Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

SFY 2025 PIP Validation Report

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

for

Region 5—Mid-State Health Network

November 2025

For Validation Year 4

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Copyrights

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1. Background

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Michigan, Department of Health and Human Services, (MDHHS)—responsible for the overall administration and monitoring of the Michigan Medicaid managed care program. MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

For this year's PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

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 depends 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.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 1, 2025.

Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and non-clinical areas.

For this year's 2025 validation, **MSHN** continued its clinical PIP topic: ***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***. The PIP topic selected by **MSHN** addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Summary

Through data analysis, **MSHN** identified a disparity between its Black/African American and White populations for the PIP topic. The goals of the PIP are to improve the rate of members new to services, receiving a medically necessary service within 14 days of completing a biopsychosocial assessment for the Black/African American population and eliminate the identified disparity without a decline in performance for the White population. Receiving timely necessary services and addressing biological, psychological, and social influences improves overall mental and physical health and well-being.

Table 1-1 outlines the performance indicators for the PIP.

Table 1-1—Performance Indicators

PIP Topic	Performance Indicators
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	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. 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.

Validation Overview

For State Fiscal Year (SFY) 2025, MDHHS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIHP's compliance with each of the nine steps listed in the CMS EQR Protocol 1. With MDHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table 1-2—CMS EQR Protocol 1 Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the information and data needed to conduct the PIP validation from **MSHN**'s PIP Submission Form. This form provides detailed information about **MSHN**'s PIP related to the steps completed and evaluated by HSAG for the SFY 2025 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the PIHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement and the existing disparity was eliminated without a decline in performance for the comparison group. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - ***High Confidence*:** High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - ***Moderate Confidence*:** Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - ***Low Confidence*:** Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - ***No Confidence*:** No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - ***High Confidence*:** The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance **and** there was no statistically significant difference between the disparate group and comparison group **and** without a decline in performance for the comparison group.
   - ***Moderate Confidence*:** The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, there was a non-significant decline in performance for the comparison group.

     Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate group demonstrated statistically significant improvement over the baseline performance; however, there remains a statistically significant difference between the disparate group and the comparison group.

Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline; however, there was no statistically significant difference between the disparate group and comparison group and the comparison group did not have a decline in performance.

- ***Low Confidence*:** The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was with no statistically significant difference between the disparate group and comparison group and without a decline in performance for the comparison group.

  Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate a statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a nonsignificant decline in performance.

  Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group, and without a decline in performance for the comparison group.

  Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group and there was a nonsignificant decline for the comparison group.

- ***No Confidence*:** The remeasurement methodology was not the same as the baseline methodology for all performance indicators.

  Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and the disparate performance indicator did not demonstrate statistically significant improvement over the baseline and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a significant decline in performance over the baseline.

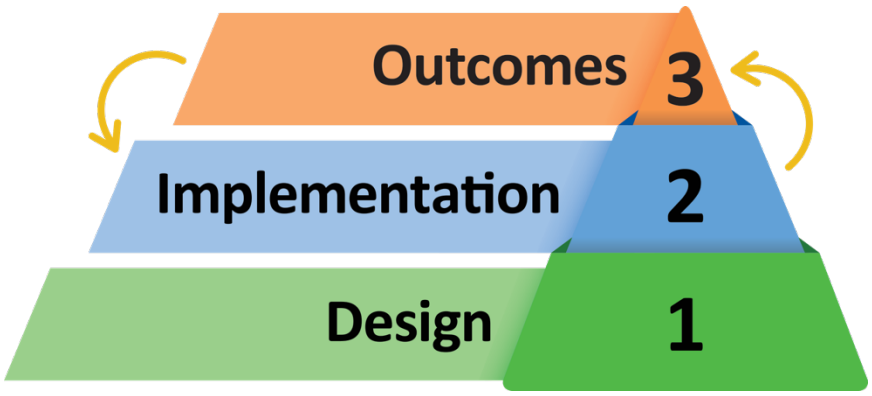
  Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and there was a statistically significant difference between the disparate group and comparison group.

  Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was a statistically significant difference between the disparate group and comparison group.

Figure 1-1 illustrates the three stages of the PIP process—Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the

methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure 1-1—Stages



Once **MSHN** establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, **MSHN** evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of elimination of the existing disparity and statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, **MSHN** should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

2. Findings

Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 2-1 summarizes the PIHP's PIPs validated during the review period, with an overall confidence level of *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence* for the two required confidence levels identified below. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* validation score, as well as the percentage score of critical elements that received a *Met* validation score. Critical elements are those within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

Table 2-1 illustrates the validation scores and confidence levels for both the initial submission and resubmission.

Table 2-1—SFY 2025 PIP Validation Results for MSHN

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
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	Initial Submission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Resubmission	*The PIHP did not resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the PIHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The ***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*** PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. **MSHN** received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *No Confidence* level that the PIP achieved significant improvement. The following subsections highlight HSAG's findings associated with each validated PIP stage.

Design

MSHN designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. **MSHN**'s Aim statement set the focus of the PIP, and the eligible population was clearly defined. **MSHN** selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the PIP was sufficient to measure and monitor PIP outcomes.

Implementation

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, were reasonably linked to their corresponding barriers, and evaluated to determine effectiveness.

Outcomes

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 second remeasurement period.

Analysis of Results

Table 2-2 displays baseline, Remeasurement 1, and Remeasurement 2 data for **MSHN**'s ***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*** PIP.

Table 2-2—Performance Improvement Project Outcomes for MSHN

Performance Indicator Results				
Performance Indicator	**Baseline (1/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2023–12/31/2023)**	**Remeasurement 2 (1/1/2024–12/31/2024)**	**Sustained Improvement**
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.	64.7%	60.0% ↓*	61.0% ⇔	
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.	69.3%	63.0% ↓*	65.4% ↓*	

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓* Designates a statistically significant decrease over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

For the baseline, **MSHN** reported that 64.7 percent of new Black/African American persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and that 69.3 percent of new White persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. The goals for the PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American population) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White population).

For the first remeasurement, **MSHN** reported that 60.0 percent of new Black/African American persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and that 63.0 percent of new White persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. The reported rate for the performance indicator did not meet the state-specific goals for the PIP, which are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate

subgroup (Black/African American population) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White population).

For the second remeasurement, **MSHN** reported that 61.0 percent of new Black/African American persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and that 65.4 percent of new White persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. The reported rate for the performance indicator did not meet the state-specific goals for the PIP, which are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American population) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White population).

The PIHP revised the baseline and Remeasurement 1 data that was reported in the prior year. The PIHP reconciled numerator/denominator logic in alignment with specification clarification.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The PIHP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the PIHP's overall success in achieving the desired outcomes for the PIP.

MSHN's causal/barrier analysis process involved data analysis, a QI team which brainstormed, developed a fishbone diagram, and used the 5 WHY's exercise to identify barriers to care. The PIHP prioritized the identified barriers based on potential impact to the affected communities, its strategic planning timeline, and available resources.

From these processes, **MSHN** determined the following barriers and interventions in order by priority.

Table 2-3 displays the barriers and interventions as documented by the PIHP.

Table 2-3—Interventions Implemented/Planned

Barriers	Interventions
Members do not show up for appointments.	Implement an appointment reminder system and modify the process for coordination between providers. Implement Teach-back method for coordination, including resolution of barriers (specifically related to race and ethnicity).
Workforce shortage; lack of qualified, culturally competent clinicians resulting in inadequate, limited available appointments within 14 days.	Recruit student interns and recent graduates from colleges and universities with diverse student populations. Use external contractors to provide services. Utilize financial incentives/scholarships to obtain/retain adequate staffing.

Barriers	Interventions
Minority groups are unaware of services offered.	Identify and engage with partner organizations that predominantly serve communities of color. Distribute community mental health services program (CMHSP) informational materials to individuals through identified partner organizations within communities of color.

3. Conclusions and Recommendations

Conclusions

The ***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*** PIP received a *Met* validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across the first eight steps validated, and a *High Confidence* validation status. The PIHP developed a methodologically sound improvement project. The causal/barrier analysis process included the use of appropriate QI tools identify and prioritize barriers, and interventions were initiated in a timely manner. The PIP received a *Met* validation score for 100 percent of critical evaluation elements, 33 percent for the overall evaluation elements for Step 9, and a *No Confidence* validation status. The performance indicator did not demonstrate statistically significant improvement over the baseline performance for the disparate population and the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period was not achieved.

Recommendations

Based on the validation of the PIP, HSAG has the following 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.

Appendix A. PIP Submission Form

Appendix A contains the final PIP Submission Form from **MSHN** submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix A: State of Michigan SFY 2025 PIP Submission Form
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service
for Region 5—Mid-State Health Network

Demographic Information	
PIHP Name: Midstate Health Network Region 5	
Project Leader Name: Kara Laferty	Title: Quality Manager
Telephone Number: (517) 299-0750 x 884	Email Address: kara.laferty@midstatehealthnetwork.org
PIP Title: ***Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service***	
Submission Date: July 25, 2025	
Resubmission Date (if applicable): *Not Applicable*	

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: 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 **without a decline in performance for the White population**.

