver Workgroup

Team Leader: Kara Hart

Report Period Covered: 10.1.20-9.30.21

Purpose of the SEDW Workgroup:

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

Responsibilities and Duties:

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

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

Defined Goals, Monitoring, Reporting and Accountability

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

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

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

Annual Evaluation Process

a. Past Year's Accomplishments:
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Increase in overall enrollments of SEDW participants—add percentage
   - Regional monitoring of SEDW standards for each CMHSP
   - Completion of second year of delegated site reviews for SEDW program specific standards as well as SEDW clinical charts
   - Development and distribution of monthly SEDW reports
   - Development and distribution of monthly overdue and coming due SEDW certifications
     - Monthly monitoring includes addition of tracking of 45-day pending information and missing Medicaid ID
   - Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, foster care county of jurisdiction, and any updated COVID-19 pandemic changes
   - Created and shared Behavior Treatment FAQ
   - Reviewed and approved draft SEDW policies and procedures
   - Adjusted processes related to service delivery due to COVID-19 pandemic
   - Shared MSHN strategic plan
   - Provided clarification about CAFAS and PECFAS scoring requirements and required timeframes
   - Clarified psychiatric level of care
   - Clarified enrollment for a year, encouraging families to stay enrolled for entire year eligible

b. Upcoming Goals:
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN SEDW findings
   - Continue to work to increase overall regional enrollments of SEDW
   - Expand SEDW enrollment and provide support of SEDW enrollment to all CMHSPs in the region
   - Emphasize the importance of and encourage participation in regional SEDW based trainings

IV. Performance Measurement Review and QAPIP Work Plan FY21

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

a) Performance Indicators

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance through The Michigan Mission Based Performance Indicator System in addition to key performance indicators established by MSHN. Performance is monitored quarterly. When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. A status of "met" indicates MSHN met the standard for FY21. A status of "not met"' indicates the standard was not met.

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

MSHN met the standards as indicated below.

Attachment 2: MSHN MMBPIS Performance Summary FY21Q4

Strategic Priority	Indicator	Committee/ Council Review	FY20	FY21	Status/ Recommendations
	Michigan Mission Based Performance Indicator System (MMBPIS)				
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	99.53%	99.58%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	99.12%	99.22%	Met/Continue
Better Care	Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	73.61%	67.39%	Continue
Better Care	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	92.39%	**80.98%	Continue
Better Care	Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	75.45%	71.34%	Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	98.10%	98.90%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	96.59%	97.02%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.29%	96.68%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	8.46%	7.97%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	12.48%	12.62%	Met/Continue

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

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

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

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

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

- BH-TEDS fields will be monitored during the DMC review.
- A full review of the BH-TEDS is performed to identify any illogical combinations.
- Quality improvement initiatives are completed based on the results of the reviews.

Attachment 3 MSHN Veterans FY21 Q1Q2

	BH-TEDS Data	Committee/ Council	FY20	FY21	Status/ Recommendations
	MSHN will demonstrate an improvement with the quality of data for the BH-TEDS data. (Military fields, living arrangements and employment, LOCUS, Medicaid ID)	QIC	NA	99%	Military Fields- Complete/Continue Living Arrangements and Employment- In Progress/Continue LOCUS-In Progress/Continue

c) 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. A project/study description is written and identifies the data collection timeframe, the data collection tool, data source, and whether measure if local or regional. The project/study description incorporates the use of standardized data collection tools and consistent data collection techniques. Each data collection delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Additionally, if sampling is used, sampling method used, the population from which a sample is pulled, and appropriate sampling techniques 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.
MSHN participated in two performance improvement projects during FY21. Two new Performance Improvement Projects (PIP) will be implemented during FY22.

Recovery Self- Assessment (PIP)
Goal: To increase the degree to which CMHSP participants and SUD Providers implement recovery-oriented practices.
MSHN met the goal for FY21.

Diabetes Monitoring (PIP-Validated by HSAG)
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 for CY21.
MSHN meet the goal of achieving a status of "Met" on the External Quality Review Performance Improvement Validation Report.

Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21
Attachment 5 MSHN MI2020-21_PIHP PIP Validation Report

Strategic Priority	Performance Improvement Projects	Committee / Council	CY20	CY21	Status/ Recommendations
Better Care	PIP – The degree to which programs implement recovery-oriented practices will demonstrate a 3.50 or above annually. (>=3.50)	QIC	4.25	4.24	Met-PIP ended. Discontinue
Better Care	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	39.07%	49.20%	Met-PIP ended. Discontinue
Better Care	MSHN will achieve a status of "Met" on the Performance Improvement Validation Review.	QIC	Not Met	Met	Met/Discontinue

d) Adverse Event Monitoring

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

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers.[5] MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action.

[5] Quality-Sentinel Events Policy

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

Goal: MSHN will demonstrate a decrease in the rate of critical incidents/sentinel events from previous reporting period.
MSHN met 9 out of 13 areas as indicated below. The following recommendations are being made:
Combine CMHSP participant goals that have been met be into one goal for a higher-level review of critical and sentinel events.
Combine the SUDTP goals into one goal due to the low number of sentinel events.

Attachment 6 MSHN Critical Incident Performance Summary FY21Q4
Attachment 7 MSHN Critical Incident Performance SUDTP Report FY21Q4

Strategic Priority	Event Monitoring and Reporting	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	*MSHN will demonstrate a 100% completion rate of Critical Incident/Event performance summary (SUDTP) quarterly.	**QIC**	**NA**	**100%**	Met/Discontinue
Better Care	The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year. (CMHSP)	QIC	0.352	0.147	Met/Combine
Better Care	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	3.165	2.813	Met/Combine
Better Care	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	0.266	0.220	Met/Combine
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	2.450	2.956	Not Met/ Continue
Better Care	The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year. (CMHSP)	QIC	0.150	0.146	Met/Combine

[6] Quality CMHSP Participant Monitoring & Oversight Procedure
[7] Quality Monitoring & Oversight of SUD Service Providers Procedure

Strategic Priority	Event Monitoring and Reporting	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year. (SUDTP)	SUD TX/UM	0.023	0.014	Met/Continue
Better Care	The rate of deaths per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.320	0.000	Met/Combine
Better Care	The rate of accidents requiring emergency medical treatment and/or hospitalization per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.000	Met/Combine
Better Care	The rate of physical illness requiring admissions to hospitals per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.320	1.808	Not Met/Combine
Better Care	The rate of arrest or convictions per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.000	Met/Combine
Better Care	The rate of serious challenging behaviors per 1000 persons served, will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.226	Not Met/Combine
Better Care	The rate of medication errors, per 1000 persons, served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.904	Not Met/Combine

e) Behavior Treatment

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

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

By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data is analyzed on a quarterly basis by MSHN and is available to MDHHS upon request. 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.

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

Attachment 8 Behavioral Treatment Performance Summary FY21Q4

Strategic Priority	Behavior Treatment	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	UM	NA	61%	Recommended-New for FY22
Better Care	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.	QIC	1.13%	1.19%	Not Met/Modify to Trend Data
Better Care	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC	0.45%	0.44%	Met/Combine physical interventions and 911 calls. See below
Better Care	The percent of 911 calls by staff for behavioral assistance per person served during the reporting period will decrease from previous year.	QIC	0.15%	0.11%	Met/Combine physical interventions and 911 calls. See below
Better Care	The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC	1.49%	0.59%	Met/Continue

f) Stakeholder and Assessment of Member Experiences

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, the Provider Network Management Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council,

CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

Goal: MSHN will provide opportunities for stakeholder/consumer feedback related to member (all populations served) experiences. MSHN will analyze trend patterns, strengths, and opportunities for improvement.
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 9 MSHN Member Satisfaction Annual Report FY2021
Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments
Attachment 3 MSHN The Recovery Self-Assessment Annual Report

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	*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	3	3	Met -Discontinue
Better Care	The rate of satisfaction with SUD services and treatment received will meet or exceed a comprehensive score of 80%.	QIC	4.58	4.61/ 95%	Met-Continue
Better Care	The rate of satisfaction with services and treatment received for a mental health (including LTSS) will meet or exceed a comprehensive score of 80%.	QIC	89%	85%	Met/Continue
Better Care	The rate of satisfaction with services and treatment received for a serious emotional disturbance will meet or exceed a comprehensive score of 80%.	QIC	4.13/ 85%	4.18/ 87%	Met/Continue
Better Provider System	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	PNMC	100%	75%	Not Met/Continue
Better Provider System	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN' s processes and communications (SUD Network) (Standard 80%)	PNMC	70%	79%	Not Met/Continue
Better Provider System	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network) (Standard 80%)	PNMC	NA	New 73%	Not Met/Continue

