QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2024

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I. Introduction

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed MSHN to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. Effective January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. Effective October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes a review of the components of the QAPIP to ensure alignment with the contract requirements, a review of the status of the QAPIP Workplan and impact on the desired outcome, and a committee/council annual review with accomplishments and goals for the upcoming year. The QAPIP Plan and associated QAPIP Work Plan was effective. Recommendations for the Annual QAPIP Plan, which include a description of each activity and a work plan for the upcoming year, are included in the FY24 QAPIP Plan. The Board of Directors will receive the Annual QAPIP Report and approve the Annual QAPIP Plan for FY24. The measurement period for this annual QAPIP Evaluation is October 1, 2023, through September 30, 2024. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Performance Measurement and QAPIP Work Plan FY24 Review

MSHN monitors longitudinal performance through an analysis of regional trends. Performance is compared to the previous measurement period or other specifically identified targets. A status of "met" or "not met" is received. When minimum performance standards or requirements are "not met", CMHSP Participants/SUD Providers participate in a quality improvement process. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. *Indicates data that has not been finalized. Based on performance and the performance measurement requirements, a recommendation is made to "continue", "discontinue", or "modify". Considerations for recommendations are based on changes in requirements and performance.

a) Michigan Mission Based Performance Indicator System

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 (MMBPIS).

Goal: MSHN will meet or exceed the MMBPIS Standards for Access (Indicators 1, 2, 3, and 4) and Outcomes (Indicator 10) as required by MDHHS.

Status: Partially Effective

MSHN exceeded the State Average Performance on 12 of the 18 indicators as demonstrated in the MMBPIS PIHP Final Report FY24Q3. Figure one demonstrates the status of each indicator.

Data collected at key points of access and service delivery (Figure 2) indicated the main reasons for not meeting the standard. The reasons were prioritized, and interventions were implemented during FY24 to address the priority areas. FY24 data was analyzed to determine effectiveness of the interventions and to make recommendations for FY25.

1. Causal Factor-No appointment available within 14 days with any staff

   Interventions (FY24):

   - Rebuild the Workforce and increase staffing levels.
     - Develop internal processes for staff coverage
     - Utilize peers for increased engagement
     - Recruitment
       - billboards, commercials, job fairs, outreach to colleges, interns.
     - Financial incentives
       - Paying for Masters-additional education.
       - Paid Internships
       - Incentives for staff referrals

   Effectiveness:

   - Financial incentives were the most effective in rebuilding and increasing the workforce thereby reducing the percentage of appointments that were not available within 14 days for both Indicator 2 and Indicator 3.

2. Causal Factor-Consumer No showed/Canceled appointment

   Interventions (FY24):

   - Appointment reminders
     - Staff phone calls
     - Automated phone calls and text messages

   Effectiveness:

   - Interventions were not effective in decreasing the rate of no shows or cancelations. The overall rate for no shows/cancelations for both Indicator 2 and 3 increased during FY24.
   - Individual CMHSP data indicates that those who utilize staff to make reminder calls or engage in warm handoffs had a decreased rate of no shows/cancelations of appointments.

Recommendations for FY25:

- Continue the use of financial incentives to obtain and retain adequate staffing levels. This will be removed from the QAPIP Workplan. Adequate staffing levels will continue to be monitored through the Network Adequacy Assessment.
- Complete additional data analysis to identify population groups that have a high rate of no shows/cancelations. This includes data collection and analysis of the social determinants of health.
- Increase the use of practices for warm hand offs, staff/peers making direct phone calls to individuals for access and engagement in services and to identify any barriers, utilization of the teachback method to ensure understanding of next steps in treatment.

Figure 1. MSHN MMBPIS Performance Data

	Population	Standard	FY23	FY24Q1	FY24Q2	FY24Q3	FY24 YTD	Status
Indicator 1: Percentage who received a Prescreen within 3 hours of request.	Children	≥95%	98.40%	98.58%	98.63%	*98.22%	98.48%	Met
	Adults	≥95%	99.45%	*99.67%	*99.33%	*99.67%	99.56%	Met
Indicator 2: Percentage of new persons who have completed Bio-psychosocial Assessment within 14 Days. (Cumulative)	MI Child	>62.0%	59.81%	*60.43%	*65.52%	*69.02%	64.76%	Met
	MI Adults	>62.0%	62.82%	*64.31%	*64.59%	*67.02%	65.26%	Met
	DD Child	>62.0%	44.27%	*43.51%	*56.63%	47.51%	49.29%	Not Met
	DD Adult	>62.0%	56.47%	*67.83%	*73.33%	*65.09%	68.71%	Met
	Total	>62.0%	60.70%	*61.79%	*64.60%	*66.21%	64.13%	Met
Indicator 2e: Percentage of new persons receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service. (Cumulative)	SUD	>75.3%		*72.40%	*74.17%	*73.30%	73.29%	Not Met
Indicator 3: Percentage of new persons who had a medically necessary service within 14 days. (Cumulative)	MI Child	>72.9%	58.83%	58.28%	58.59%	62.21%	59.58%	Not Met
	MI Adults	>72.9%	62.26%	58.09%	67.71%	68.21%	64.51%	Not Met
	DD Child	>72.9%	81.09%	*76.05%	*80.97%	*81.43%	79.59%	Met
	DD Adult	>72.9%	62.50%	65.74%	67.01%	70.71%	67.76%	Not Met
	Total	>72.9%	62.54%	59.72%	65.56%	67.52%	64.13%	Not Met
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit	Children	≥95%	97.83%	*94.67%	*97.37%	*100%	97.22%	Met
	Adults	≥95%	95.76%	*95.20%	*95.99%	*97.16%	96.14%	Met
	MSHN SUD	≥95%	97.48%	95.02%	*98.05%	91.91%	95.16%	Met
Indicator 10: Percentage who had a Re-admission to Psychiatric Unit within 30 Days	Children	≤15%	8.81%	*9.36%	*8.84%	*6.38%	8.25%	Met
	Adults	≤15%	12.31%	*10.73%	*10.95%	*12.79%	11.52%	Met

*Exceeded the Michigan State Performance. Red font indicates performance below the standard.

b) Access-Priority Populations

Goal: MSHN will demonstrate an increase in percentage of individuals identified as a priority population (pregnant with a substance use disorder, or pregnant injecting drug user) who have been screened and referred within the required time frame, based on the recommended level of care.

Status: Effective

Goal	Baseline	FY23	FY24	Status
MSHN will demonstrate an increase in percentage of individuals identified as a priority population (pregnant with a substance use disorder, or pregnant injecting drug user) who have been screened and referred within the required time frame, based on the recommended level of care.	**42%**	**35%**	**56%**	**Met/Continue**

Improvement Strategies				
Barrier/Causal Factors	**Intervention**	**Intervention Start Date**	**Who**	**Evaluation Process**
Appointment date and time does not match the admission date and time. Providers not following the correct process for documentation.	Access training was provided for the provider network	5/2023	MSHN/UM	Continued ongoing training needed.
Data Fields are blank (Admission Date/Time, Appointment Date/Time, Time from Request to Appointment)	• Access training was provided for the provider network. • Exploring additional documentation fields to explain the reasons for no appointment scheduled. • Re-opened ITR with PCE to properly pull appointment date from the LOC determination when there is no admission. • Reviewed LOC Determinations that have blank "Appointment Date" cells on the report and manually entered date that provider offered appointment and determined compliance.	5/2023 7/2023 3/2024 4/2024	MSHN/UM MSHN/IT MSHN/SUD Care Navigator	PCE was able to amend the report to include the Appointment Date when there was no Admission Date, which was previously hindering this report.
Improve access timeliness for pregnant individuals seeking SUD services	MSHN will be centralizing Access for Withdrawal Management, Residential and Recovery Housing services.	10/1/2024	MSHN/UM	Ongoing monitoring of the admission timeliness report before and after implementation date.

Recommendations for FY25:

- MSHN will be centralizing Access for Withdrawal Management, Residential and Recovery Housing services.

c) Performance Based Incentive Payment Measures

Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Data is currently available only through CY24Q1.

Goal: MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers

Status: Partially Effective

Recommendations for FY25:

- Identify Causal factors and develop improvement strategies.
- Develop an organizational plan to address disparities for both SUD providers and CMHSP Participants.

Attachment 3 FY24 Q1-Q2 Integrated Health Quarterly Report

Figure 4. MSHN Performance Based Incentive Payment Measures Performance

Strategic Priority	Joint Metrics	Standard	CY22	CY23	CY24Q1	Status/ Recommendations
Better Care	J.2 a. 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 Data Source CC360	58%	*70%	*69%	*68%	Met/Continue
Better Care	J.2 b. 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 Data Source CC360	70%	*88%	*85%	*85%	Met/Continue
Better Care	J.2 c. 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)*	0 Disparity exist	0 Disparity exist	1 Disparity exist	1 Disparity exist	Not Met/Continue
Better Care	J.3 a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence	100%	*43%	*38%	*39%	Not Met/Continue
Better Care	J.3 b. 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.*	0 Disparity exist	2 Disparity exist	2 Disparity exist	2 Disparity exist	Not Met/Continue

d) Certified Community Behavioral Health Clinics

The Certified Community Behavior Health Clinics review data quarterly to identify any areas of improvement needed and to share best practice with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures. MDHHS has provided the finalized performance data for FY23. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect

360 to monitor performance throughout the year. The data in the table below is obtained from CC360 and is only available through March 31, 2024.