MDHHS has provided a broad focus for the PIP that is aligned with the Michigan Comprehensive Quality Strategy. PIHPs are to identify existing racial or ethnic disparities within the region(s) and populations served and determine its plan-specific topic and performance indicator(s).

Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. The topic was chosen to improve access and engagement with services addressing any racial disparities that exist during the onset of treatment.

The MSHN Quality Improvement Council, through consensus chose the following topic: 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.

Provide <u>plan-specific</u> data: (Baseline CY21 data)

Baseline data was obtained for CY2021. The data was drawn from Michigan Mission Based Performance Indicator Data, Indicator 3 with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity. The Black/African American and White individuals were chosen for further analysis. A numerator and denominator were obtained for each group (Table 1), and the rate was calculated by dividing the numerator by the denominator.

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

Fisher's Exact Test was performed to determine if the black/African American minority group had a statistically significantly (p-value < 0.05) lower rate than the white (index) population. A 95% confidence interval and margin of error was also calculated for each group (Table 2). The black group (95% CI: ~~62.46, 67.62~~ 62.05, 67.3) had a statistically significantly lower rate than the white group (95% CI: ~~68.48, 70.49~~ 68.28, 70.22) with a p-value = ~~0.0015~~ 0.00145.

The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period in CY2023 and CY2024 to determine if the intervention strategies were a success.

Table 1: MSHN CMHSP Rates by Racial/Ethnic Group CY2021

Race/Ethnicity	Numerator	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper
Black/African American	~~852~~ 837	~~1310~~ 1294	~~65.04%~~ 64.68%	~~2.58%~~ 2.63%	~~62.46%~~ 62.05%	~~67.62%~~ 67.31%
White	~~5655~~ 6050	~~8138~~ 8737	~~69.49%~~ 69.25%	~~1.00%~~ .97%	~~68.48%~~ 68.28%	~~70.49%~~ 70.22%

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

The Non-clinical Performance Improvement Project will address access to services for the largest historically marginalized group, Black/African American, within the MSHN region. The identification of barriers for access to services for this group will result in action, ensuring all Black/African American individuals served have the same opportunities to be healthy both mentally and physically.

Step 2: Define the PIP Aim Statement(s). Defining the aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s): 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**?

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition: The population includes all Medicaid individuals, adult, and children, who are new to services and have received a Biopsychosocial Assessment by the PIHP.

The biopsychosocial must have been completed within the measurement period. If the completion of the biopsychosocial occurs over more than one visit the date of completion is when the professional has submitted an encounter for the assessment and has determined a qualifying diagnosis.

The African American/ Black and the white race and ethnicity will be obtained through the race/ethnicity field included in the 834 file. The 834 file is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. Information transmitted includes initial enrollment and subsequent maintenance of individuals who are enrolled in CHAMPS.

The PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20 (Attachment 2) is being utilized to identify the eligible population.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Effective 10/1/2023 the PIHP MMBPIS Codebook was updated. The updates to the FY24 MMBPIS PI Codebook include combining the PIHP and CMHSP State specific indicators and include the Michigan state required performance standards for Indicator 2 and Indicator 3.

Effective 10/1/2024, the PIHP MMBPIS Codebook was updated; the FY25 MMBPIS PI Codebook includes all Michigan state required performance standards.

Attachment 1: Appendix B: Crosswalk for Race or Ethnicity Code (page 21)

Enrollment requirements (if applicable):

Count as Medicaid eligible any person who qualified as a Medicaid Beneficiary during at least one month of the MDHHS MMBPIS defined reporting period. MDHHS defined reporting period is quarterly, therefore all individuals must be enrolled in Medicaid for at least one month per quarter to be included in this project.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

This includes individuals with traditional Medicaid, Healthy Michigan, and both Medicaid and Medicare.

It should be noted that currently all Medicaid beneficiaries have continuous enrollment. Medical Service Administration as issued a bulletin on April 6, 2020, suspending all Medicaid Closures. Once the public health emergency is terminated the continuous enrollment will also be terminated over a specific period of time as indicated by MDHHS.

The PHE ended May 11, 2023. Attachment 7a Policy Crosswalk table (Michigan.gov/mdhs/end-phe/Medicaid-benefitchanges/phe-unwind-policy-crosswalk) identifies the Medicaid response Bulletins and L letters issued with crosswalks to the corresponding Medicaid Bulletin or Letter.

The PHE policy action and impacts analysis from such action is included in Section 7.

Attachment 3a MSA 20-36
Attachment 3b MSA 20-19
Attachment 3c MSA 20-13

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Attachment 3f MSA 20-28
Attachment 3g MSA 20-12
Member age criteria (if applicable): Includes all members, adult, and child.

Inclusion, exclusion, and diagnosis criteria:

Inclusions

Individuals who have received a completed Biopsychosocial during the measurement period, have been diagnosed with a mental illness and/or an intellectual developmental disability, and have been determined eligible for mental health or intellectual and developmental disability services.

Exclusions

Individuals covered under **the Omnibus Budget Reconciliation Act** (OBRA).

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):
Allowable assessment codes based on year, as indicated in Attachment 3d and Attachment 3e.

Definitions:

- Intellectual Disability and Developmental Disability as defined in the Mental Health Code 330.1100 (12 & 25)
- Mental Illness /Serious Emotional Disturbance as any MI DSM Diagnosis
- Individuals with both a mental illness and an intellectual or developmental disability should be categorized
- New is defined as either never seen by the PIHP for mental health services or for services for intellectual and developmental disability, or it has been 90 days or more since the individual had received any MH or IDD service from the PIHP.
- "Service" means any non-emergent face-to-face CMHSP service that is included in the person's plan of service or moves a person toward development of their plan of service.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Attachment 2: PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20 updated to include the FY25 MMBPIS Codebook

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods should be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample: 100% of the Medicaid population is being used for the project.

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

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
	The study topic aligns with the Michigan Mission Based Performance Indicator System (MMBPIS) Codebook Indicator 3, initiated in 2020 by MDHHS with the addition of the disparity analysis which supports MSHN's strategic priority to eliminate disparities among persons served offering the same access to all persons served. The African American/black population group is the largest minority group within the MSHN region.
Numerator Description:	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 Description:	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

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	ongoing services. The records submitted for the MMBPIS reporting to MDHHS will be used for the denominator.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023
Remeasurement 2 Period	01/01/2024 to 12/31/2024
Mandated Goal/Target, if applicable	Eliminate the disparity without decreasing the performance of the index (white) population group. Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.
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

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	The study topic aligns with the Michigan Mission Based Performance Indicator System (MMBPIS) Indicator 3, initiated in 2020 by MDHHS with the addition of the disparity analysis which supports MSHN's strategic priority to eliminate disparities among persons served offering the same access to all persons served. The white population group is the largest population group within the MSHN region.
Numerator Description:	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 Description:	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. The records submitted for the MMBPIS reporting to MDHHS will be used for the denominator.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023
Remeasurement 2 Period	01/01/2024 to 12/31/2024

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Mandated Goal/Target, if applicable	Eliminate the disparity without decreasing the performance of the index (white) population group. Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

Use this area to provide additional information.

Numerator Exclusion-

Emergent services are excluded from the numerator. The following codes are considered emergent services:

- Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, H2011
- Intensive Crisis Stabilization, S9484
- Screening for Inpatient Program, T1023
- Psychotherapy for Crisis, 90839 & 90840
- Crisis Residential, H0018
- Any service from a psychiatric inpatient stay

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

  - Partial Hospitalization if T1023 reported, 0912, 0913

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data	[x] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section.	Data Source [x] Programmed pull from claims/encounters [ ] Supplemental data [x] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [x] Appointment/access data [ ] Delegated entity/vendor data _____ [x] Other ____834 eligibility files_____ Other Requirements	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ ___ Other Survey Requirements: Number of waves: _____

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
[ ] Data collection tool attached (required for manual record review)	[ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: __95_____ % complete. Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: Claims and encounters are submitted to MDHHS from all types of providers. MDHHS will not accept claims/encounters into the warehouse without meeting the minimum standards for submission. Providers are required to submit Medicaid encounters to MDHHS within 30 days after the service was provided. Transactions will not be accepted if they do not meet complete requirements. Typically,	Response rate: _____ Incentives used: _____

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	over 95% of the transactions are submitted within the 30 days after service datetime frames. Completeness is estimated by looking at expected levels of service and BH TEDS data based on historical counts of services provided, received, and processed through REMI. Completeness is defined as those Medicaid encounters that have been submitted to MDHHS successfully and matched with monthly reconciliation reports.	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Step 1: MSHN, through REMI (Managed Care Information System) receives an automated download of the Medicaid eligibility files (834) from the File Transfer Service (FTS). Step 2: CMHSP collect, enter, and validate encounter data in their data systems and submit (no less than monthly) to MSHN through REMI. Step 3: MSHN combines, validates, and submits files to MDHHS (weekly) Step 4: MSHN retrieves MDHHS response files from the FTS and loads into REMI (Managed Care Information System) to update the status of each encounter/claim. Step 5: MSHN, through REMI (Managed Care Information System) receives an affiliate upload (Affiliate PI Output File) from each CMHSP quarterly. The affiliate upload is administrative data, obtained from their EMR. Step 6: MSHN combines and validates the Affiliate PI Output File to create a PIHP PI File. Step 7: MSHN uses the Medicaid ID to match the race/ethnicity data from the 834 files with each member record in the PIHP PI File. Step8: The eligible population (denominator) will be the member records that are included in PIHP PI file with the race/ethnicity data. Step 9: The eligible population (numerator) will be the member records in the PIHP PI file with race/ethnicity data (denominator) that have a "in compliance" in the service column indicating administrative data has been received for a medically necessary ongoing covered service table where the Medicaid ID matches the Medicaid eligible enrollees in the denominator. The data utilized to determine the study indicator rate will be retrieved 60 days after the end of the measurement period. This will take into account the time lag allowed for the submission of claims for the CMHSP consumers and ensure the completeness and accuracy of the data in determining the study indicator rate.

