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State Fiscal Year 2024
External Quality Review Technical Report
for Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality, timeliness, and accessibility of care and services they provide, as mandated by Title 42 of the Code of Federal Regulations (42 CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

The Behavioral and Physical Health and Aging Services Administration (BPHASA) within MDHHS administers and oversees the Michigan Behavioral Health Managed Care program, which contracts with 10 prepaid inpatient health plans (PIHPs) in Michigan to provide Medicaid waiver benefits for people with intellectual and developmental disabilities (I/DD), serious mental illness (SMI), and serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs). The PIHPs contracted with MDHHS during state fiscal year (SFY) 2024 are displayed in Table 1-1.

Table 1-1—PIHPs in Michigan

PIHP Name	Abbreviation
Region 1—NorthCare Network	NCN
Region 2—Northern Michigan Regional Entity	NMRE
Region 3—Lakeshore Regional Entity	LRE
Region 4—Southwest Michigan Behavioral Health	SWMBH
Region 5—Mid-State Health Network	MSHN
Region 6—Community Mental Health Partnership of Southeast Michigan	CMHPSM
Region 7—Detroit Wayne Integrated Health Network	DWIHN
Region 8—Oakland Community Health Network	OCHN
Region 9—Macomb County Community Mental Health	MCCMH
Region 10 PIHP	Region 10

Member populations receiving services through the PIHPs are commonly referenced throughout this report using the abbreviations displayed in Table 1-2.

Table 1-2—Member Populations

Member Population	Abbreviation
Children diagnosed with serious emotional disturbance	SED Children
Adults diagnosed with mental illness	MI Adults
Children with intellectual and developmental disability	I/DD Children
Adults with intellectual and developmental disability	I/DD Adults
Adults with developmental disability	DD Adults
Adults dually diagnosed with mental illness and intellectual and developmental disability	MI and I/DD Adults
Adults diagnosed with substance use disorder	Medicaid SUD

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1] The purpose of the EQR activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate State efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2024 assessment, no PIHPs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-3 that were performed during the preceding 12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each PIHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 30, 2025.

Table 1-3—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a PIHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects (CMS EQR Protocol 1)
Performance Measure Validation (PMV)	This activity assesses whether the performance measures reported and/or calculated by a PIHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures (CMS EQR Protocol 2)
Compliance Review	This activity determines the extent to which a PIHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations (CMS EQR Protocol 3)
Network Adequacy Validation (NAV)	This activity assesses the accuracy of network adequacy indicators reported by a PIHP and the extent to which a PIHP has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy (CMS EQR Protocol 4)
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by a PIHP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)

Michigan Behavioral Health Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2024 activities to comprehensively assess the PIHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each PIHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the PIHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all PIHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Behavioral Health Managed Care program. Table 1-4 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for MDHHS to drive progress toward achieving the goals of

Michigan's Comprehensive Quality Strategy (CQS)[2] and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-4 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. A dash (–) is noted in Table 1-4 if no trends were identified through an EQR activity that substantially impacted a goal; the EQR activity results could not be used to evaluate a goal; or a CQS goal did not include a quality measure for the Michigan Behavioral Health Managed Care program's applicable populations.

Table 1-4—Michigan Behavioral Health Managed Care Program Conclusions and Recommendations

Performance Impact on Goals and Objectives[3]		Performance Domain
Goal #1: Ensure high quality and high levels of access to care		
✓	The statewide child and adult rates for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours* exceeded the CQS goal of 95 percent.	☒ Quality ☒ Timeliness ☒ Access
✗	The aggregated statewide rate for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* fell below the 50th percentile.	
✗	The aggregated statewide rate for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* fell below the 50th percentile.	
✗	The programwide compliance rate for the Coverage and Authorization of Services program area was only 71 percent. All PIHPs had challenges implementing service authorization requirements and creating adverse benefit determination (ABD) notices that included all required content, were specific to the member's circumstance, and were easily understood (e.g., the notices were not written at the state-required reading grade level).[4]	
✗	Five PIHPs had an "All-Element Accuracy Rate" below 60 percent, indicating major concerns with encounter data not being supported by the members' medical records and highlighting areas where accuracy improvements may be necessary. Accurate and complete encounter data are critical to the success of a managed care program. MDHHS relies on the	

[2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy 2023–2026*, August 2024. Available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=3add99dfefdf417fa4e12a2b346f4b3e. Accessed on: Jan 30, 2025.

[3] All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all performance measures validated through the PMV, and performance measures without a corresponding CQS quality measure were excluded.

[4] While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and objective(s) within the CQS.

	Performance Impact on Goals and Objectives[3]	Performance Domain
	quality of encounter data submissions from the PIHPs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.[4]	
m	While the programwide compliance rate for the Assurances of Adequate Capacity and Services program area was 100 percent, the two elements related to member-to-provider ratios were scored *NA*, not applicable, as MDHHS did not require these network adequacy indicators to be reported on the annual network adequacy template and had not provided specifications to the PIHPs to ensure consistent calculation of member-to-provider ratios.[4]	
–	Considering the PIHPs did not have standardized guidance at the time of network adequacy report submissions to MDHHS, many of the PIHPs applied inconsistent methodology for network adequacy time and distance indicator calculations; therefore, the PIHP network adequacy results could not be compared across PIHPs or aggregated to provide programwide results.	
–	The EQR activities do not produce data to assess the impact of the seven quality measures of the Children's Behavioral Health—Bureau of Children's Coordinated Health Policy & Supports (BCCHPS) program under CQS Objective 1.3.	
Goal #2: Strengthen person and family-centered approaches		
✓	The programwide compliance review rate for the Coordination and Continuity of Care standard was 95 percent. All PIHPs demonstrated having adequate processes for most elements for comprehensively assessing and producing person-centered service plans for its members.[4]	☒ Quality ☐ Timeliness ☐ Access
–	The CQS not does include quality measures for the Adult Behavioral Health—Bureau of Specialty Behavioral Health Services (SBHS) program under Goal #2.	
–	The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under Objective 2.1.	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	Through the Coordination and Continuity of Care standard of the compliance review activity, all PIHPs demonstrated having adequate processes to coordinate care between managed care programs, community supports, and transitions between care settings.[4]	☒ Quality ☒ Timeliness ☒ Access
–	The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under Objective 3.1. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new quality measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity.	

	Performance Impact on Goals and Objectives[3]	Performance Domain
–	The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under Objective 3.2.	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
m	While MDHHS required the PIHPs to continue with PIP topics focused on disparities within their populations, seven PIHPs did not demonstrate a statistically significant change in their performance indicator rates. Additionally, while three PIHPs demonstrated a statistically significant increase in their performance indicator rates, two of those PIHPs did not eliminate the disparity, and the third PIHP had not identified a disparity within its region's membership.	☒ Quality ☒ Timeliness ☐ Access
–	The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under Objective 4.1. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity.	
–	The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under Objective 4.1. Of note, while indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data reported are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
–	The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that MDHHS' value-based initiatives and payment reform had on improving quality outcomes.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS' CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Michigan Behavioral Health Managed Care program members:

- MDHHS is overhauling its quality assessment and performance improvement program (QAPIP) beginning SFY 2025 through SFY 2028, with the identification of new performance measures that align with CMS Core Set reporting, the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems

Performance Impact on Goals and Objectives[3]	Performance Domain
(CAHPS®)[5] survey, and CMS' Long-Term Services and Supports quality measures. As such, HSAG recommends that MDHHS conduct a comprehensive review of the CQS to determine any revisions that MDHHS should make to the existing objectives (i.e., quality measures) to ensure alignment with the new performance measures that the PIHPs will be required to report. While two of the new performance measures are already included as quality measures within the CQS, MDHHS will need to consider what other quality measures should be added to the CQS for the Behavioral Health Managed Care program to align with its QAPIP's new performance measures in support of the CQS goals and objectives. MDHHS could also consider whether it should develop and add quality measures to Goal #5 within the CQS since there are currently no identified quality measures for the Michigan Behavioral Health Managed Care program to monitor performance with *improving quality outcomes through value-based initiatives and payment reform*. • HSAG recommends that MDHHS issue formal guidance to all PIHPs, detailing its expectations for how the PIHPs should calculate time and distance to applicable providers. Additionally, HSAG recommends that MDHHS provide formal guidance to all PIHPs, clearly outlining the expectations for categorizing servicing counties during reporting to ensure better alignment with MDHHS standards. Further, HSAG recommends that MDHHS provide specifications to the PIHPs for the calculation of its member-to-provider network adequacy standards. As an assessment of network adequacy must be submitted by the PIHPs to MDHHS at least annually, HSAG also recommends that MDHHS update its network adequacy template to include member-to-provider ratio indicators. Updates to MDHHS' contract with the PIHPs and reporting template should improve MDHHS' and the PIHPs' ability to monitor for any gaps in network adequacy that may be a contributing barrier to members accessing timely care and services. • HSAG recommends that MDHHS review the PIHPs' utilization management (UM) programs to identify opportunities to streamlines processes and ensure consistent tracking and reporting across all PIHPs. Specifically, MDHHS should clarify if a service authorization request begins the 14-calendar-day time frame (or seven days effective in 2026) when a member initially contacts the PIHP/Community Mental Health Services Program (CMHSP) and requests services, or if the time frame begins when the service authorization request is submitted to the UM department for approval or denial. If MDHHS determines that the service authorization request begins when a member initially requests services with the PIHP, the PIHPs would need to complete any applicable assessments and approve/deny authorizations within 14 calendar days (or within seven days effective in 2026). • As CMS has implemented appointment timeliness standards effective in 2027, MDHHS could determine that the PIHPs have 10 business days to schedule an appointment to determine the member's service needs, and then the PIHP has seven calendar days from the appointment to render an approval/denial decision by the UM department. • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its PIHPs as follows within the required effective dates for each specific requirement: – Require the PIHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. – Require the PIHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each PIHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each PIHP, and it enables the PIHPs to assess	

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Performance Impact on Goals and Objectives[3]	Performance Domain
trends, identify areas for improvement, and work toward continuous process improvement while maintaining the necessary quality checks for quality and appropriateness of care. • To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), MDHHS should implement the following within the required effective dates for each specific requirement: – Review the maximum appointment wait time standards (e.g., 10 business days for outpatient mental health and SUD appointments) and update its contracts with its PIHPs, as applicable. – If determined by CMS to be applicable to the Michigan Behavioral Health Managed Care program, MDHHS should contract with an independent vendor to perform secret shopper surveys of PIHP compliance with appointment wait times and the accuracy of provider directories, and require directory inaccuracies to be sent to MDHHS within three days of discovery. Results from the secret shopper survey will provide assurances to MDHHS that the PIHPs' networks have the capacity to serve the expected enrollment in their service areas, and they offer appropriate access to preventive and primary care services for their members.	

2. Overview of the Michigan Behavioral Health Managed Care Program

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Table 2-1 displays the Michigan Medicaid managed care programs and the MCE(s) responsible for providing services to members.

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	Managed Care Organization (MCO)	1915(b)	July 1997	MHPs provide comprehensive healthcare services to low-income adults and children.
• MIChild (CHIP)		1915(b)	January 2016	MIChild is a Medicaid program for low-income uninsured children under the age of 19.
• Children's Special Health Care Services (CSHCS)		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
• Foster Children		1915(b)	November 2010	Most categories of foster children are mandatorily enrolled in managed care.
• Pregnant Individuals		1915(b)	October 2008	Pregnant individuals are mandatorily enrolled in managed care.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
MI Choice Waiver Program (Prepaid Ambulatory Health Plans [PAHPs])	PAHP	1915(c) since 1992 1915(b) since 2012	1992	The elderly or disabled adults (aged 18+) who meet the nursing facility level of care.
Dental Health Programs				
Healthy Kids Dental (HKD) (PAHP)	PAHP	1915(b)	October 2016	The HKD program provides dental services to beneficiaries under age 21.
Adult Dental (MHPs)	MCO	1915(b)	April 2023	Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in an MHP, ICO, or Program of All-Inclusive Care for the Elderly (PACE) receive dental benefits through their MHP.
Behavioral Health Managed Care (Children's Behavioral Health—BCCHPS and Adult Behavioral Health—SBHS)				
PIHPs/CMHSPs	PIHP	Behavioral Health 1115 Demonstration Waiver	October 2019	Individuals with I/DD, SMI, SED, and SUD
		1915(i) SPA [State Plan Amendment]	October 2022	
		1115 HMP	April 2014	
		Flint 1115 Waiver or Community Block Grant	May 2016	
		1915(c) Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Children's Serious Emotional Disturbance Waiver (SEDW)	October 2019	

Behavioral Health Managed Care

BPHASA within MDHHS administers and oversees the Behavioral Health Managed Care program, which operates under Section 1115 waivers. Behavioral health managed care services and supports in Michigan are delivered through county-based CMHSPs. Michigan uses a managed care delivery structure including 10 PIHPs who contract for service delivery with 46 CMHSPs and other providers to provide mental health, substance abuse prevention and treatment, and developmental disability services to eligible members. PIHPs are required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults, and family-driven and youth-guided services for children. Through a combination of different PIHP/CMHSP management and service delivery models, CMHSPs are normally contracted to directly provide or contract for the majority of direct services including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery.