Strategic Priority	Member Appeals and Grievance Performance Summary	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard-95%)	CSC	98%	98.27%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard-95%)	CSC	98%	98.82%	Met/Continue
Better Care	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	100%	D/C	Discontinue
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)	CSC	100%	98.72%	Met/Continue

g) Clinical Practice Guidelines

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

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

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding

evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

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

Attachment 8 MSHN Behavioral Treatment Review Data FY21Q4
Attachment 11 ACT Utilization FY21Q4

Strategic Priority	Clinical Practice Guidelines	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	CLC	NA	61% (Q3Q4)	Recommended- New for FY22
Better Care	MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes).	UMC	NA	New	Recommended new for FY22

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[8] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[9] also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

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.

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

In 2019, Human Services Advisory Group (HSAG) conducted an audit of Mid-State Health Network (MSHN) and the MSHN network resulted in findings for both the CMHSP and SUD network specific to Credentialing. As a result, MSHN has determined that increased monitoring must be implemented.

The plan for increased monitoring went into effect January 2021. Increased monitoring includes a quarterly report to be submitted with a file review by those organizations that have a score of 90% or less on the credentialing/recredentialing standards during the delegated site review. The quarterly report includes 1) the status of implementation of their CAP, specific to credentialing and recredentialing, 2) identification of training/technical assistance needs, 3) list of practitioners credentialed during the reporting quarter.

MSHN conducted 9 full reviews for CMHSP participants in FY2021. Of those, 3 of 9 scored under 90% compliance with staff credentialing/re-credentialing file reviews. Any provider scoring under 90% compliance will be subject to additional credentialing reporting/oversight.

MSHN conducted 13 full reviews for SUD providers in FY2021. Of those, 9 of 13 scored under 90% compliance with staff credentialing/re-credentialing file reviews. Any provider scoring under 90% compliance is subject to additional credentialing reporting/oversight.

Attachment 18 MSHN 2-21 Compliance Summary Report

Strategic Priority	Provider Monitoring	Committee / Council	FY20	FY21	Status/ Recommendations
Better Provider	MSHN providers will demonstrate an increase compliance with the MDHHS/MSHN credentialing, recredentialing and non-licensed provider staff qualification requirements. (SUD-Section 8; CMHSP-Section 11)	PNMC	SUDP: 69.12% (FY20) CMHSP: 96.68% (CY19) HSW-76% (MDHHS FY20) CWP-74% (MDHHS FY20) SED-89% (MDHHS FY20)	SUDP 85.88% CMHSP 91.08%	SUDP-Met/Continue CMHSP-Not Met/Continue
Better Provider	All CMHSP participants (12) will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network)	PNMC	NA	New 8	Continue

i) Verification of Services

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

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

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at the QI Council and Regional Compliance Committee meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

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

Attachment 12 MSHN FY2021 Medicaid Event Verification Methodology Report

Strategic Priority	Medicaid Event Verification	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD.	CCC	CMHSP: 99.02% SUD: 94.05%	CMHSP: 99.30% SUD: 99.50%	Met
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	CCC	CMHSP: 98.20% SUD: 95.45%	CMHSP: 98.76% SUD: 99.28%	Met

j) Utilization Management

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

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

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

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

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

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

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

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 MSHN UM Plan FY20-21
Attachment 15 MSHN UM Quarterly Report
Attachment 16 MSHN Integrated Population Health Integrated Care Report

k) Long Term Supports and Services for Vulnerable Adults

Strategic Priority	Priority Measures-	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	**UM/ Integrated Care**	56%	75%	Not Met/Continue
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	**UM**	96.50%	98.5%	Not Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	**UM**	NA	New 81.5%	Not Met/Continue
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fiscal year)	**UM**	NA	New +6%	Continue
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	**UM**	NA	New <1%	Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	**CSC**		New 95%	Not Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	**CLC**	95.60%	94.90%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	**CLC**	92%	89%	Not Met/Continue
Better Care	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD). (Standard 50%)	**CLC**	25%	50%	Met/Continue
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard 100%)	**CLC**	100%	99.07%	Not Met/Continue

l) 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.