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

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	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
01/01/2021–12/31/2021	**Baseline**	~~852~~ 837	~~1310~~ 1294	~~65.04%~~ 64.68%	N/A for baseline	NA
01/01/2023–12/31/2023	**Remeasurement 1**	~~892~~ 822	~~1496~~ 1371	~~59.69%~~ 59.96%		Two-proportions z-test comparing Baseline to Remeasurement 1: P-value = ~~.0041~~ 0.01329
01/01/2024–12/31/2024	**Remeasurement 2**	777	1273	61.04%		Two-proportions z-test comparing Baseline to Remeasurement 2: P-value = .06135

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

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

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value
01/01/2021-12/31/2021	**Baseline**	~~5655~~ 6050	~~8138~~ 8737	~~69.49%~~ 69.25%	N/A for baseline	NA
01/01/2023–12/31/2023	**Remeasurement 1**	~~6084~~ 5649	~~9665~~ 8968	~~62.95%~~ 62.99%	≥69.25%	Two-proportions z-test comparing Baseline to Remeasurement 1: P-value = .0000
01/01/2024–12/31/2024	**Remeasurement 2**	4874	7450	65.42%	≥69.25%	Two-proportions z-test comparing Baseline to Remeasurement 2: P-value = .0000

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Baseline Narrative:

Baseline data was obtained for CY2021. The data was drawn from MMBPIS Indicator 3 data with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity, and the Black/African American and White individuals were chosen for further analysis. A numerator and denominator (see Step 5) were obtained for each racial/ethnic group, and the rate was calculated by dividing the numerator by the denominator.

Fisher's Exact Test was performed to determine if the black/African American minority group had a statistically significantly (p-value < 0.05) lower rate than the white (index) population. A 95% confidence interval and margin of error was also calculated for each group (Table 2). The

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

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- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

black group (95% CI: ~~62.46, 67.62~~ 62.05%, 67.31%) had a statistically significantly lower rate than the white group (95% CI: ~~68.48, 70.49~~ 68.28%, 70.22%) with p-value = ~~0.0015~~ 0.00145.

Race/Ethnicity	Numerator	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper
Black/African American	~~852~~ 837	~~1310~~ 1294	~~65.04%~~ 64.68%	~~2.58%~~ 2.63%	~~62.46%~~ 62.05%	~~67.62%~~ 67.31%

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

White	~~5655~~ 6050	~~8138~~ 8737	~~69.49%~~ 69.25%	~~1.00%~~ .97%	~~68.48%~~ 68.28%	~~70.49%~~ 70.22%

The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period in CY2023 and CY2024 to determine if the intervention strategies were a success.

The following factors may affect the validity of the baseline and future remeasurement findings:

- Individuals who were unsure about their race/ethnicity or did not understand the question, and as a result, marked the incorrect category. It is likely, however, that these were not factors for most individuals and will not greatly impact the results.

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

- The termination of the public health emergency (PHE). Currently under the public health emergency (PHE) MDHHS has issued MSA Bulletins that suspend Medicaid disenrollment and incorporate telehealth services into the service array available. Once the PHE ends, a specific period of time is allotted to account for any changes to state policy. It is unknown at this time when the PHE will end. After such time, Michigan must initiate Medicaid renewals over a 12-month unwinding period. The impact is unknown at this time and will be assessed once the PHE has ended. The PHE expired at the end of the day May 11, 2023. Michigan has begun the unwinding phase. Medicaid policies have been developed to "unwind" policies that were implemented during the pandemic. Table 1 identifies specific action and policies that are impacted.
- Potential changes in utilization of telehealth services from CY2021 to CY2023.
- Modifications by MDHHS to the specification documents currently used to support the project may affect the data.

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

MDHHS combined the race and ethnicity fields within the 834, therefore a manual process was used to accurately obtain the race and ethnicity information.

The factors identified will be assessed. Processes will be put in place to ensure minimal, if any, impact on the data used for the project. Table 1 provides an outline of the potential impact from policy changes.

Table 1: MDHHS Policy Impact Analysis Grid

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
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PHE Temporary Bulletin	PHE Unwind Policy Action	Impact on Project
MSA 20-36	Bulletin to clarify temporary policies/procedures. MSA 20-36 includes bulletins listed below.	See below
MSA 20-12	MMP 23-17	No direct impact on this project
MSA 20-13	MMP 23-10 (Attachment 3h)	Telemedicine utilization (include summary of trends)
MSA20-14	MMP 22-40	No direct impact on this project

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MSA 20-16	MMP 23-34	No direct impact on this project
MSA 20-17	MMP 20-41	No direct impact on this project
MSA 20-18	MMP 23-27	No direct impact on this project
MSA 20-19	MMP 23-30	Direct impact on number of enrollees whose data has been included within the baseline data.
L 20-20	L 23-31	No direct impact on this project
MSA 20-28	MMP 22-38	Direct impact on number of enrolled providers and individuals qualified who are available to provide services.

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MSA 20-12	MMP 23-20 (Attachment 3j)	Direct impact on the number of those who have completed an assessment and consented to additional treatment through verbal communication.

Attachment 3a MSA 20-36
Attachment 3b MSA 20-19
Attachment 3c MSA 20-13
Attachment 3f MSA 20-28
Attachment 3g MSA 20-12

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Attachment 7a MDHHS PHE Unwind Policy Crosswalk
Attachment 7b Final Bulletin MMP 22-38
Attachment 7c Final Bulletin MMP 23-10
Attachment 7d Final Bulletin MMP 23-20
Attachment 7e Final Bulletin MMP 23-30
No other factors or Medicaid policy bulletins that might threaten the comparability of the measurement periods or validity of the project were identified for CY24/Remeasurement 2.

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Baseline to Remeasurement 1 Narrative: Remeasurement data was obtained for CY2023. The data was drawn from MMBPIS Indicator 3 data with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity, and the Black/African American and White individuals for further analysis. A numerator and denominator (see Step 5) were obtained for each racial/ethnic group, and the rate was calculated by dividing the numerator by the denominator.

A two-proportions z-test was used to compare the disparate population (Black /African American) baseline rate to the disparate population remeasurement 1 rate resulting in a P-value = ~~.0041~~ 0.01329. The P-value of ~~.0041~~ 0.01329 indicates the gap between the disparate population rate in 2023 and 2021 is statistically significant. The two-proportions z-test was used to compare index (white) population baseline rate to the

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index (white) population remeasurement 1 (CY23) rate resulting in a P-value = .0000. The P-value of .0000 indicates the gap between the index (white) population rate in 2023 and 2021 is statistically significant.

The R code provided in Figure 6 was used to calculate the p-value for the disparate population group (black) in remeasurement 1 (CY23) to the index population group (white) in remeasurement 1 (CY23). The white rate ~~62.94%~~ 62.99% was compared to the black rate ~~59.7%~~ 59.96% with a P-value of ~~.0169~~ 0.03297 indicating the gap between the disparity is statistically significant and has not been eliminated. The R code using probability testing was used to recalculate the Baseline.

Baseline to Remeasurement 2 Narrative: TBD Solutions was contracted by Mid-State Health Network in CY2024 to develop a more efficient, accurate data collection and analysis process. TBD's expertise was essential to expand the rigor of the data analysis completed for

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this PIP and to implement advanced statistical modeling to identify statistical significance of interventions attempted. As indicated in previous data tables, there were slight changes in numerators and denominators for the Baseline measurement period as well as Remeasurement 1; these changes can be attributed to several key factors. First, specification clarification and data reconciliation occurred where TBD refined the technical approach and reconciled numerator/denominator logic with MDHHS and 834 eligibility files, as a result of this, there was greater alignment with population definitions and race categorization. In addition, MDHHS' combination of race and ethnicity fields within the 834-file required manual intervention previously; with updates to SQL queries made, there is now greater data accuracy and stratification by race for inclusion within the numerators and denominators. Overall, the evolution of the data collection and analysis has resulted in more rigorous

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data validation, refined technical methods, and reconciliation of accurate information across multiple data sources. These changes ultimately enhanced the validity of the measurement process and the integrity of findings reported for remeasurement periods against the baseline.