Overview of Prepaid Inpatient Health Plans

MDHHS selected 10 PIHPs to manage the Behavioral Health Managed Care program. MDHHS defined regional boundaries for the PIHPs' service areas and selected one PIHP per region to manage the Medicaid specialty benefit for the entire region and to contract with CMHSPs and other providers within the region to deliver Medicaid-funded mental health, I/DD, and SUD supports and services to members in their designated service areas. Each region may comprise a single county or multiple counties. Table 2-2 provides a profile for each PIHP.

Table 2-2—PIHP Profiles

PIHP	Operating Region	Affiliated CMHSP(s)
NCN	Region 1	• Copper Country Mental Health Services • Gogebic Community Mental Health • Hiawatha Behavioral Health • Northpointe Behavioral Healthcare System • Pathways Community Mental Health
NMRE	Region 2	• AuSable Valley Community Mental Health Authority • Centra Wellness Network • North Country Community Mental Health • Northeast Michigan Community Mental Health Authority • Northern Lakes Community Mental Health Authority
LRE	Region 3	• Community Mental Health of Ottawa County • HealthWest • Network 180 • OnPoint • West Michigan Community Mental Health

PIHP	Operating Region	Affiliated CMHSP(s)
SWMBH	Region 4	• Barry County Community Mental Health Authority • Community Mental Health & Substance Abuse Services of St. Joseph's County • Integrated Services of Kalamazoo County • Pines Behavioral Health • Riverwood Center • Summit Pointe • Van Buren County Community Mental Health • Woodlands Behavioral Healthcare Network
MSHN	Region 5	• Bay-Arenac Behavioral Health • Community Mental Health Authority of Clinton, Eaton, & Ingham Counties • Community Mental Health for Central Michigan • Gratiot Integrated Health Network • Huron Behavioral Health • The Right Door for Hope, Recovery & Wellness • LifeWays • Montcalm Care Network • Newaygo County Mental Health • Saginaw County Community Mental Health Authority • Shiawassee Health & Wellness • Tuscola Behavioral Health Systems
CMHPSM	Region 6	• Lenawee Community Mental Health Authority • Community Mental Health Services of Livingston County • Monroe Community Mental Health Authority • Washtenaw County Community Mental Health
DWIHN	Region 7	• **DWIHN** is a single county CMHSP
OCHN	Region 8	• **OCHN** is a single county CMHSP
MCCMH	Region 9	• **MCCMH** is a single county CMHSP
Region 10	Region 10	• Genesee Health System • Lapeer County Community Mental Health • Sanilac County Community Mental Health • St. Clair County Community Mental Health

Quality Strategy

The 2023–2026 MDHHS CQS provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, long-term services and supports (LTSS), dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2023–2026 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS aligns with the 2022 CMS National Quality Strategy's (NQS') eight goals, which aim to promote the highest quality outcomes and the safest care for all individuals and focuses on a person-centric approach as individuals journey across the continuum of care. The 2023–2026 MDHHS CQS also aligns with the MDHHS 2023–2027 Strategic Priorities and supports the MDHHS mission to provide services and administer programs to improve the health, safety, and prosperity of the residents of Michigan. The 2023–2026 MDHHS CQS establishes a new three-year vision to further integrate managed care program priorities to implement quality monitoring and improvement strategies to ensure Medicaid member experience of care is positive, appropriate, and timely. To accomplish the CQS vision, the Medicaid programs collaboratively identified and agreed upon five CQS goals that pursue an integrated framework for population health improvement and a commitment to address health equity and reduce disparate outcomes. These goals and their associated objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity*.

Table 2-3—2023–2026 MDHHS CQS Goals and Objectives

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
• Goal 1: Embed Quality into the Care Journey • Goal 2: Advance Health Equity • Goal 3: Promote Safety	• Public health investment • Racial equity • Address food and nutrition, housing, and other social determinants of health (SDOH) • Improve the behavioral health service system for children and families • Improve maternal-infant health and reduce outcome disparities • Reduce lead exposure for children • Reduce child maltreatment and improve rate of permanency within 12 months • Expand and simplify safety net access • Reduce opioid and drug-related deaths	**Objective 1.1:** Monitor, track and trend the quality, timeliness and availability of care and services. **Objective 1.2:** Promote prevention, treatment, services, and supports to address acute and chronic conditions in at-risk populations. **Objective 1.3:** Ensure services are delivered to maximize beneficiaries' health and safety.

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
Goal #2: Strengthen person and family-centered approaches		
• Goal 1: Embed Quality into the Care Journey • Goal 2: Advance Health Equity • Goal 4: Foster Engagement	• Racial equity • Address food and nutrition, housing, and other SDOH • Improve the behavioral health service system for children and families • Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	**Objective 2.1**: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals. **Objective 2.2:** Ensure referrals are made to community resources to address SDOH needs.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
• Goal 4: Foster Engagement • Goal 5: Strengthen Resiliency • Goal 6: Embrace the Digital Age	• Expand and simplify safety net access • Address food and nutrition, housing, and other SDOH • Integrate services, including physical and behavioral health, and medical care with LTSS • Fully implement the Families First Preservation Services Act (FFPSA) state plan • Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	**Objective 3.1:** Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations. **Objective 3.2:** Promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
• Goal 2: Advance Health Equity • Goal 4: Foster Engagement • Goal 5: Strengthen Resiliency • Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements	• Public health investment • Racial equity • Address food and nutrition, housing, and other SDOH • Improve the behavioral health service system for children and families • Improve maternal-infant health and reduce outcome disparities • Reduce lead exposure for children • Reduce child maltreatment and improve rate of permanency • Fully implement the Families First FFPSA state plan • Expand and simplify safety net access • Reduce opioid and drug-related deaths • Ensure all administrations are managing outcomes, investing in evidence-based	**Objective 4.1:** Use evidence-informed approaches to address racial and ethnic disparities and health inequity.

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
	solutions, and ensuring program accuracy in benefit issuances	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
• Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements • Goal 8: Increasing Alignment	• Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	**Objective 5.1:** Promote value-based models that improve quality of care.

Quality Initiatives and Interventions

Through its CQS, MDHHS has also implemented many initiatives and interventions that focus on quality improvement. Examples of these initiatives and interventions include:

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or The Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring MHPs and ICOs to coordinate behavioral health services and services for persons with disabilities with the CMHSPs/PIHPs. While contracted MHPs and ICOs may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.
- **Value-Based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the SDOH, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. Managed care programs are at varying degrees

of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.

- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.
- **National Core Indicators (NCI) Adult Consumer Survey**—Michigan participates in the NCI survey, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with I/DD. Performance indicators within the survey assess individual outcomes, health, welfare, and rights (e.g., safety and personal security, health and wellness, and protection of and respect for individual rights); and system performance (e.g., service coordination, family and individual participation in provider-level decisions, the utilization of and outlays for various types of services and supports, cultural competency, and access to services).
- **Behavioral Health Quality Program Transformation**—MDHHS has conducted a comprehensive review of its QAPIP for the SBHS program toward the goal of developing and implementing a new program. The transformed program is intended to be more comprehensive, better defined, with a more rigorous methodology that aligns with other state and national requirements. The program includes a new set of performance measures that will be rolled out over a three-year period (SFY 2026 through SFY 2028 [i.e., measurement year (MY) 2025 through MY 2027]). The new measures align with CMS Core Set reporting, Home and Community-Based Services CAHPS survey, and CMS' Long-Term Services and Supports quality measures.

3. Assessment of Prepaid Inpatient Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2024 review period to evaluate the performance of the PIHPs on providing quality, timely, and accessible healthcare services to Behavioral Health Managed Care program members. Quality, as it pertains to EQR, means the degree to which the PIHPs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS' network adequacy standards) and §438.206 (adherence to MDHHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the PIHPs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each PIHP.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each PIHP to identify strengths and weaknesses that pertain to the domains of quality, timeliness, and access to services furnished by the PIHP for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about overall the quality, timeliness, and accessibility of care and services furnished by the PIHP.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weaknesses in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the PIHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 3-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 14, 2024	November 15, 2024
PMV	June 14, 2024	October 22, 2024

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	May 20, 2024	December 23, 2024
NAV	May 10, 2024	December 9, 2024
EDV	February 26, 2024	March 17, 2025

Validation of Performance Improvement Projects

For the SFY 2024 PIP activity, the PIHPs continued PIP topics that focused on disparities within their populations, as applicable, and reported quality improvement strategies for each performance indicator. HSAG conducted validation on the PIP Design stage (Steps 1 through 6), Implementation stage (Steps 7 and 8), and Outcomes stage (Step 9) of the selected PIP topic for each PIHP in accordance with the CMS EQR protocol for the validation of PIPs (CMS EQR Protocol 1).

Table 3-2 outlines the selected PIP topics and performance indicator(s) as defined by each PIHP.

Table 3-2—PIP Topic and Performance Indicator(s)

PIHP	PIP Topic	Performance Indicator(s)
NCN	*Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring Treatment from a Network Provider*	The percentage of individuals ages 12 years and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment from a member CMHSP.
NMRE	*The Percentage of Individuals Who are Eligible for OHH Services, Enrolled in the Service, and are Retained in the Service*	Client enrollment.
LRE	*FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black*	1. FUH Metric for Adults and Children Combined Who Identify as African American/Black. 2. FUH Metric for Adults and Children Combined Who Identify as White.
SWMBH	*Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	1. The percentage of African-American/Black beneficiaries with a 30-day follow-up after an ED [emergency department] visit for alcohol or other drug abuse or dependence. 2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.
MSHN	*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 Disparities Between the*	1. The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered

PIHP	PIP Topic	Performance Indicator(s)
	Black/African American Population and the White Population	service within 14 days of completing a biopsychosocial assessment. 2. The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.
CMHPSM	*Reduction of Disparity Rate Between Persons Served who are African American/Black and White and miss their appointment for an initial Biopsychosocial (BPS) Assessment and Assist Individuals in scheduling and keeping their initial assessment for services*	1. Initial assessment no-show rate for African-American consumers. 2. Initial assessment no-show rate for White consumers.
DWIHN	*Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit*	1. Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population. 2. Follow-Up within 7 Days After Hospitalization for Mental Illness for the White Population.
OCHN	*Improving Antidepressant Medication Management—Acute Phase*	1. The rate for White adult members who maintained antidepressant medication management for 84 days. 2. The rate for African-American adult members who maintained antidepressant medication management for 84 days.
MCCMH	*Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations*	1. The percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days. 2. The percentage of African-American adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.
Region 10	*Reducing Racial/Ethnic Disparities in Access to SUD Services*	1. The percentage of new persons (Black/African American) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. 2. The percentage of new persons (White) receiving a face-to-face service for treatment or supports within 14 calendar days of a

PIHP	PIP Topic	Performance Indicator(s)
		non-emergency request for service for persons with substance use disorders.

Performance Measure Validation

For the SFY 2024 PMV, HSAG validated the PIHPs' data collection and reporting processes used to calculate rates for a set of performance indicators identified through the MDHHS Codebook that were developed and selected by MDHHS for validation. The data collection and reporting processes evaluated included the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), Behavioral Health Treatment Episode Data Set (BH-TEDS) data production, and the PIHP's oversight of affiliated CMHSPs, as applicable. The PMV was conducted in accordance with the CMS EQR protocol for the validation of performance measures (CMS EQR Protocol 2) and included a PIHP information systems capabilities assessment (ISCA) and a review of data reported for the first quarter of SFY 2024.

Based on all validation methods used to collect information during the Michigan SFY 2024 PMV, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. The performance indicators developed and selected by MDHHS for the PMV are identified in Table 3-3.

