MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2023

Prepared By: MSHN Quality Manager – 11/2023
Reviewed and Approved By: Quality Improvement Council – 12/2023
Reviewed By: MSHN Leadership – 12/20/2023
Reviewed By: MSHN Operations Council – 12/18/2023
Reviewed and Approved By: MSHN Board – 1/30/2024

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I. Introduction

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

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes a review of the components of the QAPIP to ensure alignment with the contract requirements, a review of the status of the QAPIP Workplan and impact on the desired outcome, and a committee/council annual review with accomplishments and goals for the upcoming year. The QAPIP Plan and associated QAPIP Work Plan was effective. Recommendations for the Annual QAPIP Plan, which includes a description of each activity and a work plan for the upcoming year, are included in the FY24 QAPIP Plan. The Board of Directors will receive the Annual QAPIP Report and approve the Annual QAPIP Plan for FY24. The measurement period for this annual QAPIP Evaluation is October 1, 2022, through September 30, 2023. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Performance Measurement and QAPIP Work Plan FY23 Review

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

a) Michigan Mission Based Performance Indicator System

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder

Providers are measuring performance through The Michigan Mission Based Performance Indicator System.

Goal: MSHN will meet or exceed the MMBPIS Standards for the indicators as required by MDHHS.

Status: MSHN completed the objectives of the workplan. As a result, an increase in the accuracy of the data reported was demonstrated through the HSAG Performance Measure Validation. Established processes will further improve data accuracy over the next year. Access to services demonstrated the most challenge due to the workforce shortage and decreased appointment availability.

Barriers were identified and interventions were implemented. Beginning in FY24 a standard was applied to Indicator 2 and 3. MSHN has implemented a performance improvement project to address the performance of Indicator 3. The QAPIP was effective.

Attachment 2 MMBPIS Summary Report FY23

Strategic Priority	Michigan Mission Based Performance Indicator System (MMBPIS)	Committee	FY22	FY23	Status/ Recommendation
Better Care	Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	97.75%	98.40%	Met/Continue
Better Care	Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	98.90%	99.45%	Met/Continue
Better Care	Indicator 2. a. The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	62.35%	59.72%	No Standard/ Continue
Better Care	Indicator 2. E. The percentage of new persons during the quarter receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorder.	QIC/SUD	73.91%	*75.25%	No Standard / Continue
Better Care	Indicator 3: The percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	62.44%	62.14%	No Standard/ Continue
Better Care	Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	97.36%	97.47%	Met/Continue
Better Care	Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	95.72%	96.64%	Met/Continue
Better Care	Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.34%	97.87%	Met/Continue
Better Care	Indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	4.04%	9.20%	Met/Continue
Better Care	Indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	10.24%	12.66%	Met/Continue

b) Performance Based Incentive Payment Measures

Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Data is currently available only through CY23Q1.

Attachment 3 FY23 Q2-Q3 Integrated Health Quarterly Report

Strategic Priority	Joint Metrics	Committee	CY22	CY23Q1	Status/ Recommendations
Better Care	J.2 a. The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report (Standard-58%) Data Source CC360	QIC	69.88%	70.92%	Met/Continue
Better Care	J.2 b. The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%) Data Source CC360	QIC	87.87%	86.34%	Met/Continue
Better Care	J.2 c. Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	QIC	0	Not Available	Continue
Better Care	J.3 a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	43.25%	44.26%	Met/Continue
Better Care	J.3 b. Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	UMC	2*	Not Available	Continue

The Certified Community Behavior Health Clinics review data quarterly to identify any areas of improvement needed and to share best practice with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures. MDHHS has provided the finalized performance data for FY22. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect 260 to monitor performance throughout the year. The data in the table below is obtained from ICDP and has not been finalized by MDHHS.

CCBHC Quality Bonus Payments	Committee	FY22	FY23	Status/ Recommendations
Follow-Up After Hospitalization for Mental Illness (FUH -Adults) MSHN. Standard-58%	CCBHC QI	CEI: 68% Right Door: 91% SCCMHA: 79%	CEI: 62% Right Door: 61% SCCMHA: 70%	Met/Continue
Follow-Up After Hospitalization for Mental Illness (FUH-Child/Adolescents) MSHN. Standard 70%	CCBHC QI	CEI: 92% Right Door: 95% SCCMHA: 100%	CEI: 69% Right Door: 73% SCCMHA: 77%	Partial Met/Continue

Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN. Standard 58.5%	CCBHC QI	CEI: 55% Right Door: 73% SCCMHA: 71%	CEI: 59% Right Door: 95% SCCMHA: 57%	Partial Met/Continue
Initiation of Alcohol and Other Drug Dependence Treatment MSHN. Standard I-25%	CCBHC QI	CEI: 41% Right Door: 28% SCCMHA: 45%	CEI: 52% Right Door: 33% SCCMHA: 49%	Met/Continue
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN. Standard 12.5%	CCBHC QI	CEI: 27% Right Door: 19% SCCMH: 10%	CEI: 89% Right Door: 83% SCCMHA: 21%	Met/Continue
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN. Standard 23.9%	CCBHC QI	CEI: 37% Right Door: 15% SCCMH: 31%	CEI: 75% Right Door: 74% SCCMHA: 78%	Met/Continue

c) Performance Improvement Projects

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

Status: Interventions to address the identified barriers have been identified and are in development. Effectiveness will be determined following the review of CY23 data, which will be available in March of 2024.