Remeasurement data was obtained for CY2024- the data was drawn from MMBPIS Indicator 3 data with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity, and the Black/African American and White individuals for further analysis. A numerator and denominator (see Step 5) were obtained for each racial/ethnic group, and the rate was calculated by dividing the numerator by the denominator.

A two-proportions z-test was used to compare the disparate population (Black /African American) baseline rate to the disparate population remeasurement 2 rate resulting in a P-value = .06135. The P-value of .06135 indicates the gap between the disparate population rate in 2024

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and 2021 is not statistically significant; this reduction, though undesirable indicates a modest but unstable decline. The two-proportions z-test was used to compare index (white) population baseline rate to the index (white) population remeasurement 2 (CY24) rate resulting in a P-value = .0000. The P-value of .0000 indicates the gap between the index (white) population rate in 2024 and 2021 is statistically significant; this signals a broader system-wide issue in timely service access across racial groups.

The R code provided in Figure 6 was used to calculate the p-value for the disparate population group (black) in remeasurement 2 (CY24) to the index population group (white) in remeasurement 2 (CY24). The white rate 65.42% was compared to the black rate 61.04% with a P-value of .00274 indicating the gap between the disparity is statistically significant and has not been eliminated.

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Table 2. Statistical significance for the disparity rate

Time Period	Indicator Measurement	Disparate Population Group (Black) Rate	Index Population Group (White) Rate	Goal/Target	Statistical Test, Statistical Significan and *p* Value
01/01/2021-12/31/2021	Baseline	~~65.04%~~ 64.68%	~~69.49%~~ 69.25%	p-value <0.0500	Probability Test p-value = ~~0.0014~~ .00108

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01/01/2023–12/31/2023	Remeasurement 1	~~59.63%~~ 59.96%	62.99%	p-value <0.0500	Probability Test p-value = ~~.0169~~ 0.03297	
01/01/2024 - 12/31/2024	Remeasurement 2	61.04%	65.42%	p-value <0.0500	Probability Test p-value = 0.00274	

The pre-intervention period CY2021 had better compliance than the post-intervention period CY2023. When analyzing the demographic influences on compliance, a few trends emerge. The most significant trend is that the mental illness (MI) population is significantly less likely to be compliant with a difference of about 46.40% compared to those with developmental disabilities (DD) ($p < 0.001$). In addition, age had a significant effect on compliance. When compared to the adult population, children were about 13.93% ($p < 0.001$) less likely to be compliant,

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and teens were about 11.87% (p = 0.001) less likely to be compliant. Race also played a role in compliance, with black individuals being less likely to be compliant than white individuals by about 9.06% (p = 0.045).

The following factors may affect the validity of the baseline and future remeasurement findings:

- Individuals who were unsure about their race/ethnicity or did not understand the question, and as a result, marked the incorrect category. It is likely, however, that these were not factors for most individuals and will not greatly impact the results. The PIHP has minimal impact on the ability to decrease the number of unknowns due to the data source used by MDHHS for this information. An assessment comparison of the data in the 834 and the Behavioral Health Treatment Episode Data System will be completed to identify any significant discrepancies.

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- The Public Health Emergency expired at the end of the day May 11, 2023. Michigan has begun the unwinding phase. Medicaid policies have been developed to "unwind" policies that were implemented during the pandemic. Table 1 identifies specific action and policies that were impacted.
- Changes in allowance of telehealth services from CY2021 to CY2024:
  The use of telehealth services decreased from 39 unique services provided in Jan-May 2021, to 32 unique services provided in Jan-May 2023 (Appendix A figure 1). This is about an 18% decrease in services offered between Jan-May 2021 and Jan-May 2023 (Appendix A figure 1). Telehealth service codes remained consistent between CY2023 and CY2024 at 32 unique services.

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- Modifications by MDHHS to the specification documents currently used to support the project may affect the data. Attachment 2 PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20 updated to the FY25 MMBPIS Codebook. There were no changes that would impact data collection.
- The Certified Community Behavioral Health Home was implemented in October 2021. The CCBHC population includes individuals with mild to moderate illnesses. Individuals enrolled in CCBHC are included in the MMBPIS data set. In comparing compliance for CCBHC clients versus non-CCBHC clients, the CCBHC clients had lower compliance in 2021 with 62%, in 2023 with 63%, and in 2024 at 61%. Non-CCBHC clients had higher compliance in 2021 with 71%, in 2023 with 65%, and in 2024 with 69%. The highest compliance group is the clients that are non-CCBHC and DD; they had a compliance rate of 77% in 2021, 79% in 2023, and 80% in 2024 (Appendix A figure 2). In conducting a multi-method approach to analyze non-compliance factors utilizing Bayesian Hierarchical

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Logistical Regression, in FY24, CCBHC clients experience slightly more delays, though this effect is small and marginally significant. CCBHC status alone does not appear to be a major driver of service delays for this project.

- MDHHS combined the race and ethnicity fields within the 834, therefore a manual process was used to accurately obtain the race and ethnicity information.
- The Network Adequacy Assessment assesses MSHN's provider network in comparison to the MDHHS established adequacy standards. In FY23, two programs (Home-Based and Wraparound) designed for children and families who experience severe emotional disturbance did not meet the adequacy standards. MDHHS Home-Based service standard ratio is 2,000:1 Medicaid Enrollees to Providers- MSHN's FY23 Ratio: 567,553 Total Children Medicaid Enrollees to 151.85 Providers, which is under the required ratio of 283.78 FTEs. In FY24, MSHN's Ratio: 328,455 Total Children Medicaid Enrollees to 164.33 Providers, which met the required ratio

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of 164.23 FTEs. For Wraparound services, MDHHS has an established adequacy standard ratio of 5,000:1 Enrollees to Providers-MSHN's FY23 Ratio: 567,553 Total Children Medicaid Enrollees to 34.3 FTEs, which did not meet the required ratio. In FY24, MSHN's Ratio: 328,455 Total Children Medicaid Enrollees to 46.8 FTEs did not meet the required ratios, however, when looking at the total average Medicaid enrollees for children, MSHN would however meet the ratio and be in compliance with the standard.

Table 3. MDHHS Policy Impact Analysis Grid

PHE Temporary Bulletin	PHE Unwind Policy Action	Impact on Project

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- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

MSA 20-13	MMP 23-10 (Attachment 7c)	Potential impact. See Appendix A Figure 1 ~~and Figure 3~~.
MSA 20-19	MMP 23-30 (Attachment 7e)	Direct impact on number of enrollees whose data has been included within the baseline data. No direct impact. See Appendix A. Figures 4 and 5.
MSA 20-28	MMP 22-38 (Attachment 7b)	No Direct Impact
MSA 20-12	MMP 23-20 (Attachment 7d)	Direct impact on the number of those who are allowed to receive a "face to face" service versus a required "in person" service. See Appendix A Figure 1 ~~and Figure 3~~.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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Quality Improvement Team and Activities Narrative Description: Under the measurement period placeholder below corresponding to the most recent completed measurement period, add a description of the quality improvement team members, the causal/barrier analysis process, and quality improvement tools used to identify and prioritize barriers for each measurement period below.

Baseline Narrative: The QI Team consists of the MSHN regional Quality Improvement Council, representatives from the Regional Equity Advisory Committee for Health (REACH), representatives from the MSHN regional Clinical Leadership Committee, the MSHN Integrated Healthcare Coordinator, the Technology Project Manager, and the Reports/ Data Coordinator. The fishbone diagram was used to identify barriers. Brainstorming was used to identify potential interventions. The interventions were prioritized based on the potential impact to the affected communities, strategic planning timeline, and available resources. MSHN has 21 counties within the region. Due to the variability of the communities and populations within the 21-county catchment area, interventions are identified, implemented, and evaluated to ensure the barrier has been effectively addressed and the expected outcome has been achieved within the corresponding community.

Attachment 8 Fishbone Diagram PIP 1 Access-Reduction/Elimination of Racial Disparities

Remeasurement 1 Narrative: The QI Team consists of the MSHN regional Quality Improvement Council, representatives from the Regional Equity Advisory Committee for Health (REACH), representatives from the MSHN regional Clinical Leadership Committee, the MSHN Integrated Healthcare Coordinator, the Technology Project Manager, and the Reports/Data Coordinator. Additional team members added in

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FY24 include consultants from TBD Solutions LLC. Brainstorming was used to review the fishbone diagram developed for CY21. Updates to the fishbone included revised key areas and new barriers. Once the barriers were identified an impact analysis was completed to identify what barriers had the greatest impact on the outcome. A driver diagram was completed to categorize the key drivers linking them to corresponding interventions. Interventions were prioritized based on those that were expected to impact the largest number of individuals within the denominator, thereby achieving the desired outcome.