	Priority Measures	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Health	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 (Data Source-ICDP) Michigan 2020-84.43%	QIC	74.25%	84.68%	Met/Continue Maintenance
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Michigan 2020-73.16%,	CLC	46.09%	54.88%	Not Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	75.82%	60.52%	Not Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	98.61%	97.12%	Not Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	11.23%	11.59%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	89.55%	91.69%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	93.51%	95.68%	Met/Continue

m) Performance Based Incentive Payments

	Joint Metrics	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Care	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). (Data Source-ICDP)	QIC	71.32%	75.34%	Met/Continue Update to include disparities (adults and children combined)
Better Care	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) (Data Source-ICDP)	QIC	75.71%	89.32%	Met/Continue Update to include disparities (adults and children combined)
Better Health	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence.	Integrated Care/UMC	27.1% Q3	28%	Met/Continue update to include disparities.
	Performance Based Incentive Payments	**Committee/ Council**	**FY20**	**FY21**	**Status/ Recommendations**
Better Care	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	Complete	Complete	Met/Continue
Better Health	Increased data sharing with providers (narrative report)	ITC	Complete	Complete	Met/Continue
Better Care	MSHN will demonstrate an increase over previous reporting period of Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (2018 level Initiation-36.81%; Engagement 22.30%) (informational only)	SUDT	63.71% 47.61%	57.48% 50.12%	Met/Continue-Modify to include the completion of the Validation.
Better Health	Increased participation in patient centered medical homes (narrative)	UM	Complete	Complete	Met/Continue

n) External Reviews

Based on the results of the external reviews a corrective action plan was developed by MSHN in coordination with the CMHSP participants and SUDTP. The corrective action plan was approved by HSAG for completion during FY20-FY21.
Areas identified and included in the work plan and respective section of the QAPIP Report are listed below.

- 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.

The following external reviews were completed for FY21:

- HSAG Performance Measure Validation Review-Full Compliance
- HSAG Compliance Review-Partial Compliance
- HSAG Performance Improvement Project-Met

The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY22.

Attachment 17 MSHN External Quality Review Summary 2021

o) Quality Priorities and Work Plan FY21

Organizational Structure and Leadership	Objectives/Activities/Evaluation Method	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.18.2021	Complete/Continue
	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	In Progress/ Continue
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	Deputy Director/Director of Compliance, Quality, Customer Services	1.1.2022	Complete/Continue
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. Attachment Balanced Score Card. Attachment Key Priority Measures, Attachment MSHN Quarterly Compliance, Quality and Customer Services Report	Deputy Director/Director of Compliance, Quality, Customer Services	6.1.2021	Complete/Continue
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~~ Revised to 2/28/2022 10.1.2021	Complete/Continue Complete/Discontinue <u>Recommendation</u>: Modify Reporting to address timeliness of submission and Complete Data for Q4
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	Quality Manager/QIC	1.31.2022	Complete/Continue

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	*To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	Quality Manager	1.31.2021 Annually	Complete/Continue
*The Practice Guidelines MSHN will communicate practice guidelines to the providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact, and post to MSHN Website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually	Complete/Continue
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	In Progress/Continue
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	RCAC-Complete/Continue <u>Recommendation</u>: PAC-Discontinue Utilize focused Level of Care Groups in FY22
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	Complete/Continue

MMBPIS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	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	Complete/Continue
	MSHN submit MMBPIS to MDHHS quarterly.	Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021	Complete/Continue
	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	CMHSP-Complete/Continue SUD-Complete/Continue <u>Recommendation</u>: NAA Work Plan-Refer Network Adequacy issues to PNMC.
	CMHSPs to develop and submit improvement plans quarterly.	CMHSP Participants	Q1 April; Q2 July; Q3 October; Q4 January	Completed/Continue
	SUD Providers to develop improvements quarterly	SUDPs	FY21 Q3	In Progress/ Continue
	MSHN will develop or have available documentation for education and training of performance indicator requirements.	Quality Manager	Annually through QIC/PAC/SUD Provider Meeting	Complete/Continue
	MSHN to complete primary source verification of submitted records during the DMC review.	QAPI	Biennially with follows ups based on findings	Complete/Continue <u>Recommendation</u>: SUD-Indicator 4b-Verification of accurate data entry in REMI. Additional Medicaid Eligibility. (See HSAG report-New to the PIHP)

BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will improve the quality of BH-TEDS data.	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	Veterans - Complete/Continue- Employment-Minimum Wage; Living Arrangements; LOCUS; Medicaid ID- In Progress/Continue- Recommendation: QI efforts for completion through QIC/ITC.
	Causal factors will be determined based on review BH-TEDS data.	Quality Manager- QIC; IT Project Manager- CMHSPs	3.31.21	In Progress/Continue
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY21 Q1Q2 data.	CIO, Quality Manager- QIC; IT Project Manager- ITC	6.30.21	Complete/Continue
	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	Veterans Data- Complete/Continue Employment-Minimum Wage; Living Arrangements- In Progress/Continue
	MSHN QIC will monitor progress through quarterly performance reports.	Quality Manager- QIC; IT Project Manager- ITC	Quarterly	Veterans Data- Complete/Continue Employment-Minimum Wage; Living Arrangements- In Progress/Continue

Performance Improvement Projects	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
Will engage in two performance improvement projects during the waiver renewal period.	To complete the Annual Recovery Self-Assessment-Provider/Administrator Report	Quality Manager/QIC/CLC/RCAC	Annually/May	Complete Continue with new PIP
	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	Complete Continue with new PIP
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
*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	Complete/Continue <u>Recommendation</u>: Explore use of the MHSIP for SUDP. Explore for IDD or use of HCBS ongoing for IDD
	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	Complete/Continue
MSHN will assess the recovery environment	MSHN to complete the Annual RSA Report to include trends, causal factors, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July	Discontinue

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date	Status/ Recommendations
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. To submit Critical Events to MDHHS monthly	CMHSPs Quality Manager	The 26th of each month. The last day of each month	Complete/Continue Recommendation: Develop Dashboard for tracking and monitoring timeliness. Increase frequency of submission as needed. MSHN will ensure Events (Sentinel/Critical/Risk) as specified in the PIHP Contract, are monitored, and submitted to MDHHS within the required timeframes.
	To submit Critical Events to MSHN Quarterly (Provider Portal development) To submit Sentinel Events to MSHN Quarterly or sooner based on event notification requirements (Provider Portal/Supplement reporting development)	CMHSPs/SUDPs	January 15, April 15, July 15, October 14	Complete/Continue
	To submit Sentinel Events to MDHHS 2x annually	Quality Manager	Q1-Q2 April 30, Q3-Q4 October 30	Complete/Continue
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	CMHSP Complete/Continue SUDP In Progress/Continue Recommendations: Include the oversight of the Risk Event process

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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	CMHSP Complete/Continue SUDP In Progress/Continue
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 Complete/Continue SUDP In Progress/Continue (FY22)
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.	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)	Complete/Continue <u>Recommendations:</u> Add timeliness report/summary to the Quarterly report. Information Technology Request (ITR) for Dashboard Development. Further development of Risk Events
*MSHN will demonstrate a 100% completion rate of the Critical Incident Review System performance reports quarterly.				Complete/Discontinue

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date	Status/ Recommendations
Will verify delivery of services billed to Medicaid	To complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	Annual schedule for each provider	Complete/Continue
MSHN will identify trends, patterns, strengths and opportunities for improvement.	To complete The MEV Annual Methodology Report.	Director of Compliance/Quality/ CS, MEV auditor	1.31.2022	Complete/Continue
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/CS	12.31.2021	Complete/Continue
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements, utilizing uniform screening tools and admission criteria	To complete/review the MSHN Utilization Management Plan annually. To utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	Director of Utilization and Care Management	12.1.2021 Quarterly/Annually	Complete/Continue Recommendation: Change to every other year to be consistent with the MSHN policy/procedure.
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).	Director of Utilization and Care Management	Quarterly/annually See UM Reporting Schedule	Complete/Continue
*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.	Quality Assurance and Performance Improvement (QAPI) Customer Service Specialist	Biennial Full Review with follow up annually as needed. Quarterly	Complete/Continue modify language. Recommendation: Add as a performance measure
*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.	Complete/Continue Recommendation: Add as a performance measure