Attachment 4 PIP #1 Access-Reduction of Disparities Monitoring
Attachment 5 PIP #2 Penetration Rate CY21-CY23YTD

Strategic Priority	Performance Improvement Projects	Committee	CY21	CY22	CY23 YTD	Status/ Recommendations
Better Care	PIP 1– Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population. Black/African American population White population	QIC	Baseline 65.04% 69.49%	53.72% 64.17%	61.31% 63.86%	Not Met/Continue
Better Care	PIP 2- Reducing or eliminating the racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate. Black/African American population White population	QIC	Baseline 7.45% 9.51%	7.24% 9.04%	6.54% 8.36%	Not Met/Continue

d) Adverse Event Monitoring

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events which include unexpected deaths, critical incidents, and risk events.

Status: MSHN met the standards. The QAPIP was effective.

Attachment 6 MSHN Critical Incident Performance Summary
Attachment 7 MSHN Critical Incident Process Summary
Attachment 8 MSHN Critical Incident Performance SUDTP Report

	Event Monitoring and Reporting	Committee	FY22	FY23	Status/ Recommendations
Better Care	The rate of critical incidents per 1000 persons served will demonstrate a decrease from the previous year. (CMHSP) (excluding deaths)	QIC	8.561	7.41	Met/Continue
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP) (Natural Cause, Accidental, Homicidal)	QIC	6.405	5.77	Met/Discontinue
Better Care	The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	0.384	.116	Met/Continue with the addition of unexpected deaths
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	QIC/SUD	1.535	.000	Met/Discontinue

e) Behavior Treatment

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

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders.

Status: MSHN did not meet each standard.

Attachment 9 MSHN Behavior Treatment Data

Strategic Priority	Behavior Treatment	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	CLC	72%	88%	Not Met/Continue
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	QIC	0.91%	0.93%	Not Met/Continue

f) Stakeholder and Assessment of Member Experiences

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

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Health illness, Individuals with an Intellectual Developmental Disability.
- Youth Satisfaction Survey (YSS) Youth with a Severe Emotional Disturbance, Individuals with an Intellectual Developmental Disability
- Substance Use Disorder Satisfaction Survey-Individuals with a substance use disorder.
- Home and Community Based Services Survey-Individuals receiving Long Term Supports and Services (LTSS)
- Provider Network Survey-Organizations who contract with MSHN (every other year)
- Committee/Council Survey-Provider representatives on MSHN committees/councils (every other year)
- National Core Indicator Survey-Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints-All individuals receiving services.

Status: MSHN Met the standard by obtaining an 80% or higher.
MSHN in collaboration with the NCI Advisory Council will identity focus areas for FY24.

Attachment 10 MSHN Executive Summary Member Satisfaction FY2023 Annual Report
Attachment 11 National Core Indicator Summary

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee	FY22	FY23	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%	90%	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%)	QIC	87%	81%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%)	QIC	83%	80%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	QIC	83%	80%	Met/Continue
Strategic Priority	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice	UMC	93.94%	97.4%	Met/Continue

	letter within 14 calendar days for a standard request of service. (Standard 95%)				
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	96.71%	98.85%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	95.12%	100%	Met/Continue

g) Clinical Practice Guidelines

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports.

Practice guidelines are monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy.

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

Status: MSHN did not meet the standard.

Attachment 12 ACT Utilization FY23
Attachment 9 Behavior Treatment Review Data

Strategic Priority	Clinical Practice Guidelines	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines.	CLC	100%	100%	Met/Discontinue
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (95% Standard) see Section IV. e	CLC	72.2%	88%	Not Met/Continue
Better Care	MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer (85%/96 minutes-100%/120 minutes).	UMC	2/7	1/8	Not Met/Continue

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[1] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[2] also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

MSHN updated the Credentialing review process in 2022 to include monitoring of the timeliness of decision making and credentialing activities for the CMHSP participants. Any CMHSP participants scoring less than 90% on the file review would be subject to additional review of credentialing and re-credentialing records.

Status: In 2023, six of the twelve CMHSPs scored under 90%. Staff qualifications are reviewed during the MDHHS Site Review and internally through the Delegated Managed Care Review. Based on the DMC review in FY23, improvement has been made. This will continue to be monitored until the MDHHS Site Review has been completed to allow for consistent comparisons.