The clinics that perform below the standard are responsible for analyzing their organizations data and developing improvement strategies. If the causal factors are related to a system issue and a regional response is required by the lead entity, improvement strategies are developed and monitored for effectiveness. During FY24 a regional improvement strategy was not required. Regional monitoring will continue. The CCBHC program has implemented new performance measures beginning 10/1/2024. The performance year will transition to a calendar year beginning 1/1/2025 through 12/31/2025. A statewide metric workgroup has been initiated by the clinics for the new performance measures. The purpose will be clearly identified and is expected to include the provision of clarification and utilization of consistent definitions and interpretations for the data elements of new and ongoing performance measures.

Goal: CCBHC will meet the standard for the CCBHC performance measures.

Status: Partially Met/Continue

Recommendations for FY25

- MSHN, as the lead entity (LE), will complete the following:
  - Will receive CCBHC metrics template quarterly from each clinic quarterly.
  - Will review metric templates for completeness and accuracy
  - Will ensure improvement strategies are developed based on clinic and LE performance.
  - Will establish/develop an efficient method to view performance by clinic, comparing to Michigan CCBHC standards and to provide validated detail clinic data as requested to each clinic.

Figure 5. CCBHC Quality Bonus Payment Measures Performance

CCBHC Quality Bonus Payments	Standard	FY23	FY24Q2/CY24Q1 3.31.2024	Status/ Recommendations
Follow-Up After Hospitalization for Mental Illness. 30 days (FUH -Adults)	58%	Michigan CCBHC: 69.8% CEI: 62% Right Door: 61% SCCMHA: 70%	Michigan CCBHC: 70% CEI: 64% Lifeways: 77% Right Door: 78% SCCMHA: 71%	Met
Follow-Up After Hospitalization for Mental Illness (FUH-Child/Adolescents) MSHN.	70%	Michigan CCBHC: 81.5% CEI: 69% Right Door: 73% SCCMHA: 77%	Michigan: 82% CEI: 92% Lifeways: 81% The Right Door: 100% SCCMHA: 80%	Met
Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN. Standard 58.5%	58.5%	Michigan CCBHC: 54.9% CEI: 59% Right Door: 95% SCCMHA: 57%	Michigan CCBHC: 58% CEI: 61% Lifeways: 63% The Right Door: 78% SCCMHA: 56%	Partially Met
Initiation of Alcohol and Other Drug Dependence Treatment MSHN.	25%	Michigan CCBHC: 41.2% CEI: 52% Right Door: 33% SCCMHA: 49%	Michigan CCBHC: 42% CEI: 43% Lifeways: 24% The Right Door: 41% SCCMHA: 43%	Partially Met

CCBHC Quality Bonus Payments	Standard	FY23	FY24Q4/CY24Q3 9.30.2024	Status/ Recommendations
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN. Standard 12.5%	12.5%	Michigan CCBHC: 63.9% CEI: 89% Right Door: 83% SCCMHA: 21%	Michigan CCBHC: Not Available CEI: 83% Lifeways: 19% The Right Door: 86% SCCMHA: 86%	Met
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN. Standard 23.9%	23.9%	Michigan CCBHC: 78.1% CEI: 76% Lifeways: 38% Right Door: 69% SCCMHA: 74%	Michigan CCBHC: Not Available CEI: 73% Lifeways: 33% Right Door: 67% SCCMHA: 84%	Met

e) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. MSHN has approved the two Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region for CY22 through CY25.

Goal: Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment without a decline in performance for the White population? Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

STUDY INDICATORS:

Indicator 1: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:** Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid State Health Network region and are determined eligible for ongoing services.

Indicator 2: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:** Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services.

Indicator 3: The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

A comparison of the percentage of compliance between the black and white populations for each time period with a two-proportion z-test. This is used to determine if the difference in rates are statistically significant.

DATA ANALYSIS**:**

Indicator 1

CY23- When comparing the percentage of compliance for the black population between the baseline and remeasurement period 1 with a two-proportion z-test, the difference in compliance between the two time periods was significant because the p-value is less than 0.05.

CY24Q2-When comparing the percentage of compliance for the black population between remeasurement period 1 and remeasurement period 2 with a two-proportion z-test, the difference in compliance between the two time periods was not significant because the p-value is greater than 0.05.

Indicator 1 Title: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Rate (%)	Mandated Goal if applicable	*p* Value
01/01/2021–12/31/2021	*Baseline*	852	1310	65.04%	N/A for baseline	Reference
01/01/2023–12/31/2023	Remeasurement 1	890	1491	59.69%	Increase	P value .00407
01/01/2024–6/30/2024 YTD	Remeasurement 2	674	1047	64.37%	Increase	P value .77047

Indicator 2

CY23-When comparing the percentage of compliance for the black population between the baseline and remeasurement period 1 with a two-proportion z-test, the difference in compliance between the two time periods was significant because the p-value is less than 0.05.

CY24Q2-When comparing the percentage of compliance for the black population between remeasurement period 1 and remeasurement period 2 with a two-proportion z-test, the difference in compliance between the two time periods was not significant because the p-value is greater than 0.05.

Figure 3: MSHN Indicator 2 Data

Indicator 2 Title: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal, if applicable	*p* Value
01/01/2021-12/31/2021	*Baseline*	5655	8138	69.49%	N/A for baseline	Reference
01/01/2023 - 12/31/2023	Remeasurement 1	6084	9665	62.95%	≥69.49%	P value .0169
01/01/2024–6/30/2024 YTD	Remeasurement 2	4572	6539	70.02%	≥69.49%	p value .5018

Indicator 3

CY21-When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

CY23-When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

CY24Q2- When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

Figure 4: Indicator 3 Data

Indicator 3 Title: The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.								
Time Period	Indicator Measurement	White Numerator	White Denominator	Percentage	Black Numerator	Black Denominator	Percentage	p-Value (Goal p value <0.500)
01/01/2021 - 12/31/2021	Baseline	5655	8138	69.49%	852	1310	65.04%	.00139
01/01/2023 - 12/31/2023	Remeasurement 1	6084	9665	62.95%	890	1491	59.69%	.01687
01/01/2024 - 6/30/2024	Remeasurement 2	4572	6530	70.02%	674	1047	64.37%	.00028

FINDINGS: MSHN did not eliminate the disparity between the black or African Americans and the white population groups for CY24Q2. The rate of access to services for Index/White population group demonstrated a downward trend from the baseline year as indicated in the Figure 1 for CY23. The rates in CY24Q2 for both population groups have improved since CY23. The black/African American rate continues to be below the baseline rate, however, did demonstrate a significant increase in CY24Q2. The area within MSHN that has the largest Black/African American population group is CEI, Saginaw, Lifeways, and CMCMH. Interventions focused primarily in those areas will have the largest impact on the overall regional performance.

Performance Improvement Project Two:

Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate of those who are eligible for Medicaid services?

STUDY INDICATORS:

Indicator 1: The percentage of individuals who are black/African American and eligible for Medicaid and have received a PIHP managed service.

Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service. (CMHSPs Combined)

Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Indicator 2: The percentage of individuals who are white and eligible for Medicaid and have received a PIHP managed service.

Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service. (CMHSPs Combined)

Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Figure

Measurement Period	Indicators-Race	# Total Medicaid Enrollees	# Medicaid Enrollees Served	Penetration Rate	Disparity Rate
CY21Q2	African American / Black	62829	3973	6.32%	1.85%
	White	328506	26852	8.17%	
CY21 (Baseline)	African American / Black	70267	5236	7.45%	2.05%
	White	373783	35532	9.51%	
CY22Q2	African American / Black	70208	4131	5.88%	1.70%
	White	374973	28420	7.58%	
CY22	African American / Black	72377	5241	7.24%	1.80%
	White	385878	34891	9.04%	
CY23Q2	African American / Black	70385	4099	5.82%	1.76%
	White	368396	27947	7.59%	
CY23	African American / Black	74833	5500	7.35%	1.71%
	White	391423	35448	9.06%	
CY24Q2	African American / Black	66557	4373	6.57%	1.46%
	White	339843	27283	8.03%	

Figure

Test	Test Question	Test Result
Test 1	Was there disparity between the Minority rate and White rate in Year 1?	Disparity in year 1: the Minority rate was significantly lower than the White rate.
Test 2	Was there disparity between the Minority rate and White rate in Year 2?	Disparity in year 2: the Minority rate was significantly lower than the White rate.
Test 3.1	Did the Minority rate increase, stay the same, or decrease from Year 1 to Year 2?	No change in Minority rate from year 1 to year 2: there was no significant change in the Minority rate.
Test 3.2	Did the White rate increase, stay the same, or decrease from Year 1 to Year 2?	Decrease from year 1 to year 2: the White rate significantly decreased.
Test 3.3	Did the disparity between the Minority rate and the White rate decrease, stay the same, or increase from Year 1 to Year 2?	Disparity decreased significantly from year 1 to year 2

STATUS: Indicator 1 (African American or Black) and Indicator 2 (White) have both rates have increased from previous measurement period (CY24Q2). However, when compared to the baseline year (CY21Q2) both rates have decreased. The number of Medicaid eligible has increased at a higher rate than those who have received a service.

RECOMMENDATIONS: Complete additional analysis to determine areas of focus. Complete statistical testing to determine significance related to the penetration rate and change over time.