Table 3-3—Performance Indicators

Indicator Number and Description	
#1	*The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*
#2	*The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*
#2e	*The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.*
#3	*The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.*
#4a	*The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.*
#4b	*The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days.*
#5	*The percent of Medicaid recipients having received PIHP managed services.*
#6	*The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*

Indicator Number and Description	
#8	*The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.*
#9	*The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*
#10	*The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*
#13	*The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.*
#14	*The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.*

Compliance Review

MDHHS requires its PIHPs to undergo annual compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The SFY 2024 compliance review is the first year of the three-year cycle of compliance reviews. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2024 through SFY 2026. MDHHS requested that HSAG conduct a review of the first half of the standards (with the exception of Standard II) in Year One (SFY 2024) and a review of the remaining half of the standards in Year Two (SFY 2025). The SFY 2026 (Year Three) compliance review will consist of a review of the standards and elements that required a corrective action plan (CAP) during the SFY 2024 (Year One) and SFY 2025 (Year Two) compliance review activities. Table 3-4 outlines the standards that will be reviewed over the three-year review cycle. The compliance review activity was conducted in accordance with CMS EQR Protocol 3.

Table 3-4—Compliance Review Standards

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of the PIHP's Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[4]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan MHPs. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 due to upcoming changes in PIHP financial liability of emergency services and pending guidance from MDHHS.

[4] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Network Adequacy Validation

The NAV activity for SFY 2024 included validation of network adequacy standards and indicators set forth by MDHHS. HSAG assessed the accuracy of MDHHS-defined network adequacy indicators reported by the PIHPs and evaluated the PIHPs' collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and the systems and processes used in network adequacy calculations, then determined the overall validation rating, which identified the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. Table 3-5 lists the network adequacy standards and indicators HSAG validated. The NAV activity was conducted in accordance with CMS EQR Protocol 4.

Table 3-5—Network Adequacy Standards and Indicators Validated

Network Category Description	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard
Adult Inpatient Psychiatric Services	30 minutes/30 miles	90 minutes/60 miles	150 minutes/125 miles
Adult Assertive Community Treatment	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Adult Crisis Residential Programs	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Adult Opioid Treatment Programs	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Adult Psychosocial Rehabilitation Programs (Clubhouses)	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Pediatric Inpatient Psychiatric Services	60 minutes/60 miles	120 minutes/125 miles	330 minutes/355 miles
Pediatric Crisis Residential Programs	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Pediatric Home-Based Services	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles
Pediatric Wraparound Services	30 minutes/30 miles	60 minutes/60 miles	90 minutes/90 miles

Encounter Data Validation

In SFY 2024, HSAG conducted and completed an EDV activity for all 10 PIHPs. The EDV activity included:

- Medical Record Review (MRR)—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing MDHHS' electronic encounter data to the information documented in the corresponding members' medical records for physician services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records*, in the CMS EQR Protocol 5.

The goal of the MRR activity was to verify the completeness and accuracy of encounter data by cross-referencing provider-documented information for services rendered. The review encompassed medical records to validate the reported information within the encounter data.

External Quality Review Activity Results

Region 1—NorthCare Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **NCN**'s PIP (i.e., the PIP Design, Implementation and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-6 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicator.

Table 3-6—Overall Validation Rating for NCN

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring Treatment from a Network Provider	*High Confidence*	*No Confidence*	The percentage of individuals ages 12 years and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment from a member CMHSP.	17.8%	16.8% ⇔	—	NA

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
Not Applicable (NA) = The PIHP did not identify an existing disparity within its population for this PIP during the Design stage of the PIP; therefore, the results do not include an assessment of a disparity.

The goal for **NCN**'s PIP is to demonstrate statistically significant improvement over the baseline for each remeasurement period. Table 3-7 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-7—Barriers and Interventions for NCN

Barriers	Interventions
Lack of qualified, trained staff across multiple populations and providers.	Training specific to co-occurring disorders (CODs) is encouraged for all clinical staff. NorthCare is paying for clinical staff training via grant funding.
	The PIHP offers consultation to each CMH provider to increase general knowledge of medication assisted treatment (MAT) and treating CODs.
	American society of addition medicine (ASAM) books purchased by the PIHP and trainings to be held by MDHHS.
	Request MDHHS allow the PIHP to pay for CMH staff to get certified alcohol and drug counselor/certified advanced alcohol and drug counselor.
Lack of progress on the performance indicator.	Seek to understand the CMH perception regarding their inability to increase their COD treatment via a barrier analysis survey.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NCN initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine effectiveness as available. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: NCN did not achieve significant improvement over the baseline performance for the first remeasurement period with the performance indicator demonstrating a non-statistically significant decline in performance. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear why the performance indicator did not achieve significant improvement over the baseline performance, the PIHP reported that youth and young adults receive co-occurring treatment at a lower rate than adults; however, the adult population experienced a decline in performance in the first remeasurement period.

Recommendation: HSAG recommends **NCN** consider evidence-based intervention efforts and risk factors in quality of care for the targeted population, identifying barriers specific to each age grouping.

Performance Measure Validation

HSAG evaluated **NCN**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

NCN received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **NCN** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-8 presents **NCN**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **NCN** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-8—Performance Measure Results for NCN

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	100%	100%	+/- 0.00%
Adults—Indicator #1b	100%	100%	+/- 0.00%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	65.33%	62.05%	-3.28%
MI–Adults—Indicator #2b	55.94%	56.68%	+0.74%
I/DD–Children—Indicator #2c	51.85%	48.00%	-3.85%
I/DD–Adults—Indicator #2d	53.33%	66.67%	+13.34%
Total—Indicator #2	59.20%	**58.20%**	-1.00%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	64.61%	54.41%	-10.20%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	70.73%	64.83%	-5.90%
MI–Adults—Indicator #3b	69.09%	59.70%	-9.39%
I/DD–Children—Indicator #3c	65.22%	52.17%	-13.05%
I/DD–Adults—Indicator #3d	88.24%	71.43%	-16.81%
Total—Indicator #3	70.28%	61.49%	-8.79%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	100%	100%	+/- 0.00%
Adults	96.74%	100%	+3.26%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	97.06%	94.12%	-2.94%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	6.64%	6.86%	+0.22%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.06%	98.91%	+0.85%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	20.27%	21.83%	+1.56%
DD–Adults—Indicator #8b	9.01%	8.81%	-0.20%
MI and DD–Adults—Indicator #8c	8.90%	10.29%	+1.39%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	100%	98.75%	-1.25%
DD–Adults—Indicator #9b	92.00%	59.13%	-32.87%
MI and DD–Adults—Indicator #9c	91.30%	64.94%	-26.36%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	5.71%	3.13%	-2.58%
Adults—Indicator #10b	9.82%	8.11%	-1.71%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	17.31%	18.06%	+0.75%
MI and DD–Adults	22.67%	24.83%	+2.16%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	54.54%	54.36%	-0.18%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NCN reviewed all performance indicator #1 records and reported that there were three consumers who had more than one pre-admission screening on the same day. While **NCN** reviewed and confirmed it was not reporting duplicates, **NCN** explained that for future performance indicator reviews, **NCN** will review cases in which consumers have multiple pre-admission screenings on the same date to ensure that duplicates are not reported. **NCN** proactively submitted its draft version of performance indicator reporting process documentation, which included additional items that **NCN** will begin doing immediately and continuing into SFY 2025. **NCN** also explained that any recommendations from HSAG may be added to its SFY 2025 performance indicator reporting process. [**Quality**]

Strength #2: NCN's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b were 100 percent, which exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #3: NCN's reported rates for SFY 2023 and SFY 2024 for indicator #4a for both the child and adult populations were 100 percent, and the rate for indicator #4a for the adult population increased from SFY 2023 to SFY 2024 by over 3 percentage points. In addition, both rates exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance and continuous improvement, and suggesting that both children and adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days). [**Quality**, **Timeliness**, and **Access**]

Strength #4: NCN's reported rates for indicators #10a and #10b decreased from SFY 2023 to SFY 2024, demonstrating improvement, as a lower rate indicates better performance for these indicators. In addition, indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upon review of **NCN**'s member-level detail file, HSAG identified that the data counts received in the initial member-level detail file did not match the data counts that were reported to MDHHS for Q1 SFY 2024 for indicator #1b. There were 248 compliant members listed in the member-level detail file and 250 compliant members reported to MDHHS. [**Quality**]

Why the weakness exists: **NCN** clarified that staff members reviewed and reported the wrong column of data to MDHHS. **NCN** also clarified the process for submitting data to MDHHS once performance indicator data were finalized, including how staff members reviewed draft numbers against what was submitted via the MDHHS template, which allowed for data entry errors when transferring data counts from the Peter Chang Enterprises, Inc. (PCE) report to the MDHHS template. **NCN** indicated that staff members will highlight each cell in the PCE PIHP performance indicator report as they complete the report to ensure that the data counts match. Additionally, **NCN** will compare the MDHHS consultation draft with both the PIHP report and the template submitted to MDHHS to ensure that each cell is reviewed, and that all numbers align across the three documents.

Recommendation: HSAG recommends that **NCN** follow the suggested validation step of staff members highlighting each cell in the PCE PIHP performance indicator report as staff members complete it to ensure that it matches what is entered in the MDHHS template. Additionally, HSAG recommends following its suggested validation step of comparing the MDHHS consultation draft with both the PIHP report and the template submitted to MDHHS to ensure that each cell is reviewed, and all numbers align across the three documents. Additional spot checks should be incorporated as necessary prior to submitting data to MDHHS, since data validation is a crucial step in ensuring an accurate submission.

Weakness #2: During PSV, HSAG identified four cases in which the service data specific to the performance indicator reported in the member-level detail file did not match the system documentation. [**Quality**]

Why the weakness exists: One case for indicator #4a for Copper Country did not have an accurate exception reason documented within the member-level detail file. One case for indicator #1 for Hiawatha had incorrect start/stop screening times documented. One case for indicator #4b for **NCN** was marked as an exception with an inaccurate exception reason reported in the member-level detail file compared to the proof-of-service screenshot. Another case for indicator #4b for **NCN** was marked as an exception without an exception reason listed in the member-level file.

Recommendation: HSAG recommends that **NCN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.

Weakness #3: During PSV, HSAG identified two members who were incorrectly categorized. [**Quality**]

Why the weakness exists: One case for indicator #1 for Pathways was incorrectly reported as out of compliance when the member should have been reported as in compliance. One case for indicator #4b in **NCN**'s member-level detail file was incorrectly marked as an exception when it should have been marked as in compliance.

Recommendation: HSAG recommends for future reporting that **NCN** further enhance its validation process by conducting a quality check prior to submission of data for cases listed as compliant that have blank biopsychosocial assessment dates or dates outside of the 14-day criteria. HSAG recommends that **NCN** meet with CMHSP staff members to provide further training when these and

similar errors occur, in addition to reviewing a statistically significant sample of cases from each category to check CMHSP reporting accuracy before submission.

Weakness #4: NCN's SFY 2024 indicator #2 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: NCN's SFY 2024 indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

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

Weakness #5: NCN's SFY 2024 indicator #3 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: NCN's SFY 2024 indicator #3 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Weakness #6: NCN's reported rate for indicator #4b decreased by nearly 3 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4b decreased by nearly 3 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024, suggesting that some members were not seen for timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit.

Recommendation: HSAG recommends that **NCN** focus its efforts on increasing timely follow-up care for members following discharge from a substance abuse detox unit. **NCN** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-9 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **NCN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **NCN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-9—Summary of Standard Compliance Scores for NCN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	13	8	3	**62%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	15	7	1	**68%**
Total	**94**	**85**	**69**	**16**	**9**	**81%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NCN received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Strength #2: NCN received a score of 100 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for coordinating care and services; conducting initial and ongoing assessments; developing and implementing person-centered service plans; and integrating physical and behavioral health care. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: NCN received a score of 62 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NCN received a *Not Met* score for eight elements, indicating gaps in the PIHP's processes related to maintaining comprehensive member rights policies; using all MDHHS-required model member handbook language; writing all member materials in the minimum 12-point font size; notifying members of terminated network providers; disseminating the member handbook timely; informing members of independent facilitators via the provider directory; updating the provider directory timely; and maintaining a machine-readable provider directory on its website.

Recommendation: As **NCN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: NCN received a score of 68 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NCN received a *Not Met* score for seven elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; accurate categorization and member notification of service authorization resolution extensions; process for when members request the termination of services; and service authorization decisions not reached timely.

Recommendation: As **NCN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from

the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-10.