Strategic Priority	Staff Qualifications	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. FY22 MDHHS Review, FY23 DMC review	Leadership	88%	99%	Met/Continue
Better Provider	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. FY22 MDHHS Review, FY23 DMC Review	Leadership	89%	94%	Met/Continue

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

i) Verification of Services

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

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

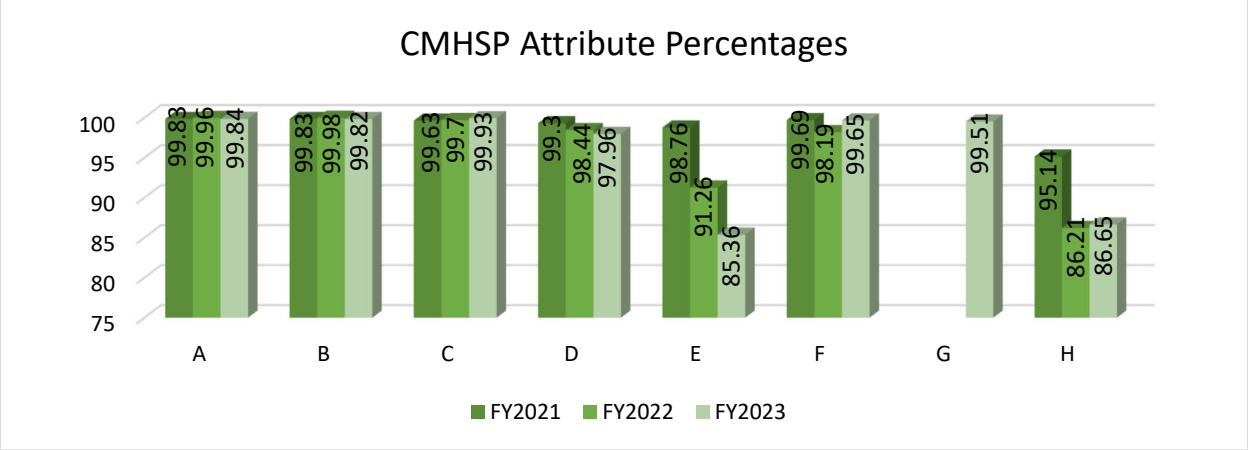
Process improvements implemented from previous MEV reviews included modifications to the forms for the claims review, summary report, plan of correction and data tracking to improve accuracy and ease of understanding how the data was represented. Improvements were also implemented to ensure proper and accurate reporting of information as part of the Office of Inspector General new reporting requirements for audit activities. The MEV forms continue to be standardized for consistency for each review. Additional improvements are being considered for FY2024 based on feedback received through the Provider network. One of the recommendations for improvement includes creating an MEV review guide for providers which would establish what documentation is required for each attribute and which findings will require voiding versus a plan of correction. The construction of this guide is currently underway.

Regionally the CMHSPs have shown slight improvements from FY2022 to FY2023 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service
2. F: Amount billed does not exceed contractually agreed upon amount
3. G: Amount paid does not exceed contractually agreed upon amount
4. H: Modifiers are used in accordance with the HCPCS guidelines

Note: FY23 Attributes F & G listed above were combined in FY22 under F.) Amount billed and paid does not exceed contractually agreed upon amount. Furthermore, Attribute H.) Modifiers are used in accordance with the HCPCS guidelines was Attribute G in FY22.

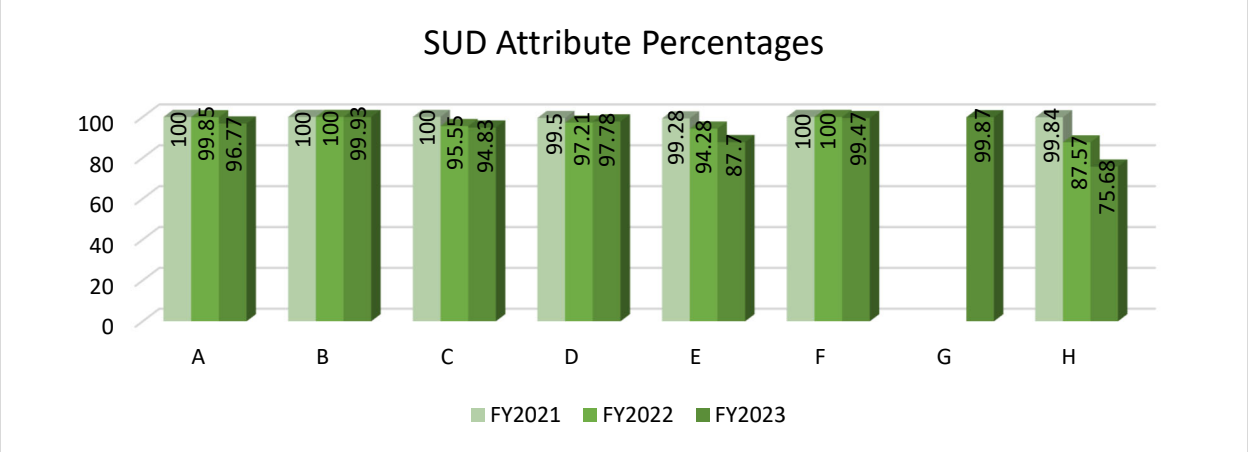
These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In addition, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.



Regionally the SUD providers did not show significant improvements from FY2022 to FY2023. However, the SUD provider scores were already at a high level and most of the scores remained in the mid-high nineties. The attributes that had slight improvements from FY2022 to FY2023 were:

1. C: Service is included in the beneficiary's individual plan of service
2. D: Documentation of the service date and time matches the claim date and time of the service

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes.