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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.	CBHO-CLC and Regional Medical Directors	Annually	Complete/Continue
*MSHN will communicate and disseminate practice guidelines to providers and members annually and upon request.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact. Upload clinical practice guidelines, including MDHHS specified guidelines to the MSHN website.	CBHO; Committee /Council Leads including sponsored workgroups.	1.31.2022 Annually	Complete/Continue
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. (Identify specific sections)	QAPI	Biennially with follows ups based on findings	Complete/Continue
*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	In Progress/Continue

Oversight of "Vulnerable People"	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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	Complete/Continue Recommendations: Identify specific measures for analysis of the vulnerable population including LTSS in Description.
	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.	Complete/Continue
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**	**Status/ Recommendations**
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, QM, Autism Coordinator	Annually	Complete/Continue
	To complete Behavior Treatment Performance Reports (including barriers, improvement efforts, recommendations, and status of recommendations) quarterly.	QM/BTPR Work Group/CLC/QIC	Q1-February Q2- May Q3- August Q4-November	Complete/Continue
	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	Complete/Continue
	CMHSPs to develop action steps based on performance.	CMHSP Participants	Quarterly	Complete/Continue
	MSHN to develop/provide education and training in coordination with the CMHSP. MSHN to complete primary source verification of reported events during the DMC Review	HCBS Manager, Autism and Waiver Coordinators	Biennial Full Review with annual follow up as needed	Complete/Continue Training will occur as part of CAPs during the DMC process.

Autism Waiver Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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	Complete/Continue
*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.	Discontinue MDHHS Autism Reviews have been phased out.

Credentialing, Provider Qualification and Selection	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*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. *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.	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 PNMC 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.	Complete-Continue Complete/Discontinue

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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.	Complete/Continue
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		Complete/Continue Recommendations: Add Performance Measure
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		Complete/Continue CY 20 Sub-Recipient Financial Review-

External Reviews	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
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 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	Complete/Continue
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.	MDHHS Waiver 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	Complete/Continue <u>Recommendations:</u> Include a smart goal specific to the compliance review and PMV review indicating an increase in the performance as it relates to specific standards/recommendation
MSHN will monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MDHHS 1915 (c) Waiver Final Report HSAG Compliance Review	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.	Complete/Continue

V. Definitions/Acronyms

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

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

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

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

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

Long Term Services and Supports (LTSS)- Older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes. (42 CFR §438.208(c)(1)(2)) MDHHS CQS – identify the Home and Community Based Services Waiver. MI-Choice to be recipients of LTSS.

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

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

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

Root Cause Analysis (RCA): Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Event (SE): Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.
SUD Providers: Refers to substance use disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.
Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

Acronyms

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

VI. Quality Assessment and Performance Improvement (QAPIP) Priorities FY22

QAPIP priorities shall guide quality efforts for FY22. The FY22 QAPIP Priorities (Figure 1) include completion of required elements of the QAPIP, growth areas based on external site reviews, and the evaluation of effectiveness of the FY21 QAPIP Plan.

Figure 1. QAPIP Priorities and Work Plan

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	11.30.2022
	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, 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.	MSHN Deputy Director MSHN-Chief Compliance and Quality Officer (CCQO)	1.1.2022 1.31.2023
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board.	MSHN Deputy Director MSHN CCQO	Quarterly
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager QIC	1.31.2022 1.31.2023
	Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	MSHN CEO	10.1.2021
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2022 1.31.2023

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.	MSHN Quality Manager	3.2.2022 2.28.2023
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN CCQO QIC, CLC, UM, ITC, CSC, SUDP, FC, OC	As needed, minimum annually
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	MSHN CCQO CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly
MDHHS Performance Indicators	**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. (PM)	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022
	Submit MMBPIS data as required to MDHHS quarterly.	MSHN-Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021
	Complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	MSHN-Quality Manager QIC, RMDC, CLC/UM	Q1 April Q2 July Q3 October Q4 January

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

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

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

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

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

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

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

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

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

Figure 2. Performance Measures FY22

Strategic Priority	Michigan Mission Based Performance Indicator System	Committee / Council	FY21
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.58%
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.22%
Better Care	Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	63.69%
Better Care	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	**80.98%
Better Care	Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	71.34%
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	QIC	98.90%
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	QIC	97.02%
Better Care	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	96.68%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	QIC	7.97%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	QIC	12.62%
Better Care	MSHN will demonstrate and increase in compliance with access standards for the priority populations. (Baseline)	UMC	New