Table 3-10—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **NCN** met the time and distance standard requirements for 100 percent of its members for three indicators. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-11. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-11—NCN Network Adequacy Compliance

	Region 10 Urban	Region 10 Rural	Region 10 Frontier
Adult Assertive Community Treatment—H0039	NA	NA	99.06%
Adult Crisis Residential Programs—H0018	NA	NA	NA
Adult Opioid Treatment Programs—H0020	NA	NA	67.00%
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	NA	100%	89.00%
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	NA	31.40%
Pediatric Crisis Residential Programs—H0018	NA	NA	NA
Pediatric Home-Based Services—H0036, H2033	NA	100%	76.68%
Pediatric Wraparound Services—H2021, H2022	NA	100%	91.00%
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	NA	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NCN had stable processes and procedures in place for data collection. [**Access**]

Strength #2: NCN had a comprehensive oversight structure with multiple layers for managing delegated entities. [**Access**]

Weaknesses and Recommendations

Weakness #1: NCN noted that a straight-line distance method was used to calculate the time and distance standard instead of the driving distance. [**Access**]

Why the weakness exists: NCN did not have formal guidance detailing its expectations for how the PIHPs should calculate time and distance to applicable providers.

Recommendation: HSAG recommends that **NCN** work with MDHHS to understand the appropriate method for calculating time and distance.

Weakness #1: NCN had one data analyst who calculated network adequacy. [**Access**]

Why the weakness exists: NCN lacked a full understanding of the expectations for how the PIHPs should calculate time and distance to applicable providers, which hindered the ability to train additional staff members effectively.

Recommendation: HSAG recommends that **NCN** train additional staff members to support network adequacy calculations as an additional layer of oversight.

Encounter Data Validation

Performance Results

Representatives from **NCN** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-12 outlines the key findings for **NCN** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-12—Key Findings for NCN

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **77.9 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Diagnosis Code* data element had a high medical record omission rate at **43.6 percent**. This indicates that the diagnosis codes in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Procedure Code Modifier* having the highest omission rate at **4.1 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.0 percent** of instances where codes were present in both the medical records and encounter data, with most errors related to inaccurate coding (**85.7 percent**), while some were attributed to procedure codes submitted in the encounter data that reflected

Analysis	Key Findings
	higher levels of service than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **98.5 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **35.7 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.4 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 3.6 percent, 2.1 percent, 2.9 percent, and 4.1 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.5 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A high rate of the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values (43.6 percent, 12.4 percent, and 17.2 percent, respectively) identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rates of unsupported *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies.

Additionally, gaps in provider training may have played a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **NCN** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submission protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **NCN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **NCN**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by the SBHS and BCCHPS. Table 3-13 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **NCN**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-13—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**NCN** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.* ✓ CQS Objective 1.1—**NCN** achieved the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.* ✗ CQS Objective 1.1—**NCN** did not achieve the 50th percentile for the total population for indicator #3: *The*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. The total rate also declined by almost 9 percentage points from the prior year. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	request for service and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 2—Northern Michigan Regional Entity

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **NMRE**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-14 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicator.

Table 3-14—Overall Validation Rating for NMRE

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
The Percentage of Individuals Who are Eligible for OHH Services, Enrolled in the Service, and are Retained in the Service	*High Confidence*	*High Confidence*	Client Enrollment.	7.7%	14.6% ↑	—	NA

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
Not Applicable (NA) = The PIHP did not identify an existing disparity within its population for this PIP during the Design stage of the PIP; therefore, the results do not include an assessment of a disparity.

The goal for **NMRE**'s PIP is to demonstrate statistically significant improvement over the baseline for each remeasurement period. Table 3-15 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-15—Barriers and Interventions for NMRE

Barriers	Interventions
Staff shortage	The PIHP advocated for MDHHS to expand qualifications to licensed practical nurses and registered nurses to provide qualifying services.

Barriers	Interventions
	The PIHP made funding available for providers to provide more training opportunities for community health workers to expand the workforce.
Provider capacity	The PIHP reached out to tribal entities and other settings to introduce the concept of expanding provider capacity.
Public health emergency ending	The PIHP provided education/resources and training at its monthly provider meetings regarding helping eligible clients from losing Medicaid benefits.
Clients concern regarding sharing their protected health information (PHI)	Clients are continuously educated to reassure that information is only shared securely for care coordination purposes.
Provider's concern around managing PHI.	The PIHP contracted with a third party to provide education to providers and their staff on how to safely share PHI for care coordination.
Clients are disenrolled in health home services if they move from one health home location to another.	The PIHP provided education to home health providers on transfers for health home versus disenrollment, which allows for the individual to remain enrolled without any disruption of service.
Complexity and lack of understanding of the enrollment process	The PIHP worked with representatives from the MDHHS to streamline the enrollment process to allow more providers to easily participate in the program.
Financial sustainability of Health Homes	The PIHP provides support to current providers, avoids inaccuracies that lead to delay in payment, monitors payment recoupments and providers who have no submitted claims.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NMRE initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Strength #2: NMRE achieved statistically significant improvement over the baseline performance for the first remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **NMRE** continue to evaluate interventions to determine the effectiveness of each effort.

Performance Measure Validation

HSAG evaluated **NMRE**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

NMRE received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **NMRE** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-16 presents **NMRE**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **NMRE** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-16—Performance Measure Results for NMRE

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	99.20%	98.43%	-0.77%
Adults—Indicator #1b	98.87%	98.86%	-0.01%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	59.24%	60.25%	-1.01%
MI–Adults—Indicator #2b	51.29%	50.99%	-0.30%
I/DD–Children—Indicator #2c	66.67%	73.44%	+6.77%
I/DD–Adults—Indicator #2d	45.71%	60.00%	+14.29%
Total—Indicator #2	54.43%	55.30%	+0.87%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	65.43%	60.15%	-5.28%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	62.33%	63.67%	+1.34%
MI–Adults—Indicator #3b	62.89%	63.51%	+0.62%
I/DD–Children—Indicator #3c	71.67%	65.71%	-5.96%
I/DD–Adults—Indicator #3d	50.00%	82.14%	+32.14%
Total—Indicator #3	62.89%	64.38%	+1.49%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	96.88%	92.00%	-4.88%
Adults	94.87%	87.20%	-7.67%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	90.08%	95.49%	+5.41%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	7.43%	7.71%	+0.28%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.47%	97.06%	+1.59%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	25.30%	25.98%	+0.68%
DD–Adults—Indicator #8b	10.74%	10.17%	-0.57%
MI and DD–Adults—Indicator #8c	15.67%	15.95%	+0.28%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.88%	99.83%	-0.05%
DD–Adults—Indicator #9b	69.13%	48.38%	-20.75%
MI and DD–Adults—Indicator #9c	93.50%	81.16%	-12.34%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	14.63%	10.77%	-3.86%
Adults—Indicator #10b	10.25%	13.06%	+2.81%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	21.85%	20.99%	-0.86%
MI and DD–Adults	32.76%	32.64%	-0.12%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	50.36%	48.61%	-1.75%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NMRE continued to demonstrate appropriate oversight and consistent processes across all its CMHSPs. Technology also continued to be leveraged to mitigate issues identified during the measurement period. [**Quality**]

Strength #2: NMRE's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #3: NMRE's reported rate for indicator #4b increased by greater than 5 percentage points from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2024, demonstrating improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: NMRE's reported rates for indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During the Northern Lakes PSV, for indicator #4a, HSAG identified one member with a date of birth (DOB) discrepancy between the member-level detail file and the system documentation. [**Quality**]

Why the weakness exists: NMRE indicated that an erroneous DOB was entered in the CMHSP's system by way of an autofill issue from the contracted crisis agency that saw the member. Northern Lakes identified the demographic changes from the autofill issue and made corrections as needed. The corrections took place after the performance indicator data were already finalized with the erroneous DOB and could not be corrected. Northern Lakes confirmed that there was only the one erroneous DOB for indicator #4a included in reporting and that it had no impact on the corresponding population (i.e., adult versus child).

Recommendation: Although the DOB issue had no impact on Northern Lake's reported indicator #4a rate, HSAG recommends that **NMRE** continue to leverage technology to prevent reoccurrence of autofill issues and conduct testing to ensure that similar errors do not persist.

Weakness #2: NMRE's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: NMRE's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **NMRE** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #3: NMRE's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: NMRE's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Weakness #4: NMRE's reported rate for indicator #4a for the child population decreased by more than 4 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. In addition, **NMRE**'s reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2023 and SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NMRE's reported rate for indicator #4a for the child population decreased by more than 4 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. In addition, **NMRE**'s reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2023 and SFY 2024. Both decreases in performance suggest that some children and adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **NMRE** continue to focus its efforts on increasing timely follow-up care for children and adults following discharge from a psychiatric inpatient unit. **NMRE** should continue to monitor the decreases in performance and implement appropriate interventions to improve performance related to the performance indicators, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-17 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **NMRE**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **NMRE** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-17—Summary of Standard Compliance Scores for NMRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	16	5	3	**76%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	16	6	1	**73%**
Total	**94**	**85**	**73**	**12**	**9**	**86%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NMRE received a score of 100 percent in the Availability of Services program area, demonstrating that the PIHP has adequate processes for monitoring its access system and the

timeliness of access to detoxification, methadone, and residential services for its SUD priority populations. [**Access** and **Timeliness**]

Strength #2: NMRE received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: NMRE received a score of 76 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NMRE received a *Not Met* score for five elements, indicating gaps in the PIHP's processes related to using all of MDHHS-required model member handbook language; writing all member materials in the minimum 12-point font size and at or below the 6.9 reading grade level; obtaining MDHHS approval of its member handbook; informing members of independent facilitators via the provider directory; organizing its provider directory via county; and maintaining a machine-readable provider directory on its website.

Recommendation: As **NMRE** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: NMRE received a score of 73 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: NMRE received a *Not Met* score for six elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; accurate categorization and member notification of service authorization resolution extensions; and service authorization decisions not reached timely.

Recommendation: As **NMRE** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as

applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-18.

Table 3-18—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **NMRE** met the time and distance standard requirements for 100 percent of its members for four indicators. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-19 "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-19—NMRE Network Adequacy Compliance

	NMRE Urban	NMRE Rural	NMRE Frontier
Adult Assertive Community Treatment—H0039	NA	100%	NA
Adult Crisis Residential Programs—H0018	NA	80.00%	NA
Adult Opioid Treatment Programs—H0020	NA	33.44%	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	NA	60.00%	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	100%	NA
Pediatric Crisis Residential Programs—H0018	NA	30.00%	NA
Pediatric Home-Based Services—H0036, H2033	NA	100%	NA
Pediatric Wraparound Services—H2021, H2022	NA	100%	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	10.00%	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NMRE and all five of its delegated CMHSPs used the managed care information system, PCE, which facilitated network adequacy calculations and reporting. [**Access**]

Strength #2: NMRE conducted quarterly medical claim verification audits of its CMHSPs, which allowed **NMRE** to confirm units of service and cross-reference expected counts. If discrepancies were identified, **NMRE** would work with the Information Technology (IT) Department to investigate voids and make necessary corrections. [**Access**]

Weaknesses and Recommendations

Weakness #1: Provider data elements and demographic information were manually entered from credentialing applications into the RECON system by **NMRE**'s staff. [**Access**]

Why the weakness exists: NMRE did not have automatic or systemic data upload capabilities in place at the time of the reporting.

Recommendation: Although **NMRE** had quality assurance checks and validations in place, HSAG recommends that **NMRE** explore options to have the data automatically or systemically uploaded from one system to another to mitigate the potential for human data entry error.

Encounter Data Validation

Performance Results

Representatives from **NMRE** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-20 outlines the key findings for **NMRE** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-20—Key Findings for NMRE

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **73.1 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code* and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **11.2 percent** and **17.6 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low to moderate encounter data omission rates with *Date of Service* having the highest omission rate at **9.6 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.8 percent** of instances where codes were present in both the medical records and encounter data, with all errors related to procedure codes submitted in the encounter data that reflected higher levels of service than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **99.8 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **68.8 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.0 percent. [**Quality**]

Strength #2: The *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rate of 2.8 percent. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 99.8 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 11.0 percent of the *Procedure Code* and more than 17.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rates of unsupported *Procedure Code* and *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **NMRE** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocol, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **NMRE**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **NMRE**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-21 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **NMRE** s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-21—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**NMRE** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✗ CQS Objective 1.1—**NMRE** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. The total rate also declined by approximately 5 percentage points from the prior year. ✗ CQS Objective 1.1—**NMRE** did not achieve the 50th percentile total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	☒ Quality ☒ Timeliness ☐ Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 3—Lakeshore Regional Entity

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **LRE**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-22 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-22—Overall Validation Rating for LRE

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black	*Low Confidence*	*No Confidence*	*FUH* Metric for Adults and Children Combined Who Identify as African American/Black.	60.3%	57.2% ⇔	—	Yes
			FUH Metric for Adults and Children Combined Who Identify as White	72.0%	70.2% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

With the 2024 annual submission, **LRE** revised the baseline data that was reported in 2022. The PIHP did not provide the rationale for this revision.