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

MSHN will continue to provide ongoing support to our provider network to ensure compliance with the attributes reviewed during the MEV site reviews. This will include training opportunities and identified quality improvements based on data trends.

MSHN also reviews the event verification results with the following council and committees:

- MSHN Compliance Committee (internal committee)
- Regional Compliance Committee (external committee consisting of members of the CMHSPs)
- MSHN Quality Improvement Council (external committee consisting of members of the CMHSPs)
- MSHN Operations Council (internal committee)

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Status: MSHN did not meet the goal as indicated below for FY23.

Strategic Priority	Medicaid Event Verification	Committee	FY22	FY23	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.	CCC	CMHSP: 86.21% SUD: 87.57%	CMHSP: 86.65% SUD: 75.68%	Not Met/Continue

j) Utilization Management

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

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

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

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

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

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

assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

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

Status: Effective/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 FY23 Service Auth Denial Report
Attachment 3 FY23Q2-Q3 Integrated Health Quarterly Report

k) Long Term Supports and Services for Vulnerable Adults

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

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

Status: Met/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report

Strategic Priority	Priority Measures	Committee	FY22	FY23	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM/ IC	78%	Not Available	/Continue

Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	100%	100%	Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	85%	70.1 68.2%	Not Met/Continue Explore options for more accurate monitoring.
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous FY)	UM	+10%	-	Unknown, unable to monitor after March. Discontinue
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%	1%	Met/Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	UM	95%	95%	Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	93.50%	94%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	93%	87%	Not Met/Continue
Strategic Priority	**Priority Measures**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**
Better Health	MSHN will demonstrate improvement from previous reporting period of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	81.74%	81.42%	Not Met/Continue
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP)	CLC	43.10%	48.65%	Met/Discontinue-will utilize cardiovascular monitoring measure.
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	76.27%	76.96%	Met/Continue

Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	96.04%	96.84%	Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	10.88%	13.64%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	86.35%	87.46%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	95.19%	95.59%	Met/Continue

l) Provider Monitoring and External Reviews

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

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

The following external reviews were completed for FY23:

- HSAG Performance Measure Validation Review-Received a status of “Reportable”
- HSAG Compliance Review-Corrective Action Follow up from 2021 and 2022. All CAPs were accepted except Standard XII-Health Information Systems 7. Application Programming Interface.
- HSAG Performance Improvement Project-Received a status of “Met” the PIP received 100% validation.
- MDHHS Waiver Review- 90 Day Follow up was completed.

MSHN filed an appeal for standards P.5.1 and P.5.2 which were not found to be in full compliance.

Status: Effective/Continue
The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY24.

Strategic Priority	Provider Monitoring	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard >=3.50)	Leadership	3.60	3.73	Met/Discontinue
Better Provider	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard >= 3.50)	Leadership	3.95	4.09	Met/Continue
Better Provider	MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. Comprehensive Score for FY21 and FY22. (Next measurement is FY25)	QIC/CLC	87%	NA	Met/Continue

m) Quality Priorities and Work Plan FY23

Organizational Structure and Leadership	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2023	Complete/Continue
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP.	Quality Manager	9.30.2023	Complete/Continue Recommend development of standard templates for use in organizational performance improvement projects and QI plan.
Governance	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the Board. (Attachment 17-MSHN Governing Board Form)	MSHN Deputy Director	1.1.2023 1.31.2024	Complete/Continue
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. (Balanced Scorecard Review, Quarterly Department Reports)	MSHN Deputy Director	Quarterly	Complete/Consider agenda item related to MSHN Performance and indicate any discussion
QAPIP description, associated work plan, and list of members of the Governing Body will be submitted to Michigan Department of Health and Human Services annually by February 28th	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue

Mechanisms for Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. Post to the MSHN Website. Ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	2.28.2023 2.28.2024	Complete/Continue
Guidance on Standards, Requirements, and Regulations	Complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN Leadership	As needed, minimum annually	Complete / Continue
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	Present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly	Complete/Continue
Performance Measurement and Quality reports are made available to stakeholders and general public	Upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Leadership	Quarterly	Complete/Continue
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	3/15/2023 6/15/2023 9/15/2023 12/10/2023	Complete/Continue
	Complete performance summary reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees' councils.	QIC	10/27/2022 1/27/2023 4/28/2023 7/28/2023	Complete/Continue

	Complete primary source verification of submitted records during the DMC review.	MSHN-QM	Annually	Complete/Discontinue Recommend completing primary source during external review and prior to Quarterly submission to MDHHS.
	Ensure accuracy of data through REMI validations, and increased sample for those that had findings during external reviews.	MSHN-QM	Annually	Complete/Discontinue
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	1/27/2023	Complete/Continue
Performance Improvement Projects	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM QIC	Quarterly 6/30/2023 6/30/2024	Complete/Continue
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit to MDHHS with QAPIP Evaluation and/or upon request.	MSHN-QM QIC	Quarterly 2/28/2024	Complete/Continue