Improvement Strategies					
Barrier		**Interventions**			
Priority Ranking	**Barrier Description**	**Initiation Date (MM/YY)**	**Description**	**Status**	**Member, Provider, System**
1	No shows-lack of appointment follow up	10/1/2024 8/31/2024 10/1/2024	• Implement appointment reminder system **completed by a staff person/peer.** • Implement/modify process for coordination between providers (warm hand off) • **Provide training for Teach back method.** • **Implement Teach back method for coordination including resolution of barriers. Including barriers specifically related to race and ethnicity.**	Revised Continued **New** **New**	Provider Provider **System** **Provider**
2	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in limited available appointments within 14 days.	10/1/2022	• Recruit of student interns and recent graduates from colleges and universities with diverse student populations.	Continued	Provider Intervention
		10/1/2022	• Utilization of external contractors to provide services.	Continued	Provider Intervention
3	Minority Groups are not aware of services offered	8/1/2024	• Identify and engage with partner organizations that predominantly serve communities of color. (examples: faith- based/religious groups, community recreation centers, tribal organizations, etc.)	Continue, revise the timeline	Provider
	Minority Groups are not aware of services offered	8/1/2024	• Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	Continue, revise the timeline	Provider
4	**Ratio established by MDHHS for Wrap-around and Homebased Services staffing not met.**	**CY25**	• **Develop action steps to increase network adequacy for children services.**	**New**	**System/Provider**
5	Insufficient data to identify Social Determinants of Health (SDOH) such as inadequate Housing, food insecurity, transportation needs, employment/income challenges	**CY26**	• MSHN will work with partner CMHSPs to develop a standardized a process for collecting and sharing data related to social determinants of health including the use of SDOH z codes on service encounters.	**Continue, revise timeline.**	**System**

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments, and other data were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Customer Services 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. The tools used for each population group are listed below. The individuals who have received treatment for a substance use disorder utilized the MHSIP for the first time this year. An electronic version of the tool was developed in survey monkey. The tools, instructions, and a link for the data submission was made available through the MSHN website.

- Mental Health Statistics Improvement Program (MHSIP)-Adults receiving treatment for a Mental Health Diagnosis, an Intellectual Developmental Disability, a substance use disorder, and or receiving long term supports or services.
- Youth Satisfaction Survey (YSS) Youth receiving treatment for a Severe Emotional Disturbance (SED), an Intellectual Developmental Disability, and or receiving long term supports and services
- Provider Network Survey-Organizations who contract with MSHN (every other year)
- Committee/Council Survey-Provider representatives on MSHN committees/councils (every other year)
- National Core Indicator Survey-Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints-All individuals receiving services.

Goal: MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and

- Assess issues of quality, availability, accessibility of care,
- take specific action as needed, identifying sources of dissatisfaction,
- outline systematic action steps,
- evaluate the effects of improvement activities and,
  communicate results to providers, recipients, and the Governing Body

Status: Effective. MSHN Met the standard by obtaining an 80% or higher

Goal: MSHN will adhere to the timeliness standards for Appeal and Grievance Reporting

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Status: Effective. MSHN Met the Standard

Recommendations for FY25:

- Provide /update instructions and tools on the MSHN website for all surveys.
- Update process and instructions to include the submission of template on the MSHN website.

- Develop electronic version of the tool and establish process for data distribution once completed.
- Explore the use of an external contractor to complete the analysis of the survey data and annual report.

Attachment 4 MSHN Experience of Care Executive Summary 2024

Strategic Priority	Goal-Stakeholder Feedback	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services.	80%	95%	90%	87%	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services.	80%	87%	81%	82%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services.	80%	83%	80%	80%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.	80%	83%	80%	85%	Met/Continue
Strategic Priority	**Goal-Stakeholder Feedback**	**Standard**	**FY22**	**FY23**	**FY24**	**Status/ Recommendations**
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.	95%	96.71%	98.85%	97.25%	Met/Continue
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.	95%	95.12%	100%	100%	Met/Continue

g) Adverse Event Monitoring

Goal:
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy.

Goal: Improve timeliness of remediation response in the CIRS-CRM

Status: The QAPIP was partially effective.
MSHN completed four of the six objectives on the work plan.

Recommendations for FY25:

- Monitor performance indicators including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence quarterly.
- Increase the rate of critical incidents submitted within the required time frame.
- Increase the rate of remediations completed within the required time frame.

  - Develop training documents and complete training outlining the requirements of reporting critical, sentinel, immediately reportable, and news media events.
  - Validate / reconcile reported data through the CRM.
  - Establish electronic process for submission of sentinel events/ immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated service. (CRM)
  - Monitor timeliness of submissions and remediation response in the CIRS-CRM through development of dashboard in REMI
  - Track CIRS changes and barriers through the CIRS Process Improvement Report.

Attachment 5 MSHN Critical Incident Performance Report FY24 Q3

	Goal-Event Monitoring and Reporting	Standard	FY22	FY23	FY24Q3	Status/ Recommendations
Better Care	The rate of critical incidents per 1000 persons served will demonstrate a decrease from the previous year. (CMHSP) (excluding deaths)	Track and Trend	8.561	9.550	8.848	Continue
Better Care	The rate, per 1000 persons served, of unexpected deaths will demonstrate a decrease from previous year. (CMHSP) (Accidental, Homicide, Suicide)	Track and Trend		1.109	.395	Continue
Better Care	The rate of natural cause deaths, including the leading causes of death.	Track and Trend		5.915	4.112	Continue
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	Track and Trend	0.91%	0.77 %	.74%	Continue

h) Behavior Treatment

Goal: MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis.
Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX

Goal: MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans.
Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX

Status: MSHN did not meet each standard.

Recommendations:

Attachment 6 MSHN Behavior Treatment Review Data FY24 Q3

Strategic Priority	Behavior Treatment	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	Track and Trend	0.91%	0.77%	.74%	Continue

i) 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 are 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.

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.

Status: MSHN did not meet the standard.

Attachment 6 MSHN Behavior Treatment Review Data FY24 Q3
Attachment 7 ACT Utilization FY24 Q2

Strategic Priority	FY24 Goal-Clinical Practice Guidelines	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	95%	72.2%	88%	50%	Not Met/Continue
Better Care	MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer	(85%/96 minutes-100%/120 minutes).	2/7	1/8	1/8	Not Met/Continue

	MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS					

III.Provider Monitoring

a) Credentialing and Re-credentialing

MSHN has established written policy and procedures[1] 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 three (3) years thereafter. MSHN written policies and procedures[2] 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, 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 compliance with federal, state, and local regulations and requirements through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. In addition, MSHN has established an increased monitoring process that focuses on timeliness not decision making and recredentialing as reported bi-annually by CMHs. Any CMH that does not meet 90% compliance is subject to increased morning.

FY24 Q1-Q2, three of the twelve CMHSPs scored under 90% and were required to submit plans of correction as well as put on increased monitoring plans (quarterly). At the time of this report, a summary of the full FY24 credentialing was not available as reporting was not due to MSHN and MDHHS until after the report due date.

The CMHSPs have been making adjustments to their current systems to ensure compliance with requirements without making significant costly changes. It was recommended by MSHN for CMHSPs to find interim ways to meet compliance that aligned with the implementation of the MDHHS Universal credentialing system expected in FY25. MDHHS created the system as a result of legislation requiring MDHHS to have a universal system for PIHPs/CMHSPs. The system will house all documentation required as outlined in the MDHHS Credentialing and Re-credentialing policy for licensed providers and provider network organizations.

<u>Implementation and Next Steps</u>: The MDHHS training and implementation plan for the MSHN region begins October 2025. In FY25, MSHN will assist CMHSPs in the implementation of the new system and will plan to conduct credentialing reviews directly from the Universal Credentialing system in FY26.

[1] Provider Network Credentialing/Recredentialing Policy and Procedure
[2] Provider Network Non-Licensed Provider Qualifications

Status: Effective.

Recommendations:

- Discontinue the goal as indicated below.
- Implement the Universal Credentialing System.

Strategic Priority	Goal-Staff Qualifications	FY22	FY24	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. FY22 MDHHS Review, FY24 MDHHS Review	88%	95%	Met/Discontinue

b) Verification of Services

Status: MSHN did meet the goal as indicated below for the CMHSP Providers FY24. MSHN did not meet the goal for the SUD Providers.

Recommendations for FY25:

Goal: SUD-Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. 90% Standard

Goal: CMHSP- Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed. 90% Standard

- SUD Lunch and Learn which included overview of the MEV SUD Guide,
- SUD MEV Guide has been added to the website, sent out in the Constant Contact, and linked in the checklist that providers receive prior to the review.
- Presented to the SUD Residential workgroup and discussed requirements, documentation suggestions, and how to prepare for the review i.e., documentation required.
- Recommendations to all providers during the review process and within the final reports
- Created a CMH MEV Guide which has been provided to CMHs via MSHN committees, added to the MSHN website, and linked in the CMH Review checklists.
- Met with the MSHN Compliance Committee in FY23Q3 to discuss the attribute compliance and make recommendations for improvement.
- Met with QIC and discussed this specific attribute and provided recommendations for improvement that CMHs could implement.
- Make recommendations to all CMHs during the review process and within the final reports.

Strategic Priority	Goal-Medicaid Event Verification	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.	90%	CMHSP: 86.21% SUD: 87.57%	CMHSP: 86.65% SUD: 75.68%	CMHSP: 91.6% SUD: 85.65%	CMHSP- Met/Discontinue SUD-Not Met Continue

c) Customer Services

Strategic Priority	Goal-Stakeholder Feedback	Standard	FY22	FY23	FY24	Status/ Recommendations
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.	95%	96.71%	98.85%	97.25%	Met/Continue
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.	95%	95.12%	100%	100%	Met/Continue

Status: Effective

Recommendations for FY25:

- Continue to monitor goals for effectiveness.

d) 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.