The goals for **LRE**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-23 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-23—Barriers and Interventions for LRE

Barriers	Interventions
Lack of timely *FUH* follow-up encounter data due to data lags.	Modify and develop reporting platforms to identify consumers without the prescribed FUH follow-up for FUH 7-day and 30-day metrics.
Lack of data integrity from CMHSPs/lack of standardization of data expectation.	Develop *FUH* reporting templates and train CMHSPs. Develop error reports to identify CMHSP data errors for follow-up and retraining with CMHSPs. Ensure each CMHSP has trained backup staff to cover reporting of *FUH* data to the PIHP.
Lack of data integrity from Zenith Technology Solutions (ZTS).	Modify ZTS programming logic to ensure measure data integrity.
Lack of CC360 (MDHHS data warehouse) data availability/CC360 data lag.	Develop predictive models that reduce the risk of CC360 data lag.
Lack of *FUH* collaboration at MHP level.	Develop *FUH* reporting templates and train CMHSPs. Determine best timing and frequency of uploading *FUH* data into CC360. Hold quarterly meetings with MHPs to discuss *FUH* measure.
Lack of *FUH* collaboration at CMHSP level	Present *FUH* data errors to the CMHSP. Hold quarterly meetings with CMHSP staff.
Lack of *FUH* collaboration at provider level	Drafted value-based incentive program for providers to establish goals. Collaborate with providers to identify opportunities for CMHSP/MHP to meet with consumer/guardian prior to discharge. Develop educational materials for members prior to discharge.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LRE initiated interventions that were reasonably linked to their corresponding barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: LRE did not provide intervention evaluation results to determine the effectiveness of each effort. [**Quality**]

Why the weakness exists: It is unclear why the PIHP did not provide intervention evaluation data. HSAG provided feedback with the initial submission; however, the PIHP elected not to resubmit its PIP for final validation.

Recommendation: HSAG recommends that **LRE** develop and initiate active interventions that can be tracked and trended over time to determine the success of each effort.

Weakness #2: LRE did not achieve the state-defined goals for the PIP with both performance indicators demonstrating non-statistically significant declines in performance as compared to the baseline. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear why the goal was not achieved or why the performance indicators declined, the data suggest that barriers exist for both populations for receiving a follow-up visit following a hospital discharge.

Recommendation: HSAG recommends **LRE** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **LRE**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

LRE received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **LRE** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-24 presents **LRE**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **LRE** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-24—Performance Measure Results for LRE

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	97.56%	98.70%	+1.14%
Adults—Indicator #1b	98.22%	98.42%	+0.20%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	58.94%	58.03%	-0.91%
MI–Adults—Indicator #2b	55.57%	48.00%	-7.57%
I/DD–Children—Indicator #2c	60.64%	39.29%	-21.35%
I/DD–Adults—Indicator #2d	66.20%	54.17%	-12.03%
Total—Indicator #2	57.86%	51.73%	-6.13%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	67.22%	67.86%	+0.64%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	52.58%	59.84%	+7.26%
MI–Adults—Indicator #3b	56.31%	60.81%	+4.50%
I/DD–Children—Indicator #3c	64.13%	47.75%	-16.38%
I/DD–Adults—Indicator #3d	59.46%	51.90%	-7.56%
Total—Indicator #3	55.28%	58.72%	+3.44%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	93.55%	96.81%	+3.26%
Adults	96.20%	94.80%	-1.40%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	98.06%	100%	+1.94%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	5.18%	5.37%	+0.19%
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.29%	95.00%	-0.29%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	21.77%	23.54%	+1.77%
DD–Adults—Indicator #8b	10.82%	13.12%	+2.30%
MI and DD–Adults—Indicator #8c	10.87%	11.68%	+0.81%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.85%	99.78%	-0.07%
DD–Adults—Indicator #9b	95.41%	84.76%	-10.65%
MI and DD–Adults—Indicator #9c	93.75%	87.31%	-6.44%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	9.92%	18.49%	+8.57%
Adults—Indicator #10b	8.90%	12.79%	+3.89%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	15.02%	13.61%	-1.41%
MI and DD–Adults	22.39%	19.89%	-2.50%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	45.11%	40.93%	-4.18%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.
SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.
* A lower rate indicates better performance.
[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.
[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.
[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LRE continued to demonstrate strength in its efforts toward quality improvement, performance monitoring, and CMHSP oversight using its Power Business Intelligence (Power BI) technology dashboard and Arc of Treatment Model. [**Quality**]

Strength #2: LRE also demonstrated strength in its efforts to ensure BH-TEDS data completeness and accuracy. **LRE** hired an actuarial to research factors impacting performance indicator rates, and in doing so was able to identify that the BH-TEDS completion rate had a significant rate impact. **LRE** then actively worked with most of its CMHSPs (three of five) on timely improvement efforts. In addition, **LRE** continued to use its dashboard for overall BH-TEDS completeness monitoring and oversight. [**Quality**]

Strength #3: LRE's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #4: LRE's reported rate for indicator #4a for the child population increased from SFY 2023 to SFY 2024 by over 3 percentage points. In addition, the rate exceeded the established performance standard for SFY 2024, demonstrating improvement, and suggesting that children discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days). [**Quality**, **Timeliness**, and **Access**]

Strength #5: LRE's reported rate for indicator #4b increased by nearly 2 percentage points from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #6: LRE's reported rate for indicator #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upon review of OnPoint's member-level detail file, HSAG identified one case with an incorrect discharge date documented for indicator #4b. [**Quality**]

Why the weakness exists: **LRE** noted that OnPoint pulled its performance indicator data using Streamline and ran a separate report for each indicator. OnPoint then manually reviewed the performance indicator data, added any missing data, and corrected any obvious errors. Then, OnPoint manually added any missing "Reason Codes" with explanation, if applicable, at that time. After each report was reviewed and corrected, if necessary, OnPoint manually aggregated the data into one Microsoft Excel spreadsheet for submission to **LRE**. OnPoint conceded that this process introduced the potential for human error.

Recommendation: While OnPoint expects that the manual errors will be primarily eliminated due to transitioning its electronic health record (EHR) to PCE Systems by October 1, 2024, and the incorrect discharge date had no significant impact on the rate, HSAG recommends that **LRE** continue to work with the CMHSP to expand upon or implement additional process enhancements to improve the accuracy of indicator #4b data. This should include a reduction of manual processes, wherever possible. Additionally, OnPoint should implement another level of validation that includes reviewing a statistically significant sample of cases each quarter to confirm accurately reported discharge dates.

Weakness #2: Upon review of Ottawa's member-level detail file, HSAG identified one case with an incorrect discharge date documented for indicator #4b. [**Quality**]

Why the weakness exists: **LRE** noted that Ottawa utilized a two-step process to pull performance indicator data for indicator #4b. Once Ottawa initially pulled data, it then looked at claims to ensure that detox discharges were not missed. Ottawa then merged the data, and during the data merge the error occurred (i.e., the last billed detox service date was reported as the discharge date).

Recommendation: While Ottawa has since updated its manual process so that the same type of error does not occur in the future and expects that these type of errors will be primarily eliminated due to transitioning its EHR to PCE Systems in July 2025, HSAG recommends that **LRE** continue to work with the CMHSP to expand upon or implement additional process enhancements when necessary to improve the accuracy of indicator #4b data. This should include implementing another level of validation that includes reviewing a statistically significant sample of cases each quarter to confirm accurately reported discharge dates.

Weakness #3: **LRE**'s SFY 2024 indicator #2 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: **LRE**'s SFY 2024 indicator #2 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **LRE** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and

accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #4: LRE's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: LRE's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Weakness #5: LRE's reported rate for indicator #4a for the adult population decreased by nearly 2 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: LRE's reported rate for indicator #4a for the adult population decreased by nearly 2 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. The decrease in performance suggests that some adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **LRE** continue to focus its efforts on increasing timely follow-up care for adults following discharge from a psychiatric inpatient unit. **LRE** should continue to monitor the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Weakness #6: LRE's reported rate for indicator #10a for the child population increased by more than 5 percentage points and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: LRE's reported rate for indicator #10a for the child population increased by more than 5 percentage points and fell below the established performance standard for SFY 2024, suggesting an increase in readmissions for children to an inpatient psychiatric unit within 30 days of discharge and that children may have been prematurely discharged or follow-up was not timely following discharge.

Recommendation: HSAG recommends that **LRE** focus its efforts on reducing the number of inpatient psychiatric unit readmissions for children by working with providers on adequate discharge planning, patient education, and coordination of services post-discharge. In addition, HSAG recommends that **LRE** also consider the root cause of the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as educating providers on the potential of telemedicine as an option for providing post-discharge follow-up care and providing encouragement to members to access follow-up services via telemedicine where possible.

Compliance Review

Performance Results

Table 3-25 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **LRE**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **LRE** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-25—Summary of Standard Compliance Scores for LRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	16	5	3	**76%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	15	7	1	**68%**
Total	**94**	**85**	**73**	**12**	**9**	**86%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LRE received a score of 100 percent in the Availability of Services program area, demonstrating that the PIHP has adequate processes for monitoring its access system and the timeliness of access to detoxification, methadone, and residential services for its SUD priority populations. [**Access** and **Timeliness**]

Strength #2: LRE received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Strength #2: LRE received a score of 100 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for coordinating care and services; conducting initial and ongoing assessments; developing and implementing person-centered service plans; and integrating physical and behavioral health care. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: LRE received a score of 76 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: LRE received a *Not Met* score for five elements, indicating gaps in the PIHP's processes related to using all of MDHHS-required model member handbook language; including taglines in the provider directory; writing all member materials in the minimum 12-point font size; including the full addresses of MHPs in the member handbook; informing members of independent facilitators via the provider directory; and organizing its provider directory via county.

Recommendation: As **LRE** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: LRE received a score of 68 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: LRE received a *Not Met* score for seven elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; process for when a member no longer wishes services; ABD notices for when a claim payment denial occurs; and service authorization decisions not reached timely.

Recommendation: As **LRE** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-26.

Table 3-26—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **LRE** did not meet the time and distance standard requirements for 100 percent of its members across any indicators, which were reported as results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-27. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of

urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-27—LRE Network Adequacy Compliance

	LRE Urban	LRE Rural	LRE Frontier
Adult Assertive Community Treatment—H0039	99.10%	98.94%	NA
Adult Crisis Residential Programs—H0018	99.34%	99.78%	NA
Adult Opioid Treatment Programs—H0020	98.91%	93.33%	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	97.69%	99.34%	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	99.95%	95.76%	NA
Pediatric Crisis Residential Programs—H0018	84.90%	75.69%	NA
Pediatric Home-Based Services—H0036, H2033	99.83%	99.63%	NA
Pediatric Wraparound Services—H2021, H2022	99.81%	99.39%	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	99.98%	99.97%	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LRE's PCE system, Lakeshore Integrated Data Solutions (LIDS), had built-in, automatic validation routines that combed through enrollment and eligibility files to identify any errors or discrepancies. The PCE software generated a categorized error report that **LRE** used to resolve any issues efficiently. [**Access**]

Strength #2: LRE's monthly Regional Operations Advisory Team (ROAT) meetings improved the quality and usability of **LRE**'s provider website Uniform Resource Locator (URL) strings in the regional provider directory. [**Access**]

Weaknesses and Recommendations

Weakness #1: LRE was unable to calculate driving/travel time for the time and distance metrics per MDHHS' requirement during the NAV reporting period due to system limitations. **LRE** used straight-line distance when calculating the time and distance standard. [**Access**]

Why the weakness exists: LRE did not have the necessary software in place to calculate driving time and distance.

Recommendation: HSAG recommends that **LRE** adhere to guidance issued by MDHHS regarding time and distance methodology and using driving distance when reporting on network adequacy standards.

Weakness #2: Provider data elements and demographics were manually entered from credentialing applications into the LIDS system by **LRE**'s data submissions coordinator. [**Access**]

Why the weakness exists: LRE did not have any automated data feeds available to transmit provider information from the credentialing applications to the LIDS system.

Recommendation: Although **LRE** had quality assurance checks and validations in place, HSAG recommends that **LRE** explore options to have the data automatically or systemically uploaded from one system to another to mitigate the potential for human data entry error.