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, and communicating results.	Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Quality Manager	3/31/2023	Not complete/Continue
	Implement standard survey/assessment for all populations (SUD, CCBHC, MH, SED, IDD) that provides meaningful and actionable data.	QIC, MSHN Quality Manager	6/30/2023	Not complete/Continue. Recommend MHSIP be used for SUD
	Document and CMHSP / Provider Network action steps for improvement in the QIC action plan	CMHSP participants	9/30/2023	Complete/Continue
	Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils.	QIC, MSHN Quality Manager	8/30/2023	Complete/Continue
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.)	MSHN-CBHO CLC	Quarterly	Discontinued by MDHHS
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly	Completed/Continue
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored,	Establish standard data element for mortality reviews	MSHN QM, QIC	4/30/2023	Complete/Discontinue
	Establish standard data elements/form for a Root Cause Analysis	MSHN QM, QIC	4/30/2023	Complete/Discontinue

reported, and followed up on as specified in the PIHP Contract.	Develop Dashboard for tracking and monitoring timeliness	MSHN QM, QIC	4/30/2023	In Progress/Continue
	Develop training documents, including policies/procedures based on the new requirements and process for reporting	MSHN QM, QIC	2/28/2023	In Progress/Continue
	Develop control charting with upper and lower control limits	MSHN QM, QIC	2/28/2023	In Progress/Continue
	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN QM, QIC	3/23/2023 6/22/2023 9/22/2023 12/15/2023	Complete/Continue Recommend continuing a process improvement report and performance report.
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule	Complete/Continue
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Aud.	12/31/2022 12/31/2023	Complete/Continue
Utilization Management Plan	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Dir.	2023	Complete/Continue
	MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue. SIS was discontinued.

				MichiCans and MiCAS will be implemented
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Dir.	Annually	Complete/Continue
	Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed as required.	Oversight of compliance in accordance with the 42 CFR 438.404 with during Delegated Managed Care Reviews.	MSHN-Customer Service Manager	Annually	Complete/Continue
Practice Guidelines	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies.	MSHN-QM/QIC	1/31/2023	In progress/Continue
	MSHN will coordinate a regional training to address Person Centered Planning and the development of the Individual Plan of Service.		1/31/2023	Not complete/Modify to include provision of resources
MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	Monitor compliance with standards. DMC	MSHN Waiver Administrator, CLC	Annually	Completed/Continue
	Implement Behavior Treatment Training Modules	MSHN Waiver Administrator, CLC	1/31/2023	Complete/Discontinue
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress. Explore adding to the Program Specific DMC	MSHN-UCM Director UMC	Quarterly	Complete/Continue

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
MSHN will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving LTSS.	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.	MSHN-CBHO	Annually/ Quarterly	Complete/Continue
Behavior Treatment	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
The percentage of emergency physical interventions per person served during the reporting period will decrease from previous year.	Develop BTPR Module Specifications/Development (subgroup)	CLC/QIC	6/30/2023	Not Started/Continue
	Develop control charting with upper and lower control limits for track and trend data.	QIC	2/28/2023	In Progress/Continue
Provider Monitoring	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI	Annually	Complete/Continue
	Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Relevant committees	9/30/2023	Complete/Continue
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN QM	9/30/2023	Complete/Continue

MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QM-QIC MSHN-CIO-ITC	9/30/2023	Complete/Continue
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-Waiver Managers, CBHO	9/30/2023	Complete/Continue
Provider Qualifications	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Complete Primary Source Verification utilizing the Credentialing Report submitted to MDHHS	Leadership/ PNM	Quarterly	Not Complete/Discontinue
	Require individual remediation for records that are not in full compliance with the credentialing requirements, and additional monitoring for those CMHSPs that have a compliance rate of =<90%.	Leadership/ PNM	Annually	Complete/Continue with modifications
	Primary Source Verification and review of the credentialing/recredentialing policy and procedure will occur during the DMC review. Providers who score less than 90% on the file review will be subject to additional review of credentialing and re-credentialing records.	Leadership/ PNM	Annually	Not complete/Continue with modifications
	Include primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	QIC/PNM	Annually	In Progress/Continue
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Develop regional guidelines for training documentation consistent with MDHHS expectations.	QIC	1/31/2023	Complete/Discontinue
	Continue to update the training grid as required.	QIC/PNM	1/31/2023	Complete Discontinue

III. MSHN Councils Annual Reports FY23

Team Name: Mid-State Health Network Operations Council

Team Leader: Joe Sedlock, MSHN Chief Executive Officer

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The MSHN Board has created the Operations Council to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[3]