	BH-TEDS Data	Committee /Council	FY21
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS living arrangements fields. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS employment fields. 3 categories. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS LOCUS fields. (Baseline)	QIC	New
Better Care	MSHN will increase access and service utilization for Veterans and Military members. (Baseline)	QIC	New
	Performance Improvement Projects	**Committee /Council**	**FY21**
Better Care	PIP 1: The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (Baseline)	QIC	New
Better Care	PIP 2: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. (Baseline)	QIC	New
	Assessment of Member Experiences	**Committee /Council**	**FY21**
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%/4.61
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	87%/4.18
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	85%
Better Care	Percentage of individuals indicating satisfaction with long term supports and services. (Standard 80%/3.50)	QIC	85%
Better Care	MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (Baseline)	CLC	New
Better Care	MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline)	CLC	New

	Member Appeals and Grievance Performance Summary	Committee /Council	FY21
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	CSC	98.27%
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	98.82%
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	98.72%
	Adverse Event Monitoring and Reporting)	**Committee /Council**	**FY21**
Better Care	The rate of critical incidents, per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	QIC	8.343
Better Health	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal)	QIC	2.96
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	SUD	0.014
	Joint Metrics	**Committee /Council**	**FY21**
Better Care	Percent of care coordination cases that were closed due to successful coordination (Standard-<= to 50%)	UMC/IC	100%
Better Value	Reduction in number of visits to the emergency room for individual in care coordination. (Standard 100%)	UMC/IC	75%
Better Care	J.1 Implementation of Joint Care Management Processes	UMC	Complete
Better Care	J.2 The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%)	QIC	75.34%
Better Care	J.2 The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%)	QIC	89.32%

	Joint Metrics	FY21	Joint Metrics
Better Care	J.2 Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	QIC	0
Better Care	J.3 Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	28%
Better Care	J.3 Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	UMC	1
	Performance Based Incentive Payments	**Committee /Council**	**FY21**
Better Care	P.1 Identification of beneficiaries who may be eligible for services through the Veterans Administration. a. MSHN will demonstrate an improvement or maintain data quality on the BH-TEDS military and veteran fields. b. Monitor and analyze data discrepancies between VSN and the BH-TEDS data.	ITC/QIC	Complete
Better Health	P.2 Increased data sharing with other providers (narrative report) (include action steps in work plan)	ITC	Complete
Better Care	P.3 The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. (Completion of the Validation only)	SUDT	Complete
Better Health	P.4 Increased participation in patient centered medical homes (Narrative)	UMC	Complete

	Priority Measures	Committee /Council	FY21
Better Care	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 (Data Source-ICDP) Michigan 2020-84.43%	QIC	84.68%
Better Health	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Standard-Incremental progression toward meeting the performance rate of Michigan 2020-73.16%	CLC	54.88%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Standard- Incremental progression toward meeting the performance rate of Michigan 2020-44.44%	CLC	60.52%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Standard- 2020 54.65%	CLC	97.12%
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Standard-Michigan 2020 9.09%	UM	11.59%
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Standard-Michigan 2020 82.49%	UM	91.69%
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Standard-Michigan 2020 89.64%	UM	95.68%
Better Care	MSHN will demonstrate an increase over previous reporting period of Initiation in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	57.48%
Better Care	MSHN will demonstrate an increase over previous reporting period of Engagement in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	50.12%

	Utilization Management/LTSS	Committee /Council	FY21
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	98.50%
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	81.50%
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fiscal year) standard is 1-10% decrease.	UM	6%
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% or greater HSW slot utilization.	CLC	94.90%
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	89%
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard increase over 2016 or 95%?)	CLC	99.07%
Better Care	MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (Baseline)	UMC	New
	Behavior Treatment	**Committee /Council**	**FY21**
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOSs reviewed during the reporting period. (95%)	QIC/CLC	61% (2 quarters)
Better Care	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques. (Track and trend)	QIC	1.16%
Better Care	The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC	0.59%
	Trauma	**Committee /Council**	**FY21**
Better Care	MSHN will demonstrate a 95% rate for the completion of Trauma Organizational Assessments every three years.	CLC	99.07%