Weakness #3: LRE's LIDS system did not track or log any provider demographic changes. The PCE software could track these changes, but **LRE** did not have access to that information; therefore, the LIDS provider management module only contained current provider information with a "last change" date noted. Backup data would need to be researched by the change date to visually compare what change was made. [**Access**]

Why the weakness exists: LRE's software lacked systemic data capabilities to manage provider-related information across the PCE and LIDS systems effectively at the time of the reporting.

Recommendation: HSAG recommends that **LRE** explore options for a provider management database that retains historical provider data elements that can easily be retrieved for reference.

Weakness #4: LRE did not use the correct parameters for calculating the network adequacy indicators related to time and distance for all provider types. Upon correction and resubmission of its results, there was a significant improvement in results identified for the pediatric inpatient psychiatric services indicator. [**Access**]

Why the weakness exists: LRE was unfamiliar with the network adequacy reporting parameters and encountered user error while preparing the data for the reporting template.

Recommendation: HSAG recommends that **LRE** ensure parameters utilized in the calculations of time and distance for all provider types align with standards provided by MDHHS.

Encounter Data Validation

Performance Results

Representatives from **LRE** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-28 outlines the key findings for **LRE** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-28—Key Findings for LRE

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **50.6 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code Modifier* data element had a relatively high medical record omission rate at **18.9 percent.** This indicates that the diagnosis codes in the encounter data were not adequately supported by the members' medical records.

Analysis	Key Findings
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Procedure Code* having the highest omission rate at **3.1 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.6 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.6 percent** of instances where codes were present in both the medical records and encounter data, with errors related to inaccurate coding **(66.7 percent)** and procedure codes submitted in the encounter data that reflected higher levels of service than those supported in the medical records **(33.3 percent)**.
Procedure Code Modifier Accuracy Rate	• *The Procedure Code Modifier* data element was accurate in **98.8 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **69.4 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.0 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.4 percent, 2.3 percent, 3.1 percent, and 2.9 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.8 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Nearly 19.0 percent of the *Procedure Code Modifier* data element values identified within the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rate of unsupported *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **LRE** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **LRE**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **LRE**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-29 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **LRE**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-29—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**LRE** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✗ CQS Objective 1.1—**LRE** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. The total rate also declined by approximately 6 percentage points from the prior year. ✗ CQS Objective 1.1—**LRE** did not achieve the 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	☒ Quality ☒ Timeliness ☐ Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 4—Southwest Michigan Behavioral Health

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **SWMBH**'s PIP (i.e., the PIP Design, Implementation and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-30 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-30—Overall Validation Rating for SWMBH

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	*High Confidence*	*Low Confidence*	The percentage of African-American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.	14.5%	25.8% ↑	—	Yes
			The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.	23.4%	42.7% ↑	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).

The goals for **SWMBH**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-31 displays the barriers identified through quality improvement and causal/barrier

analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-31—Barriers and Interventions for SWMBH

Barriers	Interventions
Inconsistent coordination between ED and PIHP/providers.	Provide feedback to Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment) programs and ED staff; collaborate to identify ways to increase the percentage of Blacks/African Americans who receive follow-up care. Expand Project ASSERT peer intervention to Van Buren County.
Data sharing gaps between Project ASSERT programs and PIHP/MDHHS.	Project ASSERT programs to report encounters for ED follow-up services using H0002 code, beginning with Integrated Services of Kalamazoo.
Stigma in the African American/Black community regarding behavioral health treatment.	Anti-stigma/accessibility campaign launched in the PIHPs region to impact health care disparities in behavioral health.
Lack of provider awareness of drivers in disparities in care.	Educate behavioral health providers through providing symposium and at least eight workshops/trainings for providers.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SWMBH initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Strength #1: SWMBH achieved statistically significant improvement over the baseline for both performance indicators. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: SWMBH did not achieve the state-defined goal of eliminating the existing disparity in the first remeasurement period. [**Quality** and **Access**]

Why the weakness exists: While it is unclear why the goal was not achieved, **SWMBH** made significant progress in improvement performance among both populations.

Recommendation: HSAG recommends that **SWMBH** revisit its causal barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **SWMBH**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

SWMBH received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **SWMBH** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-32 presents **SWMBH**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **SWMBH** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-32—Performance Measure Results for SWMBH

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	96.39%	99.57%	+3.18%
Adults—Indicator #1b	97.85%	99.52%	+1.67%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	50.23%	61.77%	+11.54%
MI–Adults—Indicator #2b	67.47%	68.58%	+1.11%
I/DD–Children—Indicator #2c	52.67%	75.44%	+22.77%
I/DD–Adults—Indicator #2d	73.68%	84.85%	+11.17%
Total—Indicator #2	61.15%	**67.17%**	+6.02%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	62.34%	59.09%	-3.25%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	56.24%	54.91%	-1.33%
MI–Adults—Indicator #3b	56.68%	56.98%	+0.30%
I/DD–Children—Indicator #3c	57.58%	46.28%	-11.30%
I/DD–Adults—Indicator #3d	80.00%	91.18%	+11.18%
Total—Indicator #3	57.12%	56.28%	-0.84%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	94.74%	96.20%	+1.46%
Adults	94.80%	96.62%	+1.82%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	98.92%	100%	+1.08%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	6.37%	7.15%	+0.78%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	89.41%	96.50%	+7.09%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	23.74%	26.16%	+2.42%
DD–Adults—Indicator #8b	8.78%	10.12%	+1.34%
MI and DD–Adults—Indicator #8c	10.00%	11.14%	+1.14%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.93%	99.88%	-0.05%
DD–Adults—Indicator #9b	93.41%	94.08%	+0.67%
MI and DD–Adults—Indicator #9c	92.45%	93.79%	+1.34%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	2.94%	7.89%	+4.95%
Adults—Indicator #10b	9.57%	12.59%	+3.02%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	17.81%	17.59%	-0.22%
MI and DD–Adults	21.45%	24.34%	+2.89%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	48.25%	47.44%	-0.81%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SWMBH continued to demonstrate strength in its collaboration and process improvements across all of the CMHSPs. Through committee meetings, process improvement trainings, and Power BI dashboard checks and balances, **SWMBH** has continued its efforts to ensure standardization of CMHSP data entry that supports accurate performance indicator reporting while providing the PIHP with the ability to readily monitor CMHSP performance. [**Quality**, **Timeliness**, and **Access**]

Strength #2: SWMBH continues to see an improvement in data quality as all delegated CMHSPs work in the same PCE-based EHR system, which includes extensive data controls and validation steps. [**Quality**]

Strength #3: SWMBH's reported rates for both SFY 2023 and SFY 2024 for indicator #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #4: SWMBH's reported SFY 2024 total rate for indicator #2 increased by greater than 5 percentage points from SFY 2023 to SFY 2024 and exceeded the 75th percentile benchmark, demonstrating improvement and suggesting that new persons during the quarter were receiving a biopsychosocial assessment within 14 calendar days of a non-emergency request for service most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #5: SWMBH's reported rates for indicator #4a for both the child and adult populations increased from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2024, demonstrating improvement and suggesting that both children and adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days). [**Quality**, **Timeliness**, and **Access**]

Strength #6: SWMBH's reported rate for indicator #4b was 100 percent for SFY 2024, increased from SFY 2023 to SFY 2024, and exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistent improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit. [**Quality**, **Timeliness**, and **Access**]

Strength #7: SWMBH's reported rate for indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small

percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, multiple CMHSPs' indicator #2e cases were identified as erroneously reported as expired requests, including one Barry case, one Berrien case, one **SWMBH** SUD case, and three Pines cases. [**Quality**]

Why the weakness exists: **SWMBH** sampled additional cases for each of the impacted CMHSPs and did not identify any findings; however, it noted that the issues were due to manual data entry errors and later than expected implementation of PIHP-enhanced monitoring reports.

Recommendation: HSAG recommends that **SWMBH** continue to evaluate and improve its matching algorithm and monitor the effectiveness of the SFY 2024 Q1 updates to ensure appropriate linking between the CMHSP identifier (ID) in the request for services and the master ID in the SmartCare EHR system to look for all BH-TEDS encounters. HSAG also recommends that **SWMBH** evaluate the updates it made to its Expired Request Tableau report, to ensure that the report is supporting all CMHSPs in promptly identifying inaccurately documented expired requests. Lastly, **SWMBH** indicated that it has modified its contract language related to CMHSPs' BH-TEDS admissions timeliness, which HSAG encourages **SWMBH** to continue working toward implementing.

Weakness #2: During PSV, HSAG identified one Berrien indicator #10 case that was incorrectly reported as an exception because the provided documentation did not support the case being considered an exception. [**Quality**]

Why the weakness exists: **SWMBH** researched the case and noted that it was an isolated error, as **SWMBH** confirmed its manual review of all other indicator #10 case exceptions did not identify any other inaccuracies.

Recommendation: HSAG recommends that **SWMBH** increase manual validation of indicator #10 exceptions and require Berrien to conduct validation of 100 percent of indicator #10 case exceptions for a PIHP-defined time period.

Weakness #3: During HSAG's review of member-level data, HSAG identified a misalignment between the member-level detail data counts and Michigan's Mission-Based Performance Indicator System (MMBPIS) reporting to MDHHS as follows:

- Indicators #2a and #2 total—The member-level data count was 405 for the number of new persons completing the biopsychosocial assessment within 14 calendar days or at first request for service, but the final report count was 404, which impacted the total count in the final report.
- Indicator #4a adults—The member-level data count for the number of discharges that were exceptions was 210, the number of net discharges was 326, and the number of discharges followed up by the CMHSP/PIHP within seven days was 315. The final report count was 211, 325, and 314, respectively. [**Quality**]

Why the weakness exists: **SWMBH** indicated that the misaligned counts were specifically related to Summit Pointe's and Riverwood's inaccurate MMBPIS report submissions to **SWMBH**.

Recommendation: HSAG recommends that **SWMBH** carry out its proposed CAP for both CMHSPs, requiring them to complete additional data checks prior to submission of performance indicator data to **SWMBH**. HSAG further recommends that **SWMBH** add steps to validate that total counts align with the supporting member-level data reported by the CMHSPs to **SWMBH**.

Weakness #4: During PSV, HSAG identified that one indicator #4b case was incorrectly reported as compliant when in fact the case should have been reported as an exception, because the member left the facility against medical advice (AMA). [**Quality**]

Why the weakness exists: SWMBH researched the case and noted that it was an isolated error, as **SWMBH** confirmed it did not identify additional cases that were inaccurately noted as compliant when the member actually had been discharged early due to leaving AMA or the facility terminated care early.

Recommendation: HSAG recommends that **SWMBH** follow through on its proposed action to verify that its monitoring report logic identifies cases where providers did not complete follow-up care when an individual was discharged early AMA or due to termination of care by the facility, to ensure that these cases are not inaccurately reported as compliant in indicator #4b. As noted by **SWMBH**, the report updates should include adding a "Discharge Reason" to ensure accurate identification of both AMA and facility-terminated care-related discharges. HSAG additionally recommends that **SWMBH** complete provider training on appropriate documentation of members who were discharged AMA and members whose care was terminated by the facility, to avoid future data errors.

Weakness #5: SWMBH's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: SWMBH's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Compliance Review

Performance Results

Table 3-33 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **SWMBH**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **SWMBH** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-33—Summary of Standard Compliance Scores for SWMBH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	18	3	3	**86%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	16	6	1	**73%**
Total	**94**	**85**	**76**	**9**	**9**	**89%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SWMBH received a score of 100 percent in the Availability of Services program area, demonstrating that the PIHP has adequate processes for monitoring its access system and the timeliness of access to detoxification, methadone, and residential services for its SUD priority populations. [**Access** and **Timeliness**]

Strength #2: SWMBH received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Strength #3: SWMBH received a score of 100 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for coordinating care and services; conducting initial and ongoing assessments; developing and implementing person-centered service plans; and integrating physical and behavioral health care. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: SWMBH received a score of 73 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: SWMBH received a *Not Met* score for six elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and member notification of service authorization resolution extensions; process for when a member no longer wishes services; and service authorization decisions not reached timely.

Recommendation: As **SWMBH** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-34.