A. Past Year Accomplishments. FY23

- Reviewed and approved the FY22 Operations Council Annual Report
- Supported the forming of the 1915(i) Workgroup
- Reviewed and approved the FY22 QAPIP Annual Report
- Reviewed and approved the FY23 QAPIP Plan
- Supported MSHN position to appeal citations for the use of service ranges language in plans of service.
- Encouraged and supported MSHN in approaching MDHHS to offer to work together on special populations issues.
- Discussed and reviewed the Operating Agreement in regard to the local funds for OHH and BHH.
- Planned for the FY2024-2025 Strategic Plan Process
- Requested MSHN/region to look for opportunities to do more advocacy with MDHHS regarding how the state determines State Hospital placement.
- Supported the proposal to MSHNs Board of Directors to extend the Provider Staffing Crisis Stabilization Program thru the end of FY23.
- Supported MSHN and SWMBH collaboration in dialogue with MDHHS to assist with improving access for Children in Child Welfare.
- Reviewed and supported the Service Authorization Denial Summary and Procedure
- Reviewed MSHN Strategic Plan
- Examined Regional Savings Estimates-CMHSP regional partners to take a closer watch on current budget and expenditures. May need to develop regional strategy and/or regional cost containment plans.
- Discussed and reviewed the CFAP resolution
- Collaboration on issues raised by DHHS regarding Children's Access Issues
- Reviewed the FY22 Network Adequacy Addendum report
- Reviewed and approved FY24 ABA Contract
- Reviewed and approved FY24 Financial Management Services Contract
- Reviewed and approved the MSHN/CMHSP FY24 Medicaid Subcontract
- Reviewed and approved FY24 MSHN Training Grid
- Reviewed the FY23 budget amendment and the FY24 budget
- Monthly reviews of MDHHS disenrollment reports

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

- Supported MSHN to advocate with MDHHS to correct technological problems in the Customer Relationship Management (CRM) system and EGrAMS.
- Reviewed and approved the Ops Council Charter annual review
- Reviewed BCBS and Medicare Advantage services for Crisis Stabilization, Urgent Care and Mobile Crisis to encourage CMHSPs to consider participating.

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

Goal
Relating to conflict free access and planning, advocate for system reform changes that comply with the federal rule that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Work with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Ensure effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.
As a region and as individual entities: address, reduce, and eliminate health disparities.
Address funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements
Monitor and expand Behavioral Health Homes, Opioid Health Homes and Certified Community Behavioral Health Clinics in the MSHN region
Continue to educate MDHHS and other stakeholders on the governmental (non-commercial) nature of the public behavioral health system and work to avoid shaping the system to function like a private health plan
Work with MDHHS to establish a practical vision for use of the State CRM and work toward implementation

Team Name: Finance Council
Team Leader: Leslie Thomas, Chief Financial Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

Goal
•FY 2023 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2023 and February 2024. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2024 and compliance exams by June 2024. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
•Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2023 Final Reports due to MDHHS March 31, 2024, are received from the CMHSPs to the PIHP. The goal for FY 2023 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
•Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
•Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
•If applicable, develop regional and local cost containment strategies to align projected revenue and expenses.

Team Name: Information Technology Council
Team Leader: Steven Grulke, MSHN CIO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Representation from each CMHSP Participant at all Meetings.
    - There was a 95% attendance rate during FY23 ITC Meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
    - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: Mental health, substance use, and crisis records. (M, A, Q transactions).
- Several initiatives that ITC assisted with during FY23 are:
    - COB changes in 2023

- MCG Indicia Upgrades
- Foster Care Served Numbers for CMHSA advocacy to MDHHS
- CRM Module Implementation
- MDHHS Medicaid Redetermination – ongoing
- Detailed files for updated EQI
- Withdrawal Management BH-TEDS Adjustments – MDHHS
- Addition of the 'TF' Modifier in EHRs for mild to moderate CCBHC designation
- EVV advocacy along with CMHSA

- Facilitate health information exchange (HIE) processes:
  - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway. MSHN is ahead of all other pilots in this implementation.
- Goals Established by Operations Council:
  - Improvements with balanced scorecard reporting
  - Continue trending COVID-19 and telehealth reports (ended in May with emergency orders)
- Meet external quality review requirements:
  - Health Services Advisory Group (HSAG) conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with 1 compliance finding.

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

Goal
Representation from each CMHSP Participant at all Meetings
Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
Collaborate to develop systems or processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
Work on outcome measure data management activities as needed.
Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
Meet IT audit requirements (e.g., EQRO).

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

Annual Evaluation Process

A. Past Year Accomplishments FY23 (10.1.2022 through 9.30.2023)

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

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

Goal	Objectives/Activities	Frequency/ Due Date
Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2024	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN regional report. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations	Annually 2/28/2024
Improve health outcomes for those served in the region.	• Review regional key performance indicators. • Review regional performance (BSC/Dashboard) • Develop/identify regional improvement strategies used to identify barriers and interventions. • Analyze outliers and establish process for quality improvement in collaboration with committee/councils.	Annually Quarterly Annually- Annually