MSHN is made up of 21 counties and twelve Community Mental Health Service Programs. All CMHSP participants engage in interventions to improve access to services. Approximately 85% of new individuals included in the black/African American population and have received an assessment belong to three CMHSP participants (6 counties) which include CEI, SCCMHA, and Lifeways. The remaining 15% is split between nine CMHSP participants (15 counties). Interventions developed were primarily focused on the barriers where the majority (85%) of the Black/African American population reside. Additional data analysis was completed to identify trends and focus areas about those that did not receive an assessment within the 14 days as required.

The data calculated for remeasurement period, CY2023, was compared to data collected in the Baseline measurement period, CY2021, to determine if the intervention strategies were a success.

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In addition to the focus on reducing the disparity, an additional focus on increasing the rate will be applied for the next measurement period to address the decrease in the Index (White) rate.

Attachment 8: Fishbone Diagram Reduction / Elimination of Racial Disparities
Fishbone Diagram Access

Remeasurement 2 Narrative: Mid-State Health Network (MSHN) encompasses 21 counties and 12 Community Mental Health Service Programs (CMHSPs). In Calendar Year 2024, approximately 85% of new Black/African American individuals who received an assessment were served by just three CMHSPs: CEI, SCCMHA, and Lifeways (covering six counties). The remaining 15% were served by the other nine CMHSPs (covering 15 counties). As a result, interventions were primarily targeted toward addressing barriers within the areas serving the majority of this population, and system wide interventions were not a focus, rather, provider interventions to impact change were for this project. Further data analysis was conducted to identify trends and areas of concern related to individuals who did not receive an assessment within the required 14-day period.

During the CY2024 remeasurement period, MSHN continued to implement a comprehensive, data-informed quality improvement approach through the Quality Improvement Council (QIC). Additional support and advanced analytic consultation were provided by contractor, TBD

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Solutions. Key quality improvement tools included an expanded Fishbone Diagram—updated in partnership with QIC participants—and a region-wide 5 WHYs analysis exercise to explore the root causes behind identified barriers, particularly those affecting the Black/African American population. These tools led to the prioritization of several provider-level interventions. Intervention planning and prioritization were based on impact analysis, focusing on strategies expected to affect the greatest number of individuals within the denominator, and reviewing what, if any, interventions were statistically significant and demonstrated positive improvements.

The QIC monitored intervention effectiveness through CMHSP-level evaluation tools and regional tracking mechanisms. Interventions that demonstrate effectiveness within the CMHSPs are being institutionalized, while others are still under ongoing evaluation or/or timeline adjustments for implementation. Through this structured and multi-tiered quality improvement process, MSHN remains committed to reducing racial disparities and ensuring equitable access to timely care across the region. Evaluation efforts will continue to track progress, refine strategies, and scale successful interventions to support sustained improvement.

For Remeasurement 2, advanced statistical analysis involving regression methods were conducted by TBD Solutions noting key takeaways and detailed findings (report located here: Why the Wait? Analyzing Delays in Timely Care). The advanced regression analyses were exploratory and utilized data from FY2024 (10/1/2023-9/30/2024), to identify patterns and inform future interventions as well as test past interventions. Compared to the baseline (CY2021), analysis of the demographic influences on compliance noted several trends within FY24. Across all CMHs,

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MI youth in early childhood (0-5) face significantly higher odds (OR = 1.91, 95% CI: 1.25–2.91), indicating a system-wide delay. Individuals utilizing telehealth services are 35% less likely to experience delays in care (OR = 0.65, 95% CI: 0.53 – 0.79). This finding reinforces telehealth as a highly effective tool for improving access and suggests that expanding remote care options could further reduce service delays. Individuals with mild-to-moderate conditions are 16% less likely to experience delays than those with more severe needs (OR = 0.84, 95% CI: 0.71 – 0.99). This effect is on the margins of statistical significance, suggesting that individuals with lower-intensity needs may experience fewer scheduling barriers. Clients assessed close to holidays face 15.7% higher odds of non-compliance (OR = 1.16, 95% CI: 1.05 – 1.27). This finding highlights the need for proactive scheduling adjustments or increased provider availability during major holiday periods to mitigate access barriers. Compared to White clients, Black/African American individuals have 16% higher odds of missing the service window (OR = 1.16, 95% CI: 1.03 – 1.32).

Attachment 8a: PIP #1 Revised Fishbone
Attachment 8b: QIC 5 WHY'S Exercise for PIP
Attachment 8c: Performance Improvement Project Data Collection-Interventions Summary

Barriers/Interventions Table: In the table below, report prioritized barriers, corresponding interventions, and intervention details (initiation date, current status, and type.

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Table 4. Barrier/Intervention Table

Barrier Priority Ranking	Barrier Description	Intervention Initiation Date (MM/YY)	Intervention Description	Select Current Intervention Status	Select if Member, Provider, or System Intervention
NA	Lack of insight into what resources and community partners are available to address disparities.	10/1/2023	• Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community	Discontinued	Provider Intervention
NA		10/1/2023	• Conduct assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity	Discontinued	Provider Intervention

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NA	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in limited available appointments within 14 days.	12/31/2022	• Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests	Discontinued	System
1	**No shows-lack of appointment follow up**	10/1/2024	• Implement appointment reminder system completed by a staff person/peer/system process • Implement/modify process for coordination between providers (warm hand off)	Continued Continued	Provider Intervention Provider Intervention
		8/31/2024	• Implement Teach back method for coordination including resolution of barriers (specifically related to race and ethnicity)	New	Provider Intervention

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2	**Workforce shortage-Lack of qualified - culturally competent clinicians resulting in limited available appointments within 14 days**	10/1/2022	• Recruitment 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
		10/1/2024	• Utilize financial incentives/scholarships to obtain/retain adequate staffing	New	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.)	Continued	Provider Intervention
		8/1/2024	• Distribute CMHSP informational materials to individuals through identified	Continued	Provider Intervention

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			partner organizations within communities of color		
4	**Ratio established by MDHHS for Wrap-around and Homebased Services staffing not met**	CY26	• Develop action steps to increase network adequacy for children services	Discontinued due to implementation timeframe being outside of duration of PIP	Provider Intervention
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	Discontinued due to implementation timeframe being outside of duration of PIP	System Intervention

Intervention Evaluation Table: In the table below, list each intervention that was included in the Barriers/Interventions Table, above. For each intervention, document the processes and measures used to evaluate effectiveness, the evaluation results, and next steps taken in response to the

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evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.

Attachment 9. CMHSP Evaluation Table

Table 5. Intervention Evaluation Table

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps
CY24	Increase the workforce through recruitment of student interns and recent graduates from colleges and universities with diverse student populations, and external contractors to provide services.	Identify CMHSPs who have utilized interns, and external contractors, and what methods were used for obtaining/retaining additional staff. An analysis was completed to determine if additional staff were obtained and if the rate of "no appointments available" within the required 14 days had decreased. The CMHSPs that	The rate of appointments scheduled outside of 14 days due to "no available appointment" increased for the region from baseline to future remeasurement periods: • CY21Q4 – 6.35%	Continue with regional tracking to include required elements to adequately assess the effectiveness of this intervention (elements of this tracking include: specific intervention, date of implementation, and the outcome of the evaluation).

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		demonstrated a decrease would provide the methods used for successfully obtaining staff to address the workforce shortage. In addition, in CY24, a full evaluation of CMHSP PIP interventions was completed by evaluating causal strength; statistical analysis was conducted to determine impact on compliance using logistical regression.	• CY23 – 13.57% • CY24 – 11.70% For baseline period to remeasurement 2 (CY2024), two of the CMHSPs were successful in obtaining additional staff and decreasing the rate of "no appointments available". Four of the CMHSPs were able to maintain no change between baseline and remeasurement periods with established interventions.	

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CY23-CY24	Implement appointment reminder system.	Identify CMHSPs who have implemented an appointment reminder system and assess if the number of no shows has decreased.	Regionally, there has been a positive change overall from baseline for no shows when compared to remeasurement periods: • CY21 - 33.79% • CY23 - 29.86% • CY24 - 33.35% Those who initiated phone call/text reminders by staff or peers demonstrated a higher compliance rate overall. In total, eight of the ten CMHSPs who implemented this intervention had reduced no shows in	Continue regional tracking to monitor progress to ensure improvement is sustained. Tracking elements includes fields to adequately assess the effectiveness of this intervention (elements of this tracking include specific intervention, date of implementation, and the outcome of the evaluation).

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			remeasurement 2 compared to Baseline.	
CY23	Implement/modify process for coordination between providers (warm hand off)	Identify those CMHSPs who have implemented or modified a coordination process between providers who complete the assessment and those who provide treatment and assess if the attendance for 1st service appointments has increased.	Regionally, the percentage of compliance for attendance for 1st service appointments has decreased over this project: • CY21 - 68.39% • CY23 - 62.52% • CY24 - 65.55% Eight out of twelve of the CMHSPs implemented a modified coordination process in CY23/CY24. In reviewing these eight	Continue with regional tracking to include required elements to adequately assess the effectiveness of this intervention (elements of this tracking include specific intervention, date of implementation, and the outcome of the evaluation). If PIP continues into CY2025, additional tracking will be implemented for those using the Teach Back method for reminder phone calls to determine effectiveness of this method.