	Clinical Practice Guidelines	Committee /Council	FY21
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (Baseline Development)	CLC	New
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	CLC	61%
Better Care	MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes). (Baseline)	UMC	New
	Provider Monitoring	**Committee /Council**	**FY21**
Better Provider System	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	PNMC	73%
Better Provider System	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard 80%)	PNMC	79%
Better Provider System	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network) (Standard 80%)	PNMC	73%
Better Provider System	MSHN will demonstrate an increase in performance with the External Quality Review-Compliance Review. (PM) Comprehensive Score.	QIC/CLC	85%
Better Provider System	All CMHSP participants (12) will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network) (Standard 12)	PNMC	8
Better Provider System	MSHN will demonstrate full compliance for the Autism Benefit Standards. (Regional Monitoring) (Program Specific Monitoring). Regional Monitoring DMC Program Specific	CLC	 84.43% 82.72%
Better Provider System	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review 95.51%	PNMC	FY20 95.51%
Better Provider System	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review 72.52%	PNMC	FY20 72.52%

	Clinical SUD	Committee /Council	FY21
Better Care	Initiation of AOD Treatment. Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment). Standard above 2020 Michigan levels I: 40.8%)	SUD Clinical	55.52%
Better Care	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit. (Standard above Michigan 2020 levels. E: 12.5% 2016 needs clarification)	SUD Clinical	38.27%
	Certified Behavioral Health Clinic (CCBHC) Performance Measures	**Committee /Council**	**FY21**
Better Care	Follow-Up After Hospitalization for Mental Illness ages 18+ (adult age groups) (FUH-BH-A) Standard-58%	QI	New
Better Care	Follow-Up After Hospitalization for Mental Illness ages 6-17 (child/adolescents) (FUH-BH-A) Standard- 70%	QI	New
Better Health	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-BH) Standard 58.50%	QI	New
Better Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Standard I-42.5%; E-18.5%	QI	New
Better Health	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) Standard 13%	QI	New
Better Health	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) Standard 23.9%	QI	New
Better Health	Depressions Remission at Twelve Months (DEP-REM-12)	QI	New
Better Care	Preventative Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI_SF)	QI	New
Better Care	Preventative Care and Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	QI	New
Better Care	Preventative Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	QI	New
Better Care	Screening for Depression and Follow-Up Plan. Age 18 and older (CDF-AD)	QI	New
Better Care	Time to initial Evaluation (I-EVAL)	QI	New
Better Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	QI	New
Better Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are using Antipsychotic Medications (SSD)	QI	New
Better Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	QI	New
Better Care	Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)	QI	New
Better Health	Housing Status (HOU)	QI	New
Better Care	Patient Experience of Care Survey (PEC)	QI	New
Better Care	Youth/Family Experience of Care Survey (Y/FEC)	QI	New
Better Health	Plan All-Cause Readmission Rate (PCR-AD)	QI	New
Better Care	Antidepressant Medication Management (AMM-AD)	QI	New

Attachments

Attachment 1 MSHN QAPIP Communication

Attachment 2 MSHN MMBPIS Performance Summary FY21Q4v2

Attachment 3 MSHN Veterans Narrative FY21Q1Q2

Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21

Attachment 5 MSHN MI2020-21_PIHP_PIP-Validation_Report F1

Attachment 6 MSHN Critical Incident Performance Report FY21Q4

Attachment 7 MSHN Critical Incident Performance Report SUDTP FY21Q4

Attachment 8 MSHN Behavior Treatment Review Data FY21Q4

Attachment 9 MSHN Member Satisfaction Annual Report FY2021

Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments

Attachment 11 ACT Utilization FY21Q4

Attachment 12 MSHN FY2021 MEV Methodology Report

Attachment 13 Behavioral Health Department Quarterly Report FY21Q4

Attachment 14 MSHN_UM Plan FY20-21 Approved

Attachment 15 UM Quarterly Report 2021_Q4 FINAL

Attachment 16 MSHN Pop Health Integrated Care Report FY21Q4 Revised

Attachment 17 MSHN External Quality Review Summary 2021

Attachment 18 MSHN 2021 Compliance Summary Report

Attachment 19 MSHN Governing Body Form 9.2021