Table 3-34—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **SWMBH** met the time and distance standard requirements for 100 percent of its members for eight indicators. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-35. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-35—SWMBH Network Adequacy Compliance

	SWMBH Urban	SWMBH Rural	SWMBH Frontier
Adult Assertive Community Treatment—H0039	98.90%	100%	NA
Adult Crisis Residential Programs—H0018	86.40%	100%	NA
Adult Opioid Treatment Programs—H0020	95.40%	100%	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	96.90%	100%	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	95.40%	100%	NA
Pediatric Crisis Residential Programs—H0018	14.30%	NA	NA
Pediatric Home-Based Services—H0036, H2033	98.60%	100%	NA
Pediatric Wraparound Services—H2021, H2022	99.20%	100%	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	84.00%	100%	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SWMBH had sufficient policies and procedures in place to ensure reporting accuracy for measures in scope of review. [**Access**]

Strength #2: Although **SWMBH** only had one data analyst who supported the network adequacy reporting activities, it also hired a new data analyst in July 2024, who will be trained and capable of producing network adequacy reporting. **SWMBH** was also exploring the option of cross-training a compliance expert to produce network adequacy reporting in the future, subsequently improving business continuity related to network adequacy reporting. [**Access**]

Weaknesses and Recommendations

Weakness #1: SWMBH had one data analyst who supported the network adequacy reporting activities. [**Access**]

Why the weakness exists: SWMBH lacked a full understanding of the expectations for how the PIHPs should calculate time and distance to applicable providers, which hindered the ability to train additional staff members effectively.

Recommendation: HSAG recommends that **SWMBH** explore the capabilities of training additional staff members on supporting network adequacy reporting activities to ensure reporting continuity.

Weakness #2: SWMBH did not use the correct parameters for calculating the network adequacy indicator related to time and distance for pediatric inpatient psychiatric services, which significantly impacted results. Additionally, incorrect parameters were also used for adult inpatient psychiatric services (rural), however no significant impact to results was identified. [**Access**]

Why the weakness exists: SWMBH was unfamiliar with the network adequacy reporting parameters and encountered user error while preparing the data for the reporting template.

Recommendation: HSAG recommends that **SWMBH** ensure parameters used in the calculations of time and distance for both pediatric and adult inpatient psychiatric services align with the standards provided by MDHHS.

Encounter Data Validation

Performance Results

Representatives from **SWMBH** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-36 outlines the key findings for **SWMBH** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-36—Key Findings for SWMBH

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **63.3 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code Modifier* data element had a relatively high medical record omission rate at **15.2 percent.** This indicates that the diagnosis codes in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Date of Service* having the highest omission rate at **4.6 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.7 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.7 percent** of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.

Analysis	Key Findings
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **98.7 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **74.2 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* and *Diagnosis Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 0.0 percent and 4.8 percent, respectively. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 4.6 percent, 4.1 percent, 4.5 percent, and 1.5 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.7 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 15.0 percent of the *Procedure Code Modifier* data element values identified within the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rate of unsupported *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **SWMBH** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **SWMBH**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **SWMBH**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-37 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **SWMBH**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-37—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**SWMBH** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✓ CQS Objective 1.1—**SWMBH** achieved the 75th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. The total rate also increased by approximately 6 percentage points from the prior year. ✗ CQS Objective 1.1—**SWMBH** did not achieve MDHHS' 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment are included in the PMV activity, the data are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 5—Mid-State Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MSHN**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-38 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-38—Overall Validation Rating for MSHN

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
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 Disparities Between the Black/African American Population and the White Population	*High Confidence*	*No Confidence*	The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	65.0%	59.7% ⇔	—	Yes
			The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	69.5%	63.0% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

The goals for **MSHN**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-39 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-39—Barriers and Interventions for MSHN

Barriers	Interventions
Members do not show up for appointments.	Implement an appointment reminder system and modify the process for coordination between providers.
Workforce shortage; lack of qualified, culturally competent clinicians resulting in inadequate, limited available appointments within 14 days.	Recruit student interns and recent graduates from colleges and universities with diverse student populations. Use external contractors to provide services.
Minority groups are unaware of services offered.	Identify and engage with partner organizations that predominantly serve communities of color. Distribute community mental health services program (CMHSP) informational materials to individuals through identified partner organizations within communities of color.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MSHN initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: MSHN did not achieve the state-defined goals for the PIP with both performance indicators demonstrating non-statistically significant declines in performance as compared to the baseline. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear why the goal was not achieved or why the performance indicators declined, the data suggest that barriers exist for both populations for receiving a follow-up visit following a hospital discharge.

Recommendation: HSAG recommends that **MSHN** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **MSHN**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

MSHN received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **MSHN** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-40 presents **MSHN**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **MSHN** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-40—Performance Measure Results for MSHN

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	99.32%	98.58%	-0.74%
Adults—Indicator #1b	99.42%	99.67%	+0.25%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	59.14%	60.43%	+1.29%
MI–Adults—Indicator #2b	62.95%	64.31%	+1.36%
I/DD–Children—Indicator #2c	49.21%	43.51%	-5.70%
I/DD–Adults—Indicator #2d	57.29%	67.83%	+10.54%
Total—Indicator #2	60.81%	**61.79%**	+0.98%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	72.68%	**72.40%**	-0.28%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	56.86%	58.28%	+1.42%
MI–Adults—Indicator #3b	59.47%	58.09%	-1.38%
I/DD–Children—Indicator #3c	77.16%	76.05%	-1.11%
I/DD–Adults—Indicator #3d	61.90%	65.74%	+3.84%
Total—Indicator #3	59.53%	59.72%	+0.19%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	97.25%	94.67%	-2.58%
Adults	95.60%	95.20%	-0.40%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	97.83%	95.02%	-2.81%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	7.11%	7.35%	+0.24%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.76%	96.86%	+0.10%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	21.67%	23.35%	+1.68%
DD–Adults—Indicator #8b	8.77%	9.12%	+0.35%
MI and DD–Adults—Indicator #8c	10.12%	10.03%	-0.09%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.85%	99.67%	-0.18%
DD–Adults—Indicator #9b	92.53%	69.18%	-23.35%
MI and DD–Adults—Indicator #9c	93.75%	77.06%	-16.69%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	8.75%	9.36%	+0.61%
Adults—Indicator #10b	13.01%	10.73%	-2.28%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	19.69%	19.57%	-0.12%
MI and DD–Adults	25.91%	26.12%	+0.21%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	48.77%	48.00%	-0.77%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MSHN's subcontracted CMHSPs continued to participate in discussion at Quality Improvement Committee meetings to assist in identifying causal factors, barriers, and effective interventions. Best practices were also identified and shared with other CMHSPs and PIHPs, including processes, policies and procedures, and protocols used. [**Quality**, **Timeliness**, and **Access**]

Strength #2: MSHN implemented various improvement strategies such as increasing the number of staff members and network providers, incorporating the practice of "teach back" (i.e., having members repeat back what they are being told to confirm understanding) during care coordination and appointment reminders, performing appointment reminder phone calls to discuss any barriers and develop relationships with members, and expanding hours of operation. [**Quality**, **Timeliness**, and **Access**]

Strength #3: MSHN's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #4: MSHN's reported rate for indicator #4a for the adult population exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days). [**Quality**, **Timeliness**, and **Access**]

Strength #5: MSHN's reported rate for indicator #4b exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #6: MSHN's reported rate for indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

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

Why the weakness exists: Enrollment system information indicated that the member had a Family Planning Program waiver (Plan First) and was not eligible for Medicaid. **MSHN** confirmed that the member should be removed from indicator #10 and that, based on its review of all other reported indicator #10 cases, this was an isolated issue.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.

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

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

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

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

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

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

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

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

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

Weakness #5: MSHN's SFY 2024 indicator #2 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's SFY 2024 indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

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

Weakness #6: MSHN's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's SFY 2024 indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Weakness #7: MSHN's reported rate for indicator #4a for the child population decreased by over 2 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MSHN's reported rate for indicator #4a for the child population decreased by over 2 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. The decrease in performance suggests that some children were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **MSHN** continue to focus its efforts on increasing timely follow-up care for children following discharge from a psychiatric inpatient unit. **MSHN**

should continue to monitor the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-41 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **MSHN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MSHN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-41—Summary of Standard Compliance Scores for MSHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	16	5	3	**76%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	15	7	1	**68%**
Total	**94**	**85**	**72**	**13**	**9**	**85%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MSHN received a score of 100 percent in the Availability of Services program area, demonstrating that the PIHP has adequate processes for monitoring its access system and the timeliness of access to detoxification, methadone, and residential services for its SUD priority populations. [**Access** and **Timeliness**]

Strength #2: MSHN received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: MSHN received a score of 76 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MSHN received a *Not Met* score for five elements, indicating gaps in the PIHP's processes related to using all of MDHHS-required model member handbook language; including taglines in the paper provider directory; writing all member materials in the minimum 12-point font size; providing members with timely notice of terminated providers; and including specific provider accessibility accommodations on the online and printed provider directory.

Recommendation: As **MSHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: MSHN received a score of 68 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MSHN received a *Not Met* score for seven elements, indicating gaps in the PIHP's processes related to the content of ABD notices; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; accurate categorization and member notification of service authorization resolution extensions; ABD notices for when a claim payment denial occurs; and service authorization decisions not reached timely.

Recommendation: As **MSHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the

PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-42.

Table 3-42—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **MSHN** met the time and distance standard requirements for 100 percent of its members for five indicators. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-43. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-43—MSHN Network Adequacy Compliance

	MSHN Urban	MSHN Rural	MSHN Frontier
Adult Assertive Community Treatment—H0039	99.57%	100%	NA
Adult Crisis Residential Programs—H0018	82.17%	50.41%	NA
Adult Opioid Treatment Programs—H0020	99.41%	97.06%	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	97.51%	100%	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	99.97%	79.32%	NA
Pediatric Crisis Residential Programs—H0018	39.70%	0.00%	NA
Pediatric Home-Based Services—H0036, H2033	100%	100%	NA
Pediatric Wraparound Services—H2021, H2022	99.17%	100%	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	83.44%	45.41%	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MSHN had multiple layers of oversight and review of network adequacy indicator calculations. Once information was aggregated, it was reviewed by multiple councils, committees, and the **MSHN** Board before being submitted to MDHHS. [**Access**]

Weaknesses and Recommendations

Weakness #1: MSHN's network adequacy calculations were not routinely monitored and were only performed at a single point in time for SFY 2024 reporting. [**Access**]

Why the weakness exists: MSHN lacked a full understanding of the expectations for PIHP network adequacy reporting, which hindered the implementation of monitoring efforts.

Recommendation: HSAG recommends that **MSHN** implement more frequent reviews or a dashboard status of compliance with network adequacy standards and indicators throughout the year.

Weakness #2: It was identified that **MSHN** made a typographical error in the Network Adequacy Reporting Template for all provider types, as the time and distance standards outlined in the submission did not align with MDHHS' requirements. [**Access**]

Why the weakness exists: MSHN was unfamiliar with the network adequacy reporting parameters and encountered user error while preparing the data for the reporting template.

Recommendation: HSAG recommends that **MSHN** ensure the parameters specified in its reporting submission to MDHHS are consistent with those used in the calculation of time and distance standard.

Encounter Data Validation

Performance Results

Representatives from **MSHN** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-44 outlines the key findings for **MSHN** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-44—Key Findings for MSHN

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **75.0 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Diagnosis Code* and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **24.6 percent** and **19.5 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low to moderate encounter data omission rates, with *Procedure Code* having the highest encounter data omission rate at **7.4 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.2 percent** of instances where codes were present in both the medical records and encounter data, with errors related to inaccurate

Analysis	Key Findings
	coding **(40.0 percent)** and procedure codes submitted in the encounter data that reflected higher levels of service than those supported in the medical records **(60.0 percent)**.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **99.8 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **51.2 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 1.0 percent. [**Quality**]

Strength #2: The *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rate of 2.1 percent. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 99.2 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 24.0 percent of the *Diagnosis Code* and more than 19.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rates of unsupported *Diagnosis Code* and *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in

provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **MSHN** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **MSHN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MSHN**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-45 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MSHN**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-45—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**MSHN** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.* ✓ CQS Objective 1.1—**MSHN** achieved the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	✗ CQS Objective 1.1—**MSHN** did not achieve the 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	assessment within 14 calendar days of a non-emergency request for service and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 6—Community Mental Health Partnership of Southeast Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **CMHPSM**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-46 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-46—Overall Validation Rating for CMHPSM

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reduction of Disparity Rate Between Persons Served who are African American/Black and White and miss their appointment for an initial Biopsychosocial (BPS) Assessment and Assist Individuals in scheduling and keeping their initial assessment for services	*Low Confidence*	*No Confidence*	Initial assessment no-show rate for African-American consumers.	22.9%	30.9% ⇔	—	Yes
			Initial assessment no-show rate for White consumers.	12.2%	19.0% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

The goals for **CMHPSM**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American) will demonstrate a significant decrease over the baseline rate without an increase in performance to the comparison subgroup (White). Table 3-47 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-47—Barriers and Interventions for CMHPSM

Barriers	Interventions
There is not consistent documentation that persons initially seeking services are asked if they have any barriers to attending appointments, creating an inconsistent response to potential barriers that affect access to care and potentially impacting people's ability to attend their initial appointment.	Access staff will ask and document if individuals have any barriers to being able to attend their initial BPS appointment.
Disparities between people initially seeking services and CMH staff may create unintended biases in staff assumptions or communications and can affect the response of persons seeking services/their willingness to attend services.	Access staff will be trained on and use a script/discussion guideline in speaking with individuals in ways that reduce communication barriers related to diversity, equity, and inclusion (DEI) and reduce potential stigmatizing communication.
Persons seeking services do not have transportation or have unreliable transportation that causes them to miss appointments. There is no taxi system in some counties; if there are taxi services, it is not affordable; and if there is a Medicaid taxi system, it is often unreliable/not on time. The bus system can be in a limited area, takes a long time/requires transfers, and/or [busses] are late. There is little flexibility of CMH Access or openings to be seen later that day if [the person is] late for an appointment.	Access staff completing the screen will offer individuals additional resources if barriers are identified, such as transportation assistance (e.g., bus token, staff support).
	Access staff completing the screen will offer individuals additional resources if barriers are identified, such as same-day appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: CMHPSM initiated timely interventions that were reasonably linked to their corresponding barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: CMHPSM did not provide intervention evaluation results to determine the effectiveness of each effort. [**Quality**]

Why the weakness exists: The PIHP documented that inconsistent initiation of interventions during the intervention measurement period and the first remeasurement period resulted in limited, or no, intervention evaluation data.