	• Monitor the effectiveness of interventions	Quarterly
Establish effective quality improvement programs for CCBHC, health homes.	• Identify regional key performance indicators. • Develop/modify data platforms/reports for performance monitoring. • Establish performance monitoring schedule. • Develop/identify regional improvement strategies.	Annually Annually Annually Annually
Adhere to critical incident and event notification reporting requirements by developing an efficient and effective critical incident monitoring system	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. • Validate / reconcile reported data through the CRM. • Improve timeliness of remediation response in the CIRS-CRM • Develop dashboard for tracking and monitoring timelines. • Establish electronic process for submission of sentinel events/ immediate notification, and remediation documentations.	Annually Quarterly Quarterly 2/28/2024 4/30/2024
Achieve full compliance for the MDHHS Review.	• Ensure corrective action plans are implemented to address deficiencies.	Annually
Improve member experience of care	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS) • Identify sources of dissatisfaction • Increase response rate-streamline surveys and process. • Outline actions step for follow up. • Evaluate the effects of activities implemented to improve satisfaction. • Complete an RFP for administration and analysis by an external vendor.	Annually Annually Annually Annually Annually 6/30/2024
Achieve full compliance for the HSAG External Quality Review - Compliance	• Ensure corrective action plans and recommendations are implemented to address deficiencies.	Annually
Achieve Reportable Status for the HSAG External Quality Review – Performance Measure Validation	• Verify Medicaid Eligibility and data accuracy through primary source verification. • Validate data collection process, both administrative and manual. • Develop / modify ongoing training documents.	Quarterly Annually Annually
Achieve 100% Validation Status for the HSAG External Quality Review- Performance Improvement Project	Implement 2 PIPs • Validate data • Utilize quality tools to identify barriers and root causes • Implement interventions • Evaluate the effectiveness of interventions	 Annually Annually Annually Quarterly

b) MSHN Advisory Councils FY23 Annual Reports

Team Name: Consumer Advisory Council
Team Leader: Todd Koopmans, Chairperson; Dan Dedloff, MSHN Staff Liaison
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed the changes to the FY23 MSHN Consumer Handbook
- Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
- Reviewed and provided feedback on the MSHN Satisfaction Survey results
- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the 2023 MSHN Delegated Managed Care Reviews
- Reviewed and provided feedback on the 2024/2025 MSHN Strategic Plan
- Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
- Reviewed and provided feedback on the MSHN Website Redesign
- Reviewed and provided feedback on MSHN Adverse Benefit Determination Training
- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Integrated Care
- Education and discussion on Michigan Medicaid Autism Benefit
- Education and discussion on HCBS Rule Updates
- Education and discussion on Conflict Free Access and Planning
- Collaboration with the Healthy Democracy Healthy People
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Charter
- Discussion and feedback on MSHN Council/Committee Survey Results
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities.
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation, and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom and added an in-person meeting option.
- Explore system improvements for services directed to youth

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

Goal
Provide input on regional educational opportunities for stakeholders
Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
Review regional survey results, including SUD Satisfaction Survey and external quality reviews
Annual review and provide feedback on the QAPIP
Annual review and feedback on the Compliance Plan
Review of the MSHN FY24 Consumer Handbook
Review and advise the MSHN Board relative to strategic planning and advocacy efforts
Provide group advocacy within the region for consumer-related issues
Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
Explore ways to get more consumers involved in the RCAC and local consumer councils
Public Behavioral Health System Redesign Advocacy
Improve access to peer support specialists through CMHSPs

c) MSHN Oversight Policy Board FY23 Annual Report

Team Name: Substance Use Disorder (SUD) Oversight Policy Board
Team Leader: Chairperson Steve Glaser, SUD Board Member
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Received updates and presentations on the following:
    - MSHN SUD Strategic Plan
    - MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY22 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY23 Budget Overview
- Received PA2 Funding reports – receipts & expenditures by County
- Received Quarterly Reports on Prevention and Treatment Goals and Progress
- Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
- Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Received written updates from Deputy Director including state and federal activities related to SUD
- Received updates on MDHHS State Opioid Response Site Visit Results
- Shared prevention and treatment strategies within region
- Received information and education on opioid settlement and strategies
- Provided input on the FY24-26 MSHN SUD Strategic Plan
-

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

Goal
Approve use of PA2 funds for prevention and treatment services in each county
Improve communications with MSHN Leadership, Board Members and local coalitions
Orient new SUD OPB members as reappointments occur
Increase communication with local counties/coalitions regarding use of state and local opioid settlement funding
Monitor SUD spending to ensure it occurs consistent with PA 500
Revise and sign new Intergovernmental Agreement

d) MSHN Committee FY23 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, MSHN Chief Behavioral Health Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

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

Team Name: Regional Medical Directors Committee (RMDC)
Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
As created by the MSHN Operations Council (OC), the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Review and input into the behavioral health home initiative.
- Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
- Addressed controlled substance prescription law and shared feedback with MDHHS.
- Reviewed planned updates and gave feedback to PCE prescriber module.
- Input into Population health and Integrated Care Plan and Quarterly Reports.
- Addressed staffing status for psychiatry.
- Continued input into Conflict Free Access and Planning discussion.
- Discussed DEI initiative.
- Reviewed critical incident report.
- Reviewed telemedicine bulletin MMP 23-10 and processes.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.
- Review RMDC survey responses.
- Reviewed possibility of writing standards regarding nurse practitioners and physician's assistants.
- Reviewed issue of worker burnout.
- Reviewed and provided input into clinical care pathways relating to the CMH work when someone goes to the emergency room.

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

Goal
Address youth access to CMH services.
Continued input into behavior treatment processes.
Ongoing input into population health and integrated care.
Return to OpenBeds process conversation and define further.
Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with CLC.
Improve collaboration with MDHHS around processes related to CMH functions (i.e., determination of hospitalization).