Status: Partially Effective

Recommendations for FY25:

Goals	Standard	FY23	FY24	Status/ Recommendation
Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	100%	100.00%	97.0%	Not Met-Continue
Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	100%	68.2%	N/A	Not Met/Continue
The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	<=15%	13.64%	12.51%	Met
Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices	> 90%		98.46%(Q3)	Met/ Discontinue
Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	<= 5%	1.0%	0.01%	Met/Discontinue

e) Long Term Supports and Services for Vulnerable Adults

MSHN ensures that long term supports, and services are consistently provided in a manner that supports community integration and considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. MSHN assesses the quality and appropriateness of care furnished and community integration by monitoring population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's treatment plan and during transitions between care settings. In addition to the behavior treatment data, and adverse event data, MSHN monitors key priority measures as approved by Operations Council.

MSHN encourages community integration to occur more than once per week. Community integration is discussed with individuals at a minimum during the time of the person-centered planning to ensure their wants and desires are noted during the planning process. Documentation of community integration has been seen regularly during oversight reviews. Currently, there is not a systemic issue related to community integration as evidenced by the site review results.

Status: Effective

Recommendations for FY25

Strategic Priority		Standard	FY22	FY23	FY24	Status/ Recommendations
Better Value		100%	78%	81%	86%	Met/Continue

f) Provider Monitoring and External Reviews

MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

IV. FY24 MDHHS 1915(c) Waiver and 1915(i) State Plan (iSPA) Review Summary

Overview

The Michigan Department of Health and Human Services (MDHHS) conducted a review of the Mid-State Health Network region May 28, 2024-July 31, 2024. The review was specific to the Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Severe Emotional Disturbance Waiver (SEDW), and 1915(i) State Plan (iSPA). The review included an administrative review, samples of clinical records, and staff qualification file reviews. MDHHS also conducted interviews with individuals and their families.

MDHHS completed a review of 149 clinical records and a review of staff files for those staff working with the 149 beneficiaries selected for clinical review. MDHHS reviewed a total of 868 staff files which included 236 professional staff and 632 aide-level staff.

MDHHS sent the final report to MSHN on August 28, 2024, and requested a plan of correction for any findings identified. CMHSPs have provided individual and systemic plans of correction which were combined into a regional document and submitted to MDHHS. Once approved, MDHHS will conduct a 90-day review to ensure implementation of the plans of correction.

Elements of the administrative review:

- Critical Incidents-CMH and PIHP policies, procedures and implementation
- Contracting Policy- CMH and PIHP policies and procedures that guide contracting processes with new providers or providers who are expanding service array to ensure they do not require heightened scrutiny (due to isolating/institutional elements).
- Parity Plan- Verification that the region (i.e. PIHP/CMHP) has adhered to the Parity Plan that was approved by MDHHS.

Results: No findings. 100% Compliant.

MDHHS reviewed clinical records for individuals enrolled in the CWP, HSW, SED, iSPA. Record reviews standards encompassing the following elements:

- Person centered planning

- Plan of service and documentation requirements
- Behavior Treatment Plans
- Waiver Participant Health and Welfare

Areas for regional improvement are identified in this summary as standards that had findings in 50% or more of the records reviewed. Findings that were repeat findings (i.e. findings identified by MDHHS during the 2022 review) are identified with a red asterisk (*).

Areas for Regional Improvement –

Areas for regional improvement are identified in this summary as standards that had findings in 50% or more of the records reviewed. Findings that were repeat findings (i.e. findings identified by MDHHS during the 2022 review) are identified with a red asterisk (*).

CWP Clinical Records

- **P.1.2:** The IPOS addresses all service needs reflected in the assessments. (6/12; 50%)*
- **P.1.4:** The IPOS is developed in accordance with the policies and procedures established by MDHHS. (7/12; 58%)*
- **P.4.2:** Services and supports are provided as specified in the IPOS, including type, amount, scope duration and frequency. (9/12; 75%) *

HSW Clinical Records

- **P.2.8:** Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (8/13; 62%)*
- **P.5.1:** Specific Services and supports that align with the individual's assessed needs, including measurable goals/objectives, with amt/scope/duration and time frame of services for implementing. (33/38; 87%) *
- **P.5.2**: Services and treatment identified in the IPOS are provided as specified in the plan. (19/38; 50%)*
- **B.2:** Behavioral treatment plans are developed in accordance with the technical requirement for Behavior Treatment Plan Review Committee. (8/12; 67%) *

One urgent health and safety issue was identified and required a plan of correction to be submitted to MDHHS prior to the final report. An update to the plan of correction was submitted to MDHHS with the regional CAPs in September 2024.

SEDW Clinical Records

- **P.3.4:** The IPOS is developed in accordance with policies/procedures established by MDHHS. Plans contain measurable goals/objectives and time frames. Prior authorizations of services correspond to services identified in the plan. (15/23; 65%) *
- **P.6.1:** Services and supports are provided as specified in the IPOS including type amount scope duration and frequency. (19/23; 83%)*

iSPA Clinical Records

- **P.1.B.2:** Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (65/76; 86%)

- **P.1 B.3:** Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objectives, the type, amount scope duration, frequency and timeframe for implementing. (51/76; 67%
- **B.2:** Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. (6/6; 100%)

38% demonstrated a decrease (16)

62% increased or maintained compliance (26)

Recommendations for FY25:

- MSHN will provide monitoring and oversight to ensure corrective action plans are implemented and effective.
- Region wide quality improvement efforts will be explored to increase efficiencies and improve compliance with standards.

V. External Quality Review Summary

Overview

The Michigan Department of Health and Human Services (MDHHS) contracts with Health Services Advisory Group (HSAG) to compete federally required Medicaid Quality Reviews (EQR) of Pre-Paid Inpatient Health Plans (PIHPs) to ensure compliance with federal and state Medicaid requirements.

In FY24, HSAG conducted four reviews:

- Encounter Data Validation
- Network Adequacy Validation
- Performance Measure Validation
- Compliance

In addition, HSAG requested a progress update for areas where they made recommendations during FY23 reviews.

Encounter Data Validation (EDV) April – July

In FY24, MDHHS introduced a new review of PIHPs. The EDV is expected to be conducted every three years. The goal of the review was to evaluate MDHHS' encounter data completeness and accuracy through a review of records. The study population included members continuously enrolled in the same PIHP that had at least one visit covered by Medicaid during the review period. The review period was 10/1/22 – 9/30/23.

Initially, the case selection for each region included 411 encounters. As there were some barriers and challenges identified, the case selection size was ultimately changed to 308. Documentation for the 308 encounters was required to be submitted along with documentation for the next encounter the individual had with the same provider.

MSHN submitted all documentation within the timeframe requested (7/3/24). On 9/20/24, HSAG requested follow up documentation for the review and requested it be submitted by 9/27/24.

The final report summarizing the review is expected sometime in early FY25. A date was not provided by MDHHS or HSAG.

Network Adequacy Validation (NAV) May – August

In FY24, MDHHS introduced the NAV review to PIHPs. The review is expected to take place annually in concert with the Performance Measure Validation (PMV) review. The focus of the review included network adequacy data collection, integration, calculation, accuracy, and reporting of indicators for each required standard.

Additionally, the review included an Information Systems and Capabilities Assessment (ISCA) which included network adequacy elements and PMV review elements. During the virtual review, MSHN was provided the opportunity to show live/real-time processes used for data integration and processes for calculating time and distance.

In August 2024, MSHN received a Logic Review Report from HSAG indicating that the time and distance standard review was approved. If findings are identified via the ISCA, they will be included in an aggregate report. The NAV audit aggregate report is expected in December 2024.

Performance Measure Validation (PMV) May - August

The PMV review is conducted annually and includes validation of performance measures, an Information Systems Capabilities Assessment (ISCA), and a review of source code/programming language used to generate required performance indicator rates.

All source code reviews specific to each performance indicator were found to be approved by HSAG for all CMHs and MSHN. MSHN and HSAG reviewed a total of 310 records in the FY24 review. Of the records reviewed there were no repeat findings for five of the six recommendations/findings listed by HSAG in the

Findings:

Weakness #1: One case identified in indicator #10 for Tuscola did not involve a member who was a Medicaid beneficiary for at least one month during the reporting period. [**Quality**]

> **Why the weakness exists:** Enrollment system information indicated that the member had a Family Planning Program waiver (Plan First) and was not eligible for Medicaid. **MSHN** confirmed that the member should be removed from indicator #10 and that, based on its review of all other reported indicator #10 cases, this was an isolated issue.
>
> **Recommendation:** Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.

Weakness #2: Two cases for CMHA-CEI in indicators #2 and #3 were identified as having the incorrect populations listed in the member-level detail file. [**Quality**]

> **Why the weakness exists: MSHN** confirmed that this was due to the population designations changing after the original report was run and before the final report was submitted with final rates to MDHHS. **MSHN** indicated that it plans to put a remediation plan in place to crosswalk the initial report with the final report to identify any changes in population designations before submission. No other cases were identified with this issue.

Recommendation: Although this finding did not have a significant impact on the indicator #2 and #3 total rates, HSAG recommends that **MSHN** proceed with its outlined remediation plan. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #2 and #3 data. This should include implementing another level of validation for reviewing a statistically significant sample of cases each quarter to confirm that their associated population designations are accurately reported.

Weakness #3: HSAG identified one case in indicator #3 for Lifeways that should have been reported as out of compliance rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that crisis transportation should not have been captured as an ongoing covered service and removed the case from indicator #3. **MSHN** also indicated that it will be working with PCE to update its programming logic to ensure that crisis transportation is not counted as an ongoing covered service. MSHN confirmed that this **w**as an isolated issue after it reviewed all other reported indicator #3 cases.

Recommendation: Although **MSHN confirmed** that this was an isolated issue, HSAG recommends that **MSHN** implement the programming logic updates and also perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #3 data.