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			CMHSPs, two had increases in compliance when compared to baseline measurement.	
CY24	Implement Teach back method for coordination including resolution of barriers (specifically related to race and ethnicity)	Identify those CMHSPs that have implemented the Teach Back method for coordination and demonstrated a decrease in the disparity.	Only one CMHSP out of twelve (CEI) began the Teach Back method in CY24. In reviewing this CMH, there was a reduction in the disparity from baseline to remeasurement period 2.	Continue with regional tracking to include required elements to adequately assess the effectiveness of this intervention (elements of this tracking include specific intervention, date of implementation, and the outcome of the evaluation). If PIP continues into CY2025, additional tracking will be implemented for those using the Teach Back method for reminder phone calls to determine effectiveness of this method.

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CY 24	Utilize financial incentives to obtain/retain adequate staffing.	Identify CMHSPs who have implemented financial incentives for obtaining/retaining additional staff. The CMHSPs that demonstrated a decrease of "no appointments available" would provide the methods used for successfully obtaining staff to address workforce shortages.	The rate of appointments scheduled outside of 14 days due to "no available appointment" increased for the region from baseline to future remeasurement periods: • CY21Q4 – 6.35% • CY23 – 13.57% • CY24 – 11.70% There were no CMHSPs that successfully implemented additional financial incentives in CY24 for obtaining/retaining staff	Discontinue due to ongoing financial difficulties of the system.

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			due to the financial difficulties of the system.	
CY24	Identify and engage with partner organizations that predominantly serve communities of color. (examples: faith-based/religious groups, community recreation centers, tribal organizations, etc.)	Identify those CMHSPs that have engaged with partner organization have demonstrated a decrease in the disparity.	Four out of 12 CMHSPs engaged with partner organizations in CY2024 (Tuscola, Newaygo, CEI, and Saginaw). Regionally, the percentage of compliance for attendance for 1st service appointments has decreased over this project: • CY21 - 68.39% • CY23 - 62.52% • CY24 - 65.55%	Continue with regional tracking to include required elements to adequately assess the effectiveness of this intervention (elements of this tracking include specific intervention, date of implementation, and the outcome of the evaluation).

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			In reviewing the rates of disparity at baseline, two of the CMHSPs had positive impacts (Tuscola and CEI) on their rates of disparity overall.	
CY24	Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	Identify those CMHSPs that have distributed materials through partner organizations within communities of color have had an increase in the number of Black/African American that have completed an assessment	Four out of twelve CMHSPs distributed material to partner organizations to increase overall engagement (Tuscola, Shiawassee, The Right Door, and CEI). Regionally, the percentage of compliance for attendance for 1st service appointments has	Continue with regional tracking to include required elements to adequately assess the effectiveness of this intervention (elements of this tracking include specific intervention, date of implementation, and the outcome of the evaluation).

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			decreased over this project: • CY21 - 68.39% • CY23 - 62.52% • CY24 - 65.55% In reviewing the rates of disparity at baseline, two of the CMHSPs had positive impacts (Tuscola and CEI) on their rates of disparity overall.	
CY24	Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community.	CMHSPs that have communities of color will have developed a collaborative group to address disparities	Community partners and resources have been identified through various assessment methods	Completed/Discontinue

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	Conduct assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity.		within the local CMHSP communities.	
CY24	Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.	Cultural competency requests will be defined, with a process to collect the requests, and types of requests will be identified.	MSHN re-evaluated the process for assessing cultural competency and determined that this intervention should be discontinued. Each CMHSP has a process in place through their community needs assessment, and training to address cultural needs.	Discontinue

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CY26	Develop action steps to increase network adequacy for children services.	NA	Discontinued due to implementation timeframe being outside of duration of PIP	Discontinue
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.	NA	Discontinued due to implementation timeframe being outside of duration of PIP	Discontinue

HSAG PIP TA May 14, 2024, indicated that clinical or programmatic improvement was removed from the Protocol and will not be evaluated.

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Clinical and Programmatic Improvement Table: In the table below, describe any clinical and/or programmatic improvement that was achieved at any remeasurement period during the PIP. Specify each remeasurement period when improvement was obtained and the intervention(s) that led to the improvement. Provide intervention evaluation results in the *Supporting Quantitative or Qualitative Data* column.

Clinical Improvement		
Remeasurement Period	**Narrative Summary of Clinical Improvement**	**Supporting Quantitative or Qualitative Data**
Programmatic Improvement		
Remeasurement Period	**Narrative Summary of Programmatic Improvement**	**Supporting Quantitative or Qualitative Data**

Appendix A

Figure 1

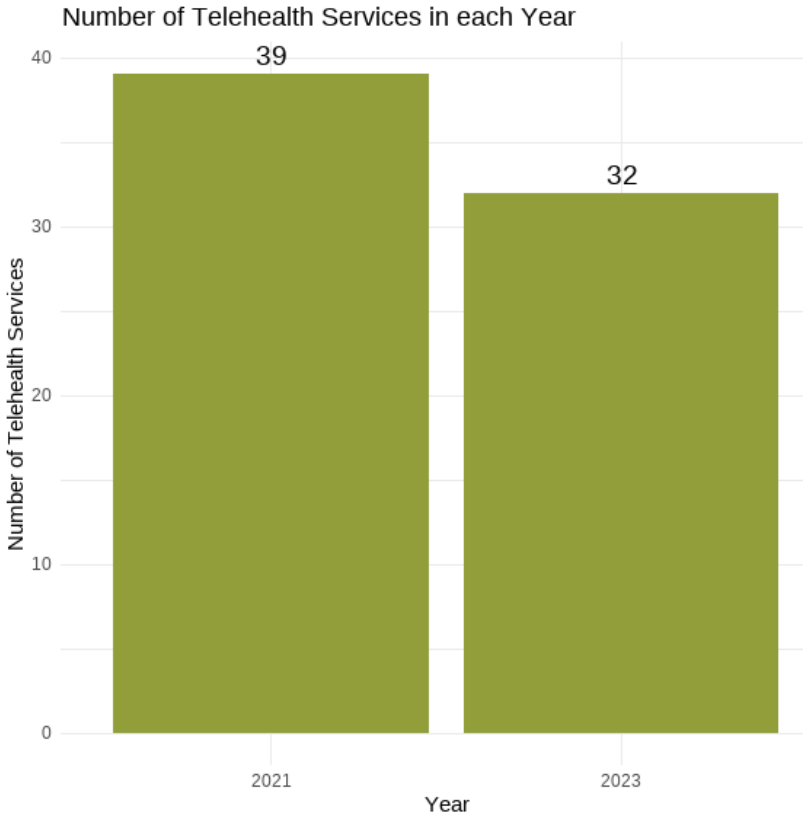
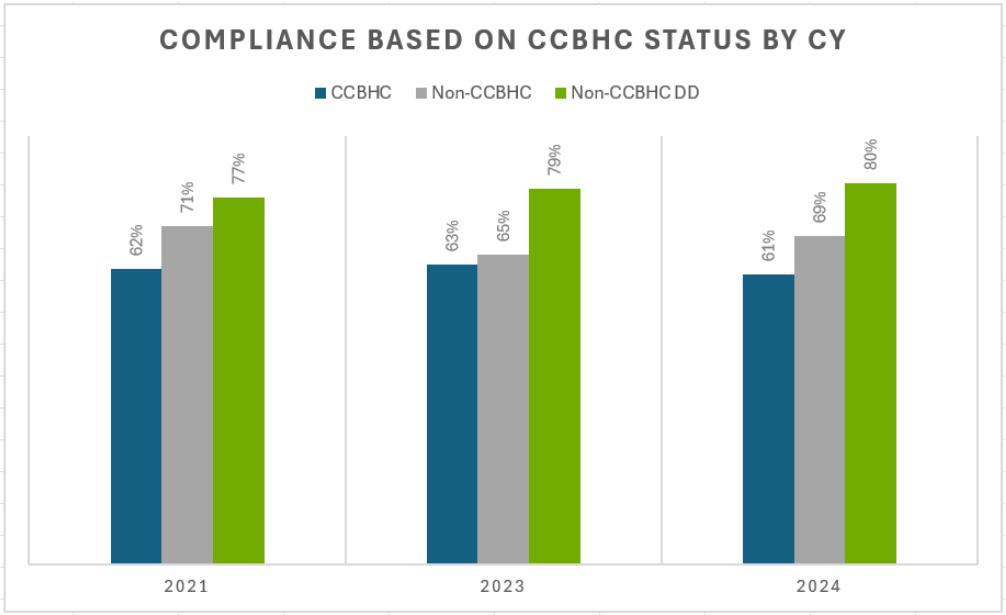