Team Name: Utilization Management Committee

Team Leader: Skye Pletcher, Chief Population Health Officer, MSHN

Report Period: 10.01.2022 through 9.30.2023

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Advocacy and appeal with MDHHS for the use of service ranges in person centered plans for waiver and non-waiver services.
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate.
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >95% adherence to medical necessity criteria

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

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

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2022 Annual Compliance Summary Report
- Reviewed and updated the committee charter.
- Reviewed HSAG Compliance Site Review Findings – Developed plan of correction for findings specific to compliance standards
- Reviewed Compliance Section for Managed Care Program Annual Report (MCPAR)
- Provided feedback on MEV site review process and updates.
- Reviewed proposed revisions to the 42 CFR Part 2 to ensure regional compliance.
- Consensus on use of signatures within the Electronic Health Records
- Reviewed results council/committee surveys- implemented changes based on feedback.
- Provided feedback on 2024-2025 MSHN Strategic Plan
- Updated Privacy Notice to ensure compliance with federal and state standards and developed consistent distribution processes.
- Medicaid Policy Updates: Telehealth compliance and end of public health emergency
- Reviewed the revised FY2023 OIG Quarterly Report changes, guidance documents, fraud referral form, and submission requirements.
- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings.
- Provided consultation on local compliance related matters.
- Reviewed and provided feedback on MSHN compliance policies and procedures.

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

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

Team Name: Provider Network Committee
Team Leader: Leslie Thomas, MSHN CFO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

Goal
Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
Establish relevant key performance indicators for the PNMC scorecard;

Monitor and implement Electronic Visit Verification as required by MDHHS;
Initiatives to support reciprocity: •Contracting: ✓ Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation Procurement: ✓ Fully implement the use of a regional web-based provider application; ✓ Publish provider selection processes on MSHN web; •Monitoring: ✓ Fully implement specialized residential reciprocity provider monitoring plan; ✓ Training: ✓ All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
Develop and implement regionally approved process for credentialing/re-credentialing reciprocity
Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services

Team Name: Customer Services Committee
Team Leader: Dan Dedloff, Customer Service & Rights Manager
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Customer Services Committee was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Chief Compliance and Quality Officer and will report through the Quality Improvement Council (QIC).

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY23 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY23 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
- Reviewed, analyzed and reported regional customer service information for:
    - Grievances
    - Appeals
    - Medicaid Fair Hearings
    - Recipient Rights
- Defined what would be considered a cultural competency request (CCR) to support network adequacy.
- Reviewed the FY22 HSAG Compliance Review results and collaborated to develop the HSAG corrective action plan.
- Reviewed and provided feedback on the Mid-State Health Network (MSHN) 2024/2025 Strategic Plan.

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

Goal
Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
Continue reporting and monitoring Customer Service information
Continue to explore regional Customer Service process improvements
Continue to develop, where applicable, MSHN standardized regional forms
Continue to identify Educational Material/Brochures/Forms for standardization across the region
Complete the bi-annual review, update, and approval of the MSHN Customer Service Policies and Procedure.
Develop and distribute an Adverse Benefit Determination Frequently Asked Questions document.

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Leader: Shelly Milligan (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:

REACH is an advisory body of community stakeholders established for the following purposes:

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

Annual Evaluation Process:

A. Past Years Accomplishments. FY23

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

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

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

e) MSHN Workgroups FY22 Annual Reports

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

Table 3

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

	and initiated.	
Ensure regional representation at quarterly MSHN Autism Workgroups.	1. MSHN to continue to send workgroup meeting invitations and agendas in a timely manner to encourage attendance. 2. Follow-up with CMHSPs that do not have consistent representation at quarterly workgroup meetings.	Frequency: throughout the fiscal year. Due date: 9/30/2024

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

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

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

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

Team Name: Habilitative Supports Waiver Workgroup
Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSP's are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

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

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

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

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

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

IV. Definitions/Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

Acronyms

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

VII. Attachments

Attachment 01 MSHN QAPIP Communication

Attachment 02 MMBPIS Performance Summary FY23Q3

Attachment 03 FY23 Q2-Q3 Integrated Health Quarterly Report

Attachment 04 PIP #1 Access-Reduction of Disparities Monitoring

Attachment 05 PIP #2 Penetration Rate CY21-CY23Q3

Attachment 06 MSHN Critical Incident Performance Report FY23

Attachment 07 MSHN Critical Incident Process Improvement Summary FY23Q3YTD

Attachment 08 MSHN Critical Incident Performance Report SUDTP FY23

Attachment 09 MSHN Behavior Treatment Review Data FY23

Attachment 10 MSHN Executive Summary member Experience of Care 2023 Annual Report

Attachment 11 National Core Indicator Summary

Attachment 12 ACT Utilization FY23

Attachment 13 Behavioral Health Department Quarterly Report FY23Q4

Attachment 14 FY23 Service Auth Denial Report Final

Attachment 15 MSHN 2023 QAPI Compliance Summary Report

Attachment 16 MSHN Governing Body Form