Weakness #4: HSAG identified one case in indicator #4a for Lifeways that should have been reported as an exception rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that the case should not have been reported as incompliance for indicator #4a due to the follow-up appointment not being documented in the out-of-network area of the REMI system, and therefore it was not captured as an exception for indicator #4a. **MSHN confirmed that this w**as an isolated issue after it reviewed of all other reported indicator #4a cases.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #4a data. Retraining on how to appropriately document various scenarios in the REMI system should be provided if found necessary.

Weakness #5: MSHN's indicator #2 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a nonemergency request for service.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #6: MSHN's indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

Recommendations FY25:

- Review a statistically significant sample prior to submission of those CMHSPs that had findings during the HSAG review.
  - TBHS-Medicaid eligibility,
  - CEI - Associated population designations are accurately reported
  - Lifeways-Accurate disposition, exceptions are coded correctly for Indicator 4.
- Ensure completion of the CMHSP/SUD Provider corrective action plans related to internal review of primary source verification.

Compliance Review May - September

HSAG conducts compliance reviews over a three-year cycle. FY24 was Year 1 of the new cycle. The focus of the review included ensuring compliance with the areas of

- Member Right and Member Information
- Availability of Services
- Assurance of Adequate Capacity and Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services

MSHN is expected to receive a final report and request for a plan of correction for any findings identified in December 2024.

Performance Improvement Projects Validation Report

1. HSAG evaluates the technical structure of the PIP to ensure that Region 5—Mid-State Health Network referred to as MSHN in this report, designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depend on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG

evaluates how well MSHN improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related

to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

MSHN Validation Rating 1 Design and Implementation

- Percentage of Evaluation Elements Met 100%
- Percentage of Critical Elements Met 100%
- MSHN Validation resulted in a *High Confidence* rating.

MSHN met 100 percent of the requirements for the data analysis and implementation of improvement

strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

MSHN

Validation Rating 2 Outcomes

- Percentage of Evaluation Elements Met 33%
- Percentage of Critical Elements Met 100%
- MSHN Validation resulted in a *No Confidence* rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the first remeasurement period.

HSAG Recommendations

- The performance indicators have not yet achieved the goals for the PIP. MSHN should consider evidence-based intervention efforts and the risk factors in quality of care for each subgroup, independently.
- MSHN should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions for both subgroups.
- MSHN should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

VI. Quality Priorities and Work Plan FY24

Goal-Organizational Structure and Leadership	Objectives/Activities	Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will complete and submit a Board approved QAPIP Plan, Evaluation and Workplan with list of members of the Governing Body. *42 CFR §438.330(a)(1) Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN QAPIP Evaluation. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations. • Submit to MDHHS via FTP site.	Quality Manager	10/31/2024 10/31/2024 9/30/2024 2/28/2024	Complete/Continue Complete/Continue Complete/Continue Complete/Continue
MSHN Board of Directors will review QAPIP Progress Reports describing performance improvement projects, actions, and results of actions.	• Establish an organizational process to monitor the status of the quality workplan and key performance indicators used to monitor clinical outcomes and process implementation. • Development of standard templates for use in organizational performance improvement projects and QI plan. • Include standard agenda items specific to the organizational performance and improvement activity (QAPIP). (Balanced Scorecard Review, Quarterly Department Reports)	Quality Manager Quality Manager Deputy Director	6/30/2024 6/30/2024 6/30/2024	In Progress/Continue In Progress/Continue Complete/Discontinue
MSHN will have an adequate organizational structure with clear administration and evaluation of the	• Evaluate the committee/structure to ensure responsibilities align with the strategic priorities.	Committee/ Council Leads	9/30/2024	Complete/Ongoing

QAPIP *Contract Schedule A—1(K)(2)(a). QAPIPs for Specialty PIHPs, Section I*	• Review committee charters to ensure effectiveness in carrying out the defined responsibilities. • Complete committee/council survey of effectiveness		10/30/2024 8/30/2024	Complete/Ongoing Complete/Next survey in 2026
MSHN will include the role of recipients of service in the QAPIP. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I*	• Recipients will provide feedback and have membership in select regional committees for the purpose of advocacy, project/policy planning and development, project implementation and evaluation. • Recipients will complete an assessment/survey of services and experiences of care. • Document member feedback in meeting minutes or other documents to ensure follow up. (QAPIP Description, Organizational Chart, Charter Membership).	Customer Services Manager Quality Manager Customer Services Manager	9/30/2024 8/30/2024	Complete/Ongoing Complete/Ongoing Complete/Ongoing
MSHN will have mechanisms or procedures for adopting and communicating process and outcome improvement. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I*	• Utilize the regional committee structure for communication and distribute policies/procedures, reports through. ○ Committee/councils, ○ MSHN Constant Contact, ○ Email. ○ Website ○ Post to the MSHN Website.	Committee/ Council Leads	Monthly	Complete/Ongoing
MSHN will have active participation of Network providers and members in the QAPIP processes. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IV*	• Document discussion and source of feedback to ensure follow up.	Committee/ Council Leads	9/30/2024	Complete/Ongoing

MSHN will provide and/or make available to consumers & stakeholders, including providers and the general public, the QAPIP Report, QAPIP Plan and other quality reports. *Contract Schedule A—1(K)(3)(a*	• Distribute the completed Board approved QAPIP Effectiveness Review (Report) and QAPIP Plan through ○ Committee/councils, ○ MSHN Constant Contact, ○ Email. ○ Website ○ Post to the MSHN Website. • Ensure CMHSP contractors have opportunity to receive the QAPIP. (DMC-check websites) • Provide to members upon request. • Distribute QAPIP progress reports which include but are not limited to Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	Quality Manager	Annually Annually As needed. Quarterly	Complete/Ongoing
Performance Measurement and Quality reports are made available to stakeholders and general public. *Contract Schedule A—1(K)(3)(a)*	• 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.	Leadership	Quarterly	Complete/Ongoing

Goal-MDHHS Performance Measures	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers.	• Review/Identify regional key performance indicators. • Monitor performance and review progress.	Quality Manager and Assigned Measure Stewards	Annually Quarterly	In Progress/Continue Include the revised BH Quality Program Performance Measures for Year 1.
MSHN will evaluate the impact and effectiveness of the QAPIP • Performance of the measures, • Outcomes and trended results • Results of efforts to support community integration for members receiving LTSS. • Analysis of improvements in healthcare and services as a result of the QI activities. • Trends in service delivery and health outcomes over time including monitoring of progress	• Establish a standardized process for MSHN committee/council to monitor the impact of intervention (quality improvement) on assigned performance areas. • Establish standard process for quality improvement in collaboration with committee/councils to analyze outliers and develop/identify regional improvement strategies used to identify barriers and interventions.	Quality Manager	Quarterly	In Progress/Continue-Develop a standard template for all committees and councils to use
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions in collaboration with committee. • Monitor the effectiveness of interventions.	Quality Manager	Annually Annually Quarterly	Completed/Continue In Progress/Continue-Develop a standardized template In Progress/Continue

Goal-Performance Improvement Projects	• Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions.	SUD Care Navigator	Quarterly	Complete/Continue
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/ African American population and the white population.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit PIP 1 to HSAG as required for validation. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 6/30/2024 2/28/2024 2/28/2025	In Progress/Continue with revisions
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 2/28/2024 2/28/2025	In Progress/Continue with revisions

Goal-Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and • Assess issues of quality, availability, accessibility of care, • take specific action as needed, identifying sources of dissatisfaction, • outline systematic action steps, • evaluate the effects of improvement activities and, • communicate results to providers, recipients, and the Governing Body. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(A-D)*	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS)	Quality Manager	6/30/2024	Complete/Continue
	• Implement MHSIP for individuals receiving SUD services.	Quality Manager	6/30/2024	Complete/Discontinue
	• Complete member experience annual report with causal factors, interventions, feedback provided from relevant committees/councils, and an evaluation of impact of the interventions to improve satisfaction.	Quality Manager	9/30/2024	Complete/Continue
	• Identify sources of dissatisfaction and document Provider Network action steps for improvement in the QIC action plan	Quality Manager	8/30/2024	In Progress/Continue
	• Establish a QI Team to streamline surveys and processes. Identify sources of feedback to include in the regional assessment of member experiences. Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	Quality Manager	3/31/2024	Complete/Discontinue
	• Complete an RFP for administration and analysis by an external vendor.	Quality Manager	6/30/2024	Not Started/On Hold

MSHN will adhere to the timeliness standards for Appeal and Grievance Reporting	• Implement a corrective action plan process for FY24 reporting when CMHSPs do not meet the 95% timeliness standard for Appeal and Grievance reporting	Customer Services Manager	1/31/2024	Completed/Discontinue
Goal- Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy. *42 CFR § 441.302(h)* *42 CFR §438.330(b)(5)(ii)* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII*	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events.	Quality Manager	4/2024	In Progress/Continue
	• Validate / reconcile reported data through the CRM.	Quality Manager	Quarterly	On Hold
	• Establish electronic process for submission of sentinel events/ immediate notification, remediation documentations, and written analysis for those deaths that occurred within one year of discharge from state operated service.	Quality Manager	9/2024	In Progress/Continue
	• Implement the use of the Root Cause Analysis template with standardized elements.	Quality Manager	9/2024	Complete/Discontinue
	• Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. • Complete CIRS Process Improvement Report.	Quality Manager	Quarterly	Complete/Continue with revisions
Improve timeliness of remediation response in the CIRS-CRM	• Develop dashboard for tracking and monitoring submission timelines and remediation timelines.	Quality Manager	9/2024	Not Started/Continue