Figure 2


COMPLIANCE BASED ON CCBHC STATUS BY CY
CCBHC
Non-CCBHC
Non-CCBHC DD
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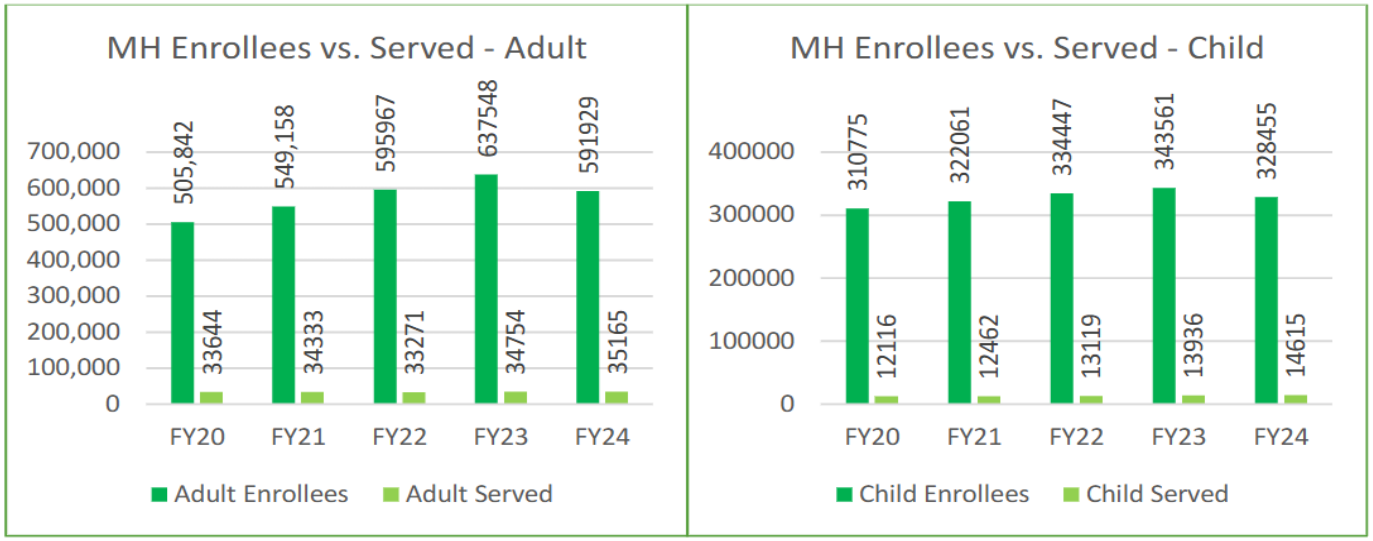
71%
77%
63%
65%
79%
61%
69%
80%
2021
2023
2024

Figure 3


MH Enrollees vs. Served - Adult
700,000
600,000
500,000
400,000
300,000
200,000
100,000
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549,158
34333
595967
33271
637548
34754
591929
35165
FY20
FY21
FY22
FY23
FY24
Adult Enrollees
Adult Served
MH Enrollees vs. Served - Child
400000
300000
200000
100000
0
310775
12116
322061
12462
334447
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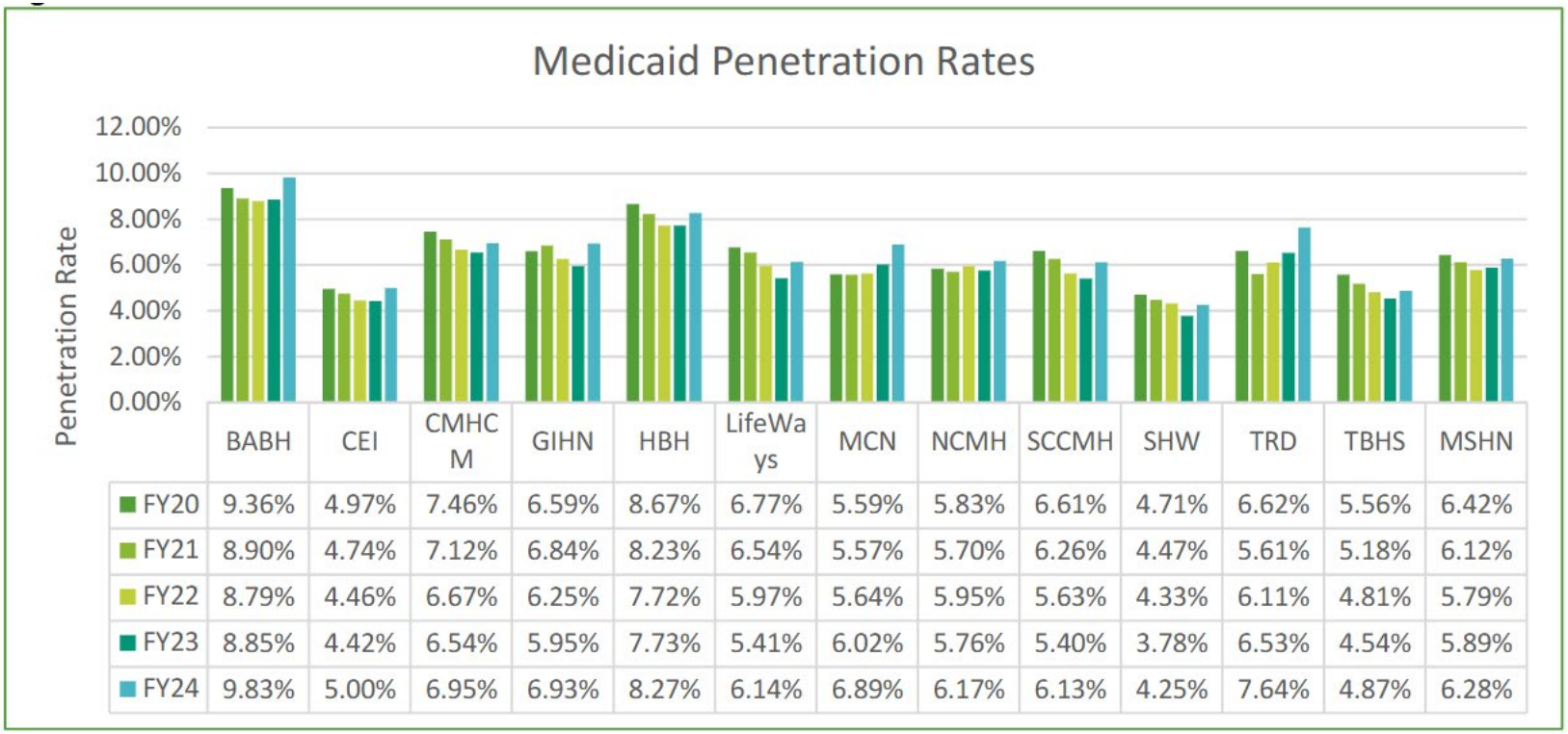
FY20
FY21
FY22
FY23
FY24
Child Enrollees
Child Served

Figure 4



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%
FY22	8.79%	4.46%	6.67%	6.25%	7.72%	5.97%	5.64%	5.95%	5.63%	4.33%	6.11%	4.81%	5.79%
FY23	8.85%	4.42%	6.54%	5.95%	7.73%	5.41%	6.02%	5.76%	5.40%	3.78%	6.53%	4.54%	5.89%
FY24	9.83%	5.00%	6.95%	6.93%	8.27%	6.14%	6.89%	6.17%	6.13%	4.25%	7.64%	4.87%	6.28%