Recommendation: HSAG recommends that **CMHPSM** develop and initiate active interventions that can be tracked and trended over time to determine the success of each effort.

Weakness #2: CMHPSM did not achieve the state-defined goals of eliminating the existing disparity in the first remeasurement period and achieving statistically significant improvement for the disparate population. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear why the goals were not achieved, **CMHPSM** made progress in improving performance for both populations.

Recommendation: HSAG recommends that **CMHPSM** revisit its causal barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **CMHPSM**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

CMHPSM received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **CMHPSM** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-48 presents **CMHPSM**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **CMHPSM** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-48—Performance Measure Results for CMHPSM

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	100%	99.30%	-0.70%
Adults—Indicator #1b	99.55%	99.84%	+0.29%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	62.13%	44.48%	-17.65%
MI–Adults—Indicator #2b	58.41%	48.42%	-9.99%
I/DD–Children—Indicator #2c	66.34%	51.75%	-14.59%
I/DD–Adults—Indicator #2d	59.38%	45.83%	-13.55%
Total—Indicator #2	60.34%	47.63%	-12.71%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	60.32%	59.22%	-1.10%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	72.57%	66.18%	-6.39%
MI–Adults—Indicator #3b	72.31%	53.12%	-19.19%
I/DD–Children—Indicator #3c	85.11%	65.98%	-19.13%
I/DD–Adults—Indicator #3d	89.29%	92.86%	+3.57%
Total—Indicator #3	74.63%	60.62%	-14.01%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	94.44%	88.10%	-6.34%
Adults	94.86%	93.51%	-1.35%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	95.73%	97.27%	+1.54%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	6.21%	6.29%	+0.08%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	90.75%	92.19%	+1.44%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	18.26%	20.51%	+2.25%
DD–Adults—Indicator #8b	10.66%	11.15%	+0.49%
MI and DD–Adults—Indicator #8c	9.18%	9.58%	+0.40%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.72%	99.34%	-0.38%
DD–Adults—Indicator #9b	93.68%	71.71%	-21.97%
MI and DD–Adults—Indicator #9c	93.33%	79.17%	-14.16%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	6.35%	18.00%	+11.65%
Adults—Indicator #10b	14.23%	9.40%	-4.83%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	25.34%	24.67%	-0.67%
MI and DD–Adults	29.24%	29.27%	+0.03%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	35.86%	36.71%	+0.85%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: CMHPSM has continued to focus its efforts on increasing regional outcome measures and key metric data visibility for the region. Dashboards were reviewed and discussed collectively at regional committee meetings; were available for individual use; and allowed **CMHPSM** to easily review all key data pieces in one place, easily identify areas of concern, and address these areas in a timely manner. **CMHPSM** used monitoring and facilitated discussions around data using dashboards across teams to increase awareness and promote performance improvement project development and regional buy-in to improvement activities. [**Quality**, **Timeliness**, and **Access**]

Strength #2: As identified previously, **CMHPSM** demonstrated overall strength in its partnerships and through consistent processes and systems used across all four CMHSPs. These efforts will help to ensure standardization in how the CMHSPs document within information systems that support performance indicator reporting, while providing the PIHP with the ability to readily oversee the CMHSP data through Power BI without creating manual workarounds or customized processes unique to only one specific CMHSP. [**Quality**, **Timeliness**, and **Access**]

Strength #3: CMHPSM's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #4: CMHPSM's reported rate for indicator #4b exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #5: CMHPSM's reported rate for indicator #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, HSAG identified one case for Washtenaw that was incorrectly reported as noncompliant for indicator #10 but should have been reported as compliant. [**Quality**]

Why the weakness exists: CMHPSM confirmed that the CMHSP should not have overridden the case. Since events were locked following submission to the State, the case could not be updated in

the report. **CMHPSM** indicated, however, that Washtenaw was re-educated on this matter, and beginning October 1, 2024, the **CMHPSM** Quality Manager will be reviewing random samples of overridden/excluded cases to validate their statuses.

Recommendation: While **CMHPSM** has since updated its validation process to include reviewing a random sample of cases for Washtenaw that were overridden/excluded to confirm their statuses, HSAG recommends that **CMHPSM** continue to work with the CMHSP to enhance or implement processes to improve the accuracy of indicator #10 data. This should include a review of manual overrides at the CMHSP level as well.

Weakness #2: CMHPSM's SFY 2024 indicator #2 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: CMHPSM's SFY 2024 indicator #2 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service. Barriers identified by **CMHPSM** were members who were a no show to appointments, members who did not reschedule following a no show appointment, and members who sought out alternate options for care or wanted an appointment outside of the required time frame.

Recommendation: HSAG recommends that **CMHPSM** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning. **CMHPSM** could consider setting up automated reminders in addition to having staff members call patients to remind them of upcoming visits to assist in reducing no show appointments. **CMHPSM** could also consider updating its cancellation policy to help make expectations clear regarding no shows or rescheduled appointments. HSAG also encourages **CMHPSM** to continue to provide telehealth options, whenever possible, to help address any barriers related to transportation, time constraints, or distance traveled to appointments.

Weakness #3: CMHPSM's indicator #3 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: CMHPSM's indicator #3 total rate declined by more than 5 percentage points from SFY 2023 to SFY 2024 and fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

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

Weakness #4: CMHPSM's reported rate for indicator #10a for the child population increased by more than 5 percentage points and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: CMHPSM's reported rate for indicator #10a for the child population increased by more than 5 percentage points and fell below the established performance standard for SFY 2024, suggesting an increase in readmissions for children to an inpatient psychiatric unit within 30 days of discharge and that children may have been prematurely discharged or follow-up was not timely following discharge.

Recommendation: HSAG recommends that **CMHPSM** focus its efforts on reducing the number of inpatient psychiatric unit readmissions for children by working with providers on adequate discharge planning, patient education, and coordination of services post-discharge. In addition, HSAG recommends that **CMHPSM** also consider the root cause of the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as educating providers on the potential of telemedicine as an option for providing post-discharge follow-up care and providing encouragement to members to access follow-up services via telemedicine where possible.

Compliance Review

Performance Results

Table 3-49 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **CMHPSM**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **CMHPSM** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-49—Summary of Standard Compliance Scores for CMHPSM

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	18	3	3	**86%**
Standard III—Availability of Services	20	18	15	3	2	**83%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VI—Coverage and Authorization of Services	23	22	16	6	1	**73%**
Total	**94**	**85**	**72**	**13**	**9**	**85%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: CMHPSM received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: CMHPSM received a score of 73 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: CMHPSM received a *Not Met* score for six elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; accurate categorization and member notification of service authorization resolution extensions; and service authorization decisions not reached timely.

Recommendation: As **CMHPSM** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating

service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-50.

Table 3-50—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **CMHPSM** met the time and distance standard requirements for 100 percent of its members for one indicator. All remaining indicators had results below 100 percent.

Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-51. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-51—CMHPSM Network Adequacy Compliance

	CMHPSM Urban	CMHPSM Rural	CMHPSM Frontier
Adult Assertive Community Treatment—H0039	93.70%	96.00%	NA
Adult Crisis Residential Programs—H0018	79.00%	19.00%	NA
Adult Opioid Treatment Programs—H0020	95.20%	96.20%	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	93.20%	98.20%	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	38.70%	58.60%	NA
Pediatric Crisis Residential Programs—H0018	NA	NA	NA
Pediatric Home-Based Services—H0036, H2033	87.10%	92.70%	NA
Pediatric Wraparound Services—H2021, H2022	84.50%	100%	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	44.90%	68.90%	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: CMHPSM provided regular communication to CMHSPs for data cleaning and data submission schedules in advance of reporting deadlines and reviews at regional meetings. **CMHPSM** reviewed submissions and had a process for returning errors to CMHSPs for corrections. [**Access**]

Weaknesses and Recommendations

Weakness #1: CMHPSM used straight-line distance when calculating the time and distance standard. [**Access**]

Why the weakness exists: CMHPSM did not have formal guidance detailing its expectations for how the PIHPs should calculate time and distance to applicable providers.

Recommendation: HSAG recommends that **CMHPSM** adhere to guidance issued by MDHHS regarding the time and distance methodology and using driving distance when reporting on network adequacy standards.

Weakness #2: It was identified that **CMHPSM** made a typographical error in the SFY 2024 Network Adequacy Reporting Template concerning the Urban Aggregated Total Time and Distance Standard for Adult Inpatient Psychiatric Services. The Data Roll-Up tab incorrectly listed the standard as "90 minutes and 60 miles" for Urban Aggregated Total Inpatient Psychiatric Services, which did not align with the correct time and distance standard. [**Access**]

Why the weakness exists: CMHPSM was unfamiliar with the network adequacy reporting parameters and encountered user error while preparing the data for the reporting template.

Recommendation: HSAG recommends that **CMHPSM** ensure the parameters specified in its reporting submission to MDHHS are consistent with those used in the calculation of time and distance.

Encounter Data Validation

Performance Results

Representatives from **CMHPSM** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-52 outlines the key findings for **CMHPSM** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-52—Key Findings for CMHPSM

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **51.0 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code Modifier* data element had a relatively high medical record omission rate at **17.1 percent.** This indicates that the diagnosis codes in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Procedure Code* having the highest omission rate at **3.2 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.6 percent** of instances where codes were present in both the medical records and encounter data, with errors related to inaccurate coding **(50.0 percent)** and procedure codes submitted in the

Analysis	Key Findings
	encounter data that reflected higher levels of service than those supported in the medical records **(50.0 percent).**
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **99.3 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **74.1 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service*, *Diagnosis Code*, and *Procedure Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 0.8 percent, 2.6 percent, and 4.8 percent, respectively. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.8 percent, 1.2 percent, 3.2 percent, and 1.9 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 99.3 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 17.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rate of unsupported *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a

role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **CMHPSM** should focus on improving provider documentation practices and by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **CMHPSM**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **CMHPSM**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-53 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **CMHPSM**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-53—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**CMHPSM** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✗ CQS Objective 1.1—**CMHPSM** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. The total rate also declined by approximately 13 percentage points from the prior year.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	✗ CQS Objective 1.1—**CMHPSM** did not achieve the 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. The total rate also declined by approximately 14 percentage points from the prior year. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 7—Detroit Wayne Integrated Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **DWIHN**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-54 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-54—Overall Validation Rating for DWIHN

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit	*High Confidence*	*No Confidence*	Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population.	35.7%	33.7% ⇔	—	Yes
			Follow-Up within 7 Days After Hospitalization for Mental Illness for the White Population.	40.2%	41.2% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

The goals for **DWIHN**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black or African-American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-55 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-55—Barriers and Interventions for DWIHN

Barriers	Interventions
Member's difficulty getting an appointment within the required time frames.	Individual data to be shared with providers. Meetings with 19 clinically responsible service providers (CRSPs) have taken place every 45 days. The PIHP's Access Department will develop an Availability Access Report indicating available 7-day follow-up appointments, including new members, in an effort to reach out to providers when they are