Goal-Medicaid Event Verification	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will address and verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors. *Contract Schedule A—1(K)(2)(a),QAPIPs for Specialty PIHPs, Section XII(A,B*	• Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	Annually	Completed/Continue
	• Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement, and actions taken.	Chief Compliance and Quality officer	12/31/2023 12/31/2024	In Progress/Continue (Due to MDHHS 12/31/2024)
Goal-Utilization Management Plan	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements: • Procedures to evaluate medical necessity, criteria used, information sources, and process to review and approve provision of medical services. • Mechanisms to identify and correct under and over utilization. • Prospective, concurrent and retrospective procedures are established and include required components. *42 CFR §438.330(b)(3)*	• MSHN to complete performance summary quarterly reviewing 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.	Chief Population Health Officer	Quarterly/ Annually	In Progress/Continue
	• Review tools for determining medical necessity for community living supports; recommend regional best practice	Chief Population Health Officer	April 2024	In Progress/Continue
	• Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals. • Develop and monitor reports and identify any areas where improvement is needed. • Integrate standard assessment tools into REMI- MichiCANS implementation.	Chief Population Health Officer Chief Information Officer	January 2024 Quarterly	In Progress/Continue

Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices.	• Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	Chief Population Health Officer	Annually	Completed/Continue
	• Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	Chief Population Health Officer	Annually	Completed/Continue
Goal-Oversight of "Vulnerable People"/Long Term Supports and Services	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including 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. *42 CFR 438.330 (b)(5)(i)* *42 CFR 438.330 (b)(4)*	• Develop process and identify report to monitor aggregate data on the quality and appropriateness of care for those receiving LTSS. • Establish process and identify report to monitor aggregate data for assessment of care between care settings. • Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings. • Include information in the QAPIP description, workplan, evaluation.	CBHO	Annually/ Quarterly	Complete/ Ongoing
Individuals receiving LTSS will be offered opportunities to participate in the community.	• MSHN clinical team will review community integration during regional site reviews, implementing quality improvement when evidence of community integration is not found, and monitor for	Waiver staff	Annually	Complete/Ongoing

	effectiveness to ensure community integration is occurring.			
Goal-Practice Guidelines	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will demonstrate an increase in fidelity to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	• Monitor utilization summary of the average. • Recommend improvement strategies where adverse utilization trends are detected.	Chief Population Health Officer	Quarterly	In Progress/Continue
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	• Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies. • Develop report to monitor, analyze, and improve the amount/scope and duration of services received by individuals enrolled in waivers and those not enrolled in waiver programs/services.	Quality Manager Chief Population Health Officer	6/30/2024 1/2024	In Progress/Continue
Goal-Behavior Treatment (Include under other areas. As indicated below)	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
(Event monitoring) MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI	Quality Manager	9/30/2024	Complete/Discontinue
	• MSHN will reach out to State Workgroup about training opportunities (including Direct Care Workers) • CMHSPs will share details of their training platforms with others (internal training, contracted trainers, etc.)	Waiver Administrator	10/2024	Complete/Ongoing

	• Regional BTR Workgroup will work together to provide/offer training opportunities for those working in direct care roles			
(Clinical Practice Guidelines) MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• BTR Workgroup members will share documentation and processes for consistent monitoring and tracking purposes. • CMHSPs will identify ways to incorporate standards into their EMR. • CMHSPs will share progress on EMR development of BTP standards. • MSHN will continue to review BTP charts through the DMC Review and the MDHHS 2024 Site Review. • MSHN will offer individual trainings as needed/requested. • MSHN will make regional BTPRC Training recording accessible to providers and stakeholders	Waiver Administrator	10/2024	Complete/Ongoing
Goal-Provider Monitoring	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will monitor the provider network including affiliates or subcontractors to which it has delegated managed care functions, including service and support provision, following up to ensure adherence to the required functions.	• Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	Compliance Administrator	Annually	Complete/Ongoing
	• Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site	Functional Area Leads	9/30/2023	In Progress/Continue

	reviews, and submission of evidence for the follow up reviews.			
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	• Implement corrective action plans for areas not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps and assigned leads.	Compliance Administrator	9/30/2024	In Progress/Continue
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	• Verify Medicaid Eligibility and data accuracy through primary source verification.	Quality Manager	Quarterly	Complete/Discontinue
	• Validate data collection process, both administrative and manual.	Quality Manager	Annually	Complete/Continue
	• Develop / modify ongoing training documents.	Quality Manager	Annually	Complete/Continue
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	• Provide technical assistance to CMHSPs related to standards. • Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	Waiver Staff	9/30/2023	In Progress/Continue
Goal-Provider Qualifications	**Objectives/Activities**	**Assessment/Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements	• Will evaluate the MDHHS credentialing report for CMHSP timeliness in decision making and credentialing activities.	Compliance Administrator	Biannually	Complete/Ongoing
	• Will complete additional monitoring for those CMHSP who demonstrate a compliance rate of =<90% based on the credentialing report.	Compliance Administrator	Quarterly	Complete/Ongoing

	• Will complete primary source verification and review of the credentialing/recredentialing policy and procedure during the DMC review.	Compliance Administrator	Annually	Not Completed/Interim year. Transitioning to the MDHHS Universal Credentialing System
	• Will complete primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	Waiver Staff	Annually	In Progress/Ongoing

VII. MSHN Council Annual Reports FY24

Team Name: Mid-State Health Network Operations Council
Team Leader: Joe Sedlock, MSHN Chief Executive Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Board has created the Operations Council 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.[3]

A. Past Year Accomplishments. FY23

- Reviewed and approved the FY22 Operations Council Annual Report
- Supported the forming of the 1915(i) Workgroup
- Reviewed and approved the FY22 QAPIP Annual Report
- Reviewed and approved the FY23 QAPIP Plan
- Supported MSHN position to appeal citations for the use of service ranges language in plans of service.
- Encouraged and supported MSHN in approaching MDHHS to offer to work together on special populations issues.
- Discussed and reviewed the Operating Agreement in regard to the local funds for OHH and BHH.
- Planned for the FY2024-2025 Strategic Plan Process

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

- Requested MSHN/region to look for opportunities to do more advocacy with MDHHS regarding how the state determines State Hospital placement.
- Supported the proposal to MSHNs Board of Directors to extend the Provider Staffing Crisis Stabilization Program thru the end of FY23.
- Supported MSHN and SWMBH collaboration in dialogue with MDHHS to assist with improving access for Children in Child Welfare.
- Reviewed and supported the Service Authorization Denial Summary and Procedure
- Reviewed MSHN Strategic Plan
- Examined Regional Savings Estimates-CMHSP regional partners to take a closer watch on current budget and expenditures. May need to develop regional strategy and/or regional cost containment plans.
- Discussed and reviewed the CFAP resolution
- Collaboration on issues raised by DHHS regarding Children's Access Issues
- Reviewed the FY22 Network Adequacy Addendum report
- Reviewed and approved FY24 ABA Contract
- Reviewed and approved FY24 Financial Management Services Contract
- Reviewed and approved the MSHN/CMHSP FY24 Medicaid Subcontract
- Reviewed and approved FY24 MSHN Training Grid
- Reviewed the FY23 budget amendment and the FY24 budget
- Monthly reviews of MDHHS disenrollment reports
- Supported MSHN to advocate with MDHHS to correct technological problems in the Customer Relationship Management (CRM) system and EGrAMS.
- Reviewed and approved the Ops Council Charter annual review
- Reviewed BCBS and Medicare Advantage services for Crisis Stabilization, Urgent Care and Mobile Crisis to encourage CMHSPs to consider participating.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Relating to conflict free access and planning, advocate for system reform changes that comply with the federal rule that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Work with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Ensure effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.

As a region and as individual entities: address, reduce, and eliminate health disparities.
Address funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements
Monitor and expand Behavioral Health Homes, Opioid Health Homes and Certified Community Behavioral Health Clinics in the MSHN region
Continue to educate MDHHS and other stakeholders on the governmental (non-commercial) nature of the public behavioral health system and work to avoid shaping the system to function like a private health plan
Work with MDHHS to establish a practical vision for use of the State CRM and work toward implementation

Team Name: Finance Council

Team Leader: Leslie Thomas, Chief Financial Officer

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: 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.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- FY 2022 Audits received unqualified opinions and clean Compliance Examinations.
- FY 2022 Fully funded Internal Service Fund and Savings of $47.8 M – both together total 14.4% of the 15% target which is an accomplishment.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
•FY 2023 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2023 and February 2024. 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 2024 and compliance exams by June 2024. 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 2023 Final Reports due to MDHHS March 31, 2024, are received from the CMHSPs to the PIHP. The goal for FY 2023 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.
•If applicable, develop regional and local cost containment strategies to align projected revenue and expenses.

Team Name: Information Technology Council
Team Leader: Steven Grulke, MSHN CIO
Report Period: 10.01.2022 through 9.30.2023
Purpose of 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.

Annual Evaluation Process:

A. **Past Year Accomplishments. FY23**
- Representation from each CMHSP Participant at all Meetings.
  - There was a 95% attendance rate during FY23 ITC Meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
- Successfully submit MDHHS required data according to MDHHS requirements 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).
- Several initiatives that ITC assisted with during FY23 are:
  - COB changes in 2023
  - MCG Indicia Upgrades

  - Foster Care Served Numbers for CMHSA advocacy to MDHHS
  - CRM Module Implementation
  - MDHHS Medicaid Redetermination – ongoing
  - Detailed files for updated EQI
  - Withdrawal Management BH-TEDS Adjustments – MDHHS
  - Addition of the ‘TF’ Modifier in EHRs for mild to moderate CCBHC designation
  - EVV advocacy along with CMHSA
- Facilitate health information exchange (HIE) processes:
  - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway. MSHN is ahead of all other pilots in this implementation.
- Goals Established by Operations Council:
  - Improvements with balanced scorecard reporting
  - Continue trending COVID-19 and telehealth reports (ended in May with emergency orders)
- Meet external quality review requirements:
  - Health Services Advisory Group (HSAG) conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with 1 compliance finding.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
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).
Work on outcome measure data management activities as needed.
Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
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).