Figure 5

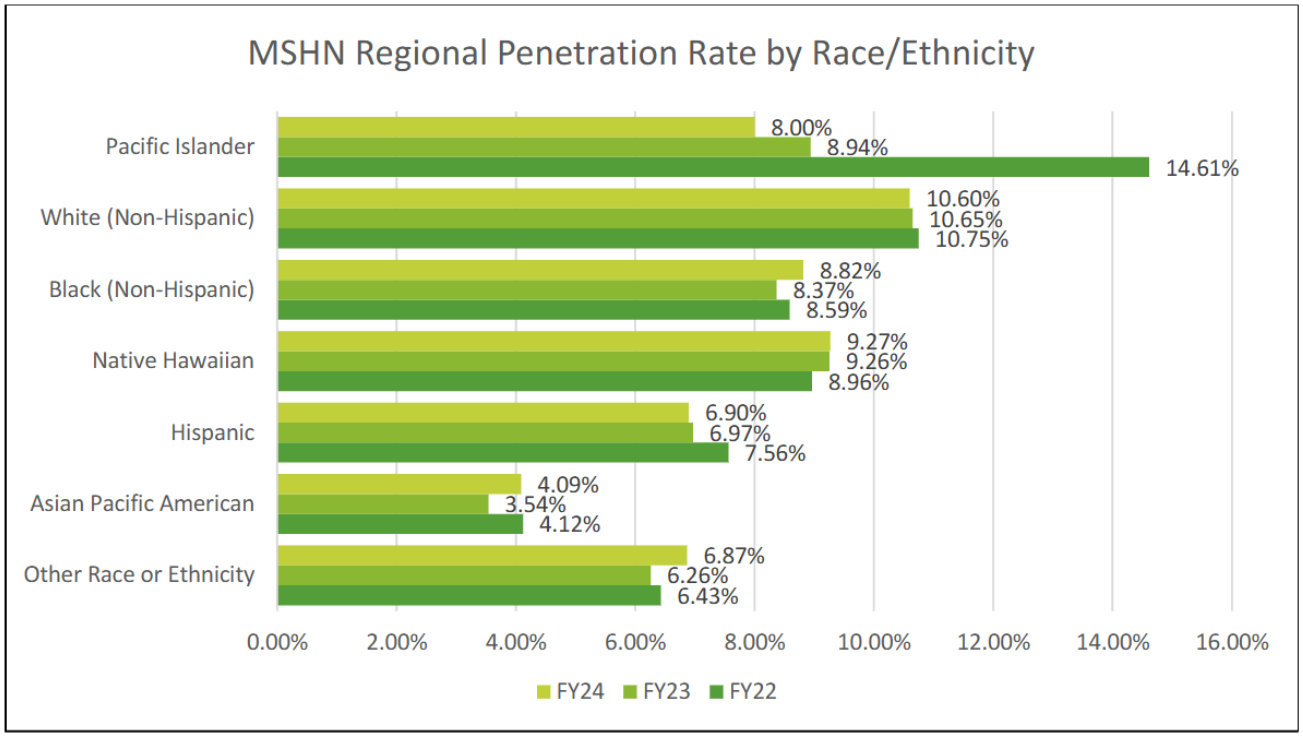

MSHN Regional Penetration Rate by Race/Ethnicity
Pacific Islander
8.00%
8.94%
14.61%
White (Non-Hispanic)
10.60%
10.65%
10.75%
Black (Non-Hispanic)
8.82%
8.37%
8.59%
Native Hawaiian
9.27%
9.26%
8.96%
Hispanic
6.90%
6.97%
7.56%
Asian Pacific American
4.09%
3.54%
4.12%
Other Race or Ethnicity
6.87%
6.26%
6.43%
0.00% 2.00% 4.00% 6.00% 8.00% 10.00% 12.00% 14.00% 16.00%
FY24 FY23 FY22

Figure 6

```
#-----------------------------------#
# Indicator 1
# Black Population
#-----------------------------------#

baseline_numerator <- 837
baseline_denominator <- 1294

remeasurement_1_numerator <- 822
remeasurement_1_denominator <- 1371

remeasurement_2_numerator <- 777
remeasurement_2_denominator <- 1273

r1_successes <- c(baseline_numerator, remeasurement_1_numerator)
r1_totals <- c(baseline_denominator, remeasurement_1_denominator)

r1_result <- prop.test(r1_successes, r1_totals)

print(r1_result)

r2_successes <- c(baseline_numerator, remeasurement_2_numerator)
r2_totals <- c(baseline_denominator, remeasurement_2_denominator)

r2_result <- prop.test(r2_successes, r2_totals)

print(r2_result)

#-----------------------------------#
# Indicator 2
# White Population
#-----------------------------------#

baseline_numerator <- 6050
baseline_denominator <- 8737

remeasurement_1_numerator <- 5649
remeasurement_1_denominator <- 8968

remeasurement_2_numerator <- 4874
remeasurement_2_denominator <- 7450

  r1_successes <- c(baseline_numerator, remeasurement_1_numerator)
r1_totals <- c(baseline_denominator, remeasurement_1_denominator)

r1_result <- prop.test(r1_successes, r1_totals)

print(r1_result)

r2_successes <- c(baseline_numerator, remeasurement_2_numerator)
r2_totals <- c(baseline_denominator, remeasurement_2_denominator)

r2_result <- prop.test(r2_successes, r2_totals)

print(r2_result)
```

```
#-----------------------------------#
# Indicator 3
# White Compared to Black Population
#-----------------------------------#

black_baseline_numerator <- 837
black_baseline_denominator <- 1294

white_baseline_numerator <- 6050
white_baseline_denominator <- 8737

black_r1_numerator <- 822
black_r1_denominator <- 1371

white_r1_numerator <- 5649
white_r1_denominator <- 8968

black_r2_numerator <- 777
black_r2_denominator <- 1273

white_r2_numerator <- 4874
white_r2_denominator <- 7450

baseline_successes <- c(black_baseline_numerator, white_baseline_numerator)
baseline_totals <- c(black_baseline_denominator, white_baseline_denominator)

baseline_result <- prop.test(baseline_successes, baseline_totals)

print(baseline_result)

r1_successes <- c(black_r1_numerator, white_r1_numerator)
r1_totals <- c(black_r1_denominator, white_r1_denominator)

r1_result <- prop.test(r1_successes, r1_totals)

print(r1_result)

r2_successes <- c(black_r2_numerator, white_r2_numerator)
r2_totals <- c(black_r2_denominator, white_r2_denominator)

r2_result <- prop.test(r2_successes, r2_totals)

print(r2_result)
```

Appendix B. PIP Validation Tool

The following contains the final PIP Validation Tool for **MSHN**.

Demographic Information			
PIHP Name:	Region 5 - Mid-State Health Network		
Project Leader Name:	Kara Laferty	**Title:**	Quality Manager
Telephone Number:	(517) 299-0750 x884	**Email Address:**	kara.laferty@midstatehealthnetwork.org
PIP Title:	*Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service*		
Submission Date:	July 25, 2025		
Resubmission Date:	*Not Applicable*		

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [N/A]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*N/A*	
2. Included the sample size for each indicator.	C*	*N/A*	
3. Included the margin of error and confidence level for each indicator.		*N/A*	
4. Described the method used to select the sample.		*N/A*	
5. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	5	2	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	1	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	8	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	6	3	*N/A (Not Applicable)*

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	**General Comment**: The PIHP should provide the rationale for the decline in performance as compared to the baseline.
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	
Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	**General Comment**: The PIHP included several intervention efforts occurring at the community mental health services program (CMHSP) level, the PIHP should also include efforts that will or have occurred at the plan level. This feedback was provided in the prior year's final validation tool.
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Met*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	

Results for Step 8			
Total Evaluation Elements**	**5**	**3**	**Critical Elements*****
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Results for Step 7 - 8			
Total Evaluation Elements	**8**	**4**	**Critical Elements**
Met	8	4	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Quality Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Met*	
2. The performance indicator(s) met the State-specific goal of eliminating the existing disparity without a decline in performance for the comparison group.		*Not Met*	The performance indicators did not achieve the state-specific goal.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline for the disparate population performance indicator.		*Not Met*	The disparate performance indicator did not demonstrate statistically significant improvement over the baseline.
4. Sustained statistically significant improvement over baseline performance for the disparate population performance indicator was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIHP had not progressed to being assessed for sustained improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	2	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Table B—1 SFY2025 PIP Validation Tool Scores for *Persons Who Have Received a Medically Necessary Ongoing Covered Service* for Region 5 - Mid-State Health Network										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *N/A***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *N/A***
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	1	0	2	0	1	1	0	0	0
Totals for All Steps	**26**	**17**	**0**	**2**	**6**	**13**	**10**	**0**	**0**	**3**

Table B—2 SFY2025 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Persons Who Have Received a Medically Necessary Ongoing Covered Service* for Region 5 - Mid-State Health Network	
Percentage Score of Evaluation Elements *Met* *	***100%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***High Confidence***

Table B—3 SFY2025 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Persons Who Have Received a Medically Necessary Ongoing Covered Service* for Region 5 - Mid-State Health Network	
Percentage Score of Evaluation Elements *Met* *	***33%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***No Confidence***

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.*
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the PIHP's PIP based on CMS EQR Protocol 1 and determined whether the PIHP produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	*High confidence* in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	*Moderate confidence* in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	*Low confidence* in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	*No confidence* in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the PIHP's PIP based on CMS EQR Protocol 1 and determined whether the PIHP produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance **and** there was no statistically significant difference between the disparate group and comparison group **and** without a decline in performance for the comparison group.
Moderate Confidence:	The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, there was a non-significant decline in performance for the comparison group. **Or** the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate group demonstrated statistically significant improvement over the baseline performance; however, there remains a statistically significant difference between the disparate group and the comparison group. **Or** the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline; however, there was no statistically significant difference between the disparate group and comparison group and the comparison group did not have a decline in performance.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was with no statistically significant difference between the disparate group and comparison group and without a decline in performance for the comparison group. **Or** the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate a statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a nonsignificant decline in performance. **Or** the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group, and without a decline in performance for the comparison group. **Or** the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group and there was a nonsignificant decline for the comparison group.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators. **Or** the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and the disparate performance indicator did not demonstrate statistically significant improvement over the baseline and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a significant decline in performance over the baseline. **Or** the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and there was a statistically significant difference between the disparate group and comparison group. **Or** the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was a statistically significant difference between the disparate group and comparison group.
Confidence Level for Significant Improvement:	***No Confidence***