Team Name: Quality Improvement Council
Team Leader: Sandy Gettel Quality Manager
Report Period Covered: 10.01.2022-9.30.2023
Purpose of Council or Committee:
The Quality Improvement Council has been established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council will be comprised of the Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by each respective CMHSP Participant Chief Executive Officer/Executive Director, consumer representatives appointed through an application process, and a MSHN SUD staff representing Substance Use Disorder services as needed. The Quality Improvement Council will be chaired by the Quality Manager. All CMHSP Participants will be equally represented on this council.

Annual Evaluation Process

A. Past Year Accomplishments FY23 (10.1.2022 through 9.30.2023)

- Completed and submit a MSHN Board approved QAPIP Plan and Report to MDHHS by the required due date (February 28th, 2023)
- Approved the Quality policies and procedures ensuring they are in compliance with regulatory requirements and have been communicated to the providers.
- Developed regional guidelines for training documentation consistent with MDHHS
- Completed Member Experience Annual Survey
- Achieved the performance standards for each areas within the QAPIP, participating in quality improvement efforts as identified:
    - Behavior Treatment Review-Provide Data to BTPR Workgroup
    - Michigan Mission Based Performance Indicator System (MMBPIS)-Collaborated with MDHHS for recommended revisions and standards for Indicator 2, 3 and other indicators. Executed a targeted remediation based on external results of primary source verification. Developed process for Medicaid eligibility verification prior to submission. Added validation step prior to submission.
    - Develop standardized elements/form for mortality reviews and root cause analysis.
    - Achieve a Performance Improvement Project Validation from the External Quality Reviewers

B. Upcoming Year's Goals FY24 (10.1.2023 through 9.30.2024)

Goal	Objectives/Activities	Frequency/ Due Date
Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2024	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN regional report. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations	Annually 2/28/2024

Improve health outcomes for those served in the region.	• Review regional key performance indicators. • Review regional performance (BSC/Dashboard) • Develop/identify regional improvement strategies used to identify barriers and interventions. • Analyze outliers and establish process for quality improvement in collaboration with committee/councils. • Monitor the effectiveness of interventions	Annually Quarterly Annually- Annually Quarterly
Establish effective quality improvement programs for CCBHC, health homes.	• Identify regional key performance indicators. • Develop/modify data platforms/reports for performance monitoring. • Establish performance monitoring schedule. • Develop/identify regional improvement strategies.	Annually Annually Annually Annually
Adhere to critical incident and event notification reporting requirements by developing an efficient and effective critical incident monitoring system	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. • Validate / reconcile reported data through the CRM. • Improve timeliness of remediation response in the CIRS-CRM • Develop dashboard for tracking and monitoring timelines. • Establish electronic process for submission of sentinel events/ immediate notification, and remediation documentations.	Annually Quarterly Quarterly 2/28/2024 4/30/2024
Achieve full compliance for the MDHHS Review.	• Ensure corrective action plans are implemented to address deficiencies.	Annually
Improve member experience of care	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS) • Identify sources of dissatisfaction • Increase response rate-streamline surveys and process. • Outline actions step for follow up. • Evaluate the effects of activities implemented to improve satisfaction. • Complete an RFP for administration and analysis by an external vendor.	Annually Annually Annually Annually Annually 6/30/2024
Achieve full compliance for the HSAG External Quality Review - Compliance	• Ensure corrective action plans and recommendations are implemented to address deficiencies.	Annually

Achieve Reportable Status for the HSAG External Quality Review – Performance Measure Validation	• Verify Medicaid Eligibility and data accuracy through primary source verification. • Validate data collection process, both administrative and manual. • Develop / modify ongoing training documents.	Quarterly Annually Annually
Achieve 100% Validation Status for the HSAG External Quality Review- Performance Improvement Project	Implement 2 PIPs • Validate data • Utilize quality tools to identify barriers and root causes • Implement interventions • Evaluate the effectiveness of interventions	 Annually Annually Annually Quarterly

VIII. MSHN Advisory Councils FY24 Annual Reports

Team Name: Consumer Advisory Council
Team Leader: Todd Koopmans, Chairperson; Dan Dedloff, MSHN Staff Liaison
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: 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 Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region.

Annual Evaluation Process:

A. **Past Year Accomplishments. FY23**
   - Reviewed the changes to the FY23 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 MSHN Satisfaction Survey results
   - Reviewed and provided feedback on the MSHN Compliance Plan
   - Reviewed and provided feedback on the 2023 MSHN Delegated Managed Care Reviews
   - Reviewed and provided feedback on the 2024/2025 MSHN Strategic Plan
   - Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
   - Reviewed and provided feedback on the MSHN Website Redesign
   - Reviewed and provided feedback on MSHN Adverse Benefit Determination Training

- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Integrated Care
- Education and discussion on Michigan Medicaid Autism Benefit
- Education and discussion on HCBS Rule Updates
- Education and discussion on Conflict Free Access and Planning
- Collaboration with the Healthy Democracy Healthy People
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Charter
- Discussion and feedback on MSHN Council/Committee Survey Results
- 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 and added an in-person meeting option.
- Explore system improvements for services directed to youth

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
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
Annual review and provide feedback on the QAPIP
Annual review and feedback on the Compliance Plan
Review of the MSHN FY24 Consumer Handbook
Review and advise the MSHN Board relative to strategic planning and advocacy efforts
Provide group advocacy within the region for consumer-related issues
Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
Explore ways to get more consumers involved in the RCAC and local consumer councils

Public Behavioral Health System Redesign Advocacy
Improve access to peer support specialists through CMHSPs

IX. MSHN Oversight Policy Board FY24 Annual Report

Team Name: Substance Use Disorder (SUD) Oversight Policy Board
Team Leader: Chairperson Steve Glaser, SUD Board Member
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: 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 Accomplishments. FY23

- Received updates and presentations on the following:
    - MSHN SUD Strategic Plan
    - MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY22 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY23 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
- Received written updates from Deputy Director including state and federal activities related to SUD
- Received updates on MDHHS State Opioid Response Site Visit Results
- Shared prevention and treatment strategies within region

- Received information and education on opioid settlement and strategies
- Provided input on the FY24-26 MSHN SUD Strategic Plan
-

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
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
Increase communication with local counties/coalitions regarding use of state and local opioid settlement funding
Monitor SUD spending to ensure it occurs consistent with PA 500
Revise and sign new Intergovernmental Agreement

X. MSHN Committee FY24 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, MSHN Chief Behavioral Health Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: 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.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Address workforce shortage.
- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Address Wraparound services as appropriate.
- Complete appeal of service range issue with MDHHS and waiver versus non-waiver service use.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Regional input into Conflict Free Access and Planning.
Review and address need for increasing access to children's services, including acute care.
Review, report, and increase use of CRM/OPEN Beds.
Address crisis resources uniformly across the region.
Address implementation of 988/MiCAL.
Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation, as appropriate.
Advocate for crossover multi-discipline process for ICSS.
Convert region to use of the CANS.
Address Inpatient Access issues and emergency department boarding.
MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).
Establish and/or work with providers to increase specialized housing options within the region.
Continue advocacy around conflict free access and planning consistent with MSHN Board adopted resolution.

Team Name: Regional Medical Directors Committee (RMDC)
Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
As created by the MSHN Operations Council (OC), the RMDC 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.

Annual Evaluation Process:

A. **Past Year Accomplishments. FY23**
    - Review and input into the behavioral health home initiative.
    - Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
    - Addressed controlled substance prescription law and shared feedback with MDHHS.
    - Reviewed planned updates and gave feedback to PCE prescriber module.
    - Input into Population health and Integrated Care Plan and Quarterly Reports.

- Addressed staffing status for psychiatry.
- Continued input into Conflict Free Access and Planning discussion.
- Discussed DEI initiative.
- Reviewed critical incident report.
- Reviewed telemedicine bulletin MMP 23-10 and processes.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.
- Review RMDC survey responses.
- Reviewed possibility of writing standards regarding nurse practitioners and physician's assistants.
- Reviewed issue of worker burnout.
- Reviewed and provided input into clinical care pathways relating to the CMH work when someone goes to the emergency room.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address youth access to CMH services.
Continued input into behavior treatment processes.
Ongoing input into population health and integrated care.
Return to OpenBeds process conversation and define further.
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 CLC.
Improve collaboration with MDHHS around processes related to CMH functions (i.e., determination of hospitalization).

Team Name: Utilization Management Committee
Team Leader: Skye Pletcher, Chief Population Health Officer, MSHN
Report Period: 10.01.2022 through 9.30.2023

Purpose of 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.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.

- Advocacy and appeal with MDHHS for the use of service ranges in person centered plans for waiver and non-waiver services.
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate.
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >95% adherence to medical necessity criteria

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
NEW - Regional input into Conflict Free Access and Planning.
NEW - Address inpatient access issues and emergency department boarding.
NEW – Review regional process for addressing in-region COFR arrangements
NEW – Implementation of MichiCANS and MiCAS
CONTINUE - Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
CONTINUE - Recommend improvement strategies where adverse utilization trends are detected.
CONTINUE - Recommend opportunities for replication where best practice is identified.
CONTINUE - Address succession planning for UMC members relative to skill set needed by committee members.
CONTINUE - Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals.

Team Name: Regional Compliance Committee
Team Leader: Kim Zimmerman, Chief Quality and Compliance Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2022 Annual Compliance Summary Report

- Reviewed and updated the committee charter.
- Reviewed HSAG Compliance Site Review Findings – Developed plan of correction for findings specific to compliance standards
- Reviewed Compliance Section for Managed Care Program Annual Report (MCPAR)
- Provided feedback on MEV site review process and updates.
- Reviewed proposed revisions to the 42 CFR Part 2 to ensure regional compliance.
- Consensus on use of signatures within the Electronic Health Records
- Reviewed results council/committee surveys- implemented changes based on feedback.
- Provided feedback on 2024-2025 MSHN Strategic Plan
- Updated Privacy Notice to ensure compliance with federal and state standards and developed consistent distribution processes.
- Medicaid Policy Updates: Telehealth compliance and end of public health emergency
- Reviewed the revised FY2023 OIG Quarterly Report changes, guidance documents, fraud referral form, and submission requirements.
- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings.
- Provided consultation on local compliance related matters.
- Reviewed and provided feedback on MSHN compliance policies and procedures.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Identify compliance related educational opportunities including those aimed at training compliance officers
Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies

Team Name: Provider Network Committee
Team Leader: Leslie Thomas, MSHN CFO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or 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.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures.
- Established regionally approved and executed CRU agreement with FHPCC.
- 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.
- Continued implementation of statewide training reciprocity plan within the MSHN region.
- Development and continued support of regional training coordinators workgroup to support implementation.
- Completed and rolled out regional web-based provider application.
- Provided input into PCE Provider Management Module enhancements.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address recommendations from the 2023 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
Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services

Team Name: Customer Services Committee
Team Leader: Dan Dedloff, Customer Service & Rights Manager
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Customer Services Committee was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. 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 Chief Compliance and Quality Officer and will report through the Quality Improvement Council (QIC).

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY23 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY23 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:
  - Grievances
  - Appeals
  - Medicaid Fair Hearings
  - Recipient Rights
- Defined what would be considered a cultural competency request (CCR) to support network adequacy.
- Reviewed the FY22 HSAG Compliance Review results and collaborated to develop the HSAG corrective action plan.
- Reviewed and provided feedback on the Mid-State Health Network (MSHN) 2024/2025 Strategic Plan.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
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
Complete the bi-annual review, update, and approval of the MSHN Customer Service Policies and Procedure.
Develop and distribute an Adverse Benefit Determination Frequently Asked Questions document.

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Leader: Shelly Milligan (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
REACH is an advisory body of community stakeholders established for the following purposes:

- Ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs.
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI).
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma.
- Address stigma and bias that may impact health outcomes.

Annual Evaluation Process:

A. Past Years Accomplishments. FY23

- REACH assisted with review of "Better Equity" strategic priority as MSHN updated its FY24-25 MSHN Strategic Plan.
- REACH assisted with review of MSHN's updates to its FY24-26 SUD strategic plan, in particular, the goals related to reducing health disparities was shared with REACH for their review.
- REACH participated in preparation and planning for MSHN's *Equity Upstream* Spring Lecture series. Several REACH members participated in various capacities in the actual trainings.
- REACH was part of preparation and planning for MSHN's *Equity Upstream* Learning Collaborative (LC) and continues to support direction and strategies related to LC activities.
- REACH members are and will be assisting with mechanisms to engage community members in seeking feedback from impacted minority communities who are underrepresented in our treatment population.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
1. Increase data sharing around equity activities and reducing health disparities
2. Support community engagement to inform Learning Collaborative activities
3. Review LC Action Plans relative to impacting health disparities
4. Support for IDEA Workgroup's internal review of MSHN policies, hiring, etc.

X. MSHN Workgroups FY24 Annual Reports

Team Name: Autism Benefit Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the Autism Benefit 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 MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The Autism Benefit Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Developed a monitoring system to address timely service delivery.
- Encouraged attendance and participation in Michigan Autism Council and Autism Alliance of Michigan meetings.
- Served as advocates for the region while working to inform and collaborate with newly formed MDHHS autism section.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 3

Goal	Objectives/Activities	Frequency/Due Date
Improve and develop solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carryout treatment).	1. Outreach to providers within the state to increase opportunities for autism benefit enrollees to participate in medically necessary services. 2. Share list of available providers with the region as well as regional results of ongoing monitoring of current providers. 3. CMHSP representatives will connect with available providers in consideration of additional contracts.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Adjust to code changes and new policy language.	1. Become aware of and understand the changes that are implemented by MDHHS. 2. Advocate for stabilization of policy to support quality service delivery. 3. Inform network and stakeholders when policy changes are proposed and initiated.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Ensure regional representation at quarterly MSHN Autism Workgroups.	1. MSHN to continue to send workgroup meeting invitations and	Frequency: throughout the fiscal year.

	agendas in a timely manner to encourage attendance. 2. Follow-up with CMHSPs that do not have consistent representation at quarterly workgroup meetings.	Due date: 9/30/2024

Team Name: Children's Waiver Program (CWP) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
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, the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed two separate CWP 101 trainings (10.04.2022 and 10.18.2022), with virtual options, in partnership with MDHHS (141 attendees total).
- Ensured full implementation of corrective action plan related to MDHHS and MSHN CWP findings.
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Demonstrated continued improvement on DMC reviews as evidenced by increased compliance scores (FY21 average chart review score 93.98%; FY23 average chart review score 98.53%).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 2
Goal
Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite.
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are

adequately informed and have the resources available to enroll and maintain a youth in the CWP.

Team Name: Home and Community-Based Services (HCBS) Workgroup
Team Leader: Kara Hart, Home & Community Based Services Waiver Administrator
Report Period Home and Community-Based Services (HCBS) Workgroup**:** 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The HCBS Workgroup was established to initiate and oversee the coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Administrator (Adults), Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Waiver Administrator chairs the HCBS Workgroup, and the Waiver Coordinators facilitate. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed site visits and data cleanup regarding the 2020 HCBS Final Rule Survey Data.
- Surveyed, assessed, and remediated, when necessary, individuals/providers for HCBS Compliance.
- Facilitated discussion on the expectations and concerns relating to the MDHHS Community Transition Program (MCTP) releasing individuals into HS facilities.
- Provided information regarding HCBS Final Rule and their intersection with the BTP process.
- Allowed for the discussion of complex cases and the barriers to placing individuals of high needs.
- Provided updates regarding HCBS sites determined to be Heightened Scrutiny.
- Provided ongoing updates regarding MDHHS role changes and structural shifts as it relates to HCBS.
- Provided support, guidance, and reminders regarding the WSA.
- Reviewed best practice strategies to address potential barriers to attaining full HCBS resolution.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Establish a monitoring process to ensure HCBS settings within the Mid-State Health Network region maintain positive HCBS compliance status.
Continue to remediate and validate HCBS survey responses and provisional approval data as it becomes available from MDHHS.
Work to resolve identified conflicts between HCBS compliance and licensing (LARA) recommendations to ensure site and case compliance with MDHHS guidelines and expectations.

Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process.

Team Name: Habilitative Supports Waiver Workgroup
Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: 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 CMHSP's are equally represented.

Annual Evaluation Process:

A. **Past Year Accomplishments. FY23**
    - Identified potential candidates for enrollment in the HSW to increase slot allocation.
    - Distributed monthly HSW reports and monthly overdue and coming due data.
    - Tracking and reporting on reason for and number of HSW recertification pend backs from both MHSN and MDHHS.
    - Worked through continued challenges related to monitoring initial HSW applications and recertifications for restrictive and intrusive technique and/or Behavior Treatment Plans.
    - Received information provided by MDHHS and successfully implemented changes.
    - Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic.

B. **Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)**

Goal
Ensure full implementation of corrective action related to MDHHS and MSHN HSW findings.
Demonstrate improvement on DMC review scores for HSW program specific standards and clinical charts.
Achieve a minimum 95% utilization of allocated HSW slots for the region.
Eliminate monthly unsubmitted/past due HSW recertifications based on established due dates from MSHN and MDHHS.
Increase the timeliness of responses to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS.
Ensure transition, as appropriate, from HSW to 1915(i) for all cases that are being disenrolled or going into inactive status.
Prepare for the upcoming MDHHS Home and Community Based Waiver Review set to occur in 2024.

Team Name: Serious Emotional Disturbance Waiver (SEDW) Workgroup

Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
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, the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Increased overall enrollments by six percent (from August 2022-August 2023). This included one CMHSP that did not have enrollees, adding one enrollee. Eleven out of 12 CMHSPs now have enrollees.
- Completed two separate SEDW 101 trainings (10.03.2022 and 10.17.2022), with virtual options, in partnership with MDHHS (154 attendees total).
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Completed full implementation of corrective action plan related to MDHHS and MSHN SEDW findings.
- Held regional Wraparound consultation with Heather Valentiny (MDHHS) on July 6, 2023 (35 attendees).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite, as appropriate.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Review and respond to system changes as influenced by Michigan Intensive Child and Adolescent Service Array (MICAS).
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.

XI. 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 consumers, 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
BHH: Behavioral Health Home
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CCBHC: Certified Community Behavioral Health Clinic
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
OHH: Opioid Health Home
PNMC: Provider Network Management Committee
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver

UMC: Utilization Management Committee
YSS: Youth Satisfaction Survey

XII. Attachments

Attachment 01 MSHN QAPIP Communication

Attachment 1 MMBPIS FY2024 Performance Summary

Attachment 2 FY24 PBIP Narrative

Attachment 3 FY24 Q2 Integrated Health Quarterly Report

Attachment 4 MSHN Experience of Care Executive Summary

Attachment 5 MSHN Critical Incident Performance Report 4 Q3

Attachment 6 MSHN Behavior Treatment Review Data Fy24 Q3

Attachment 7 ACT Utilization FY24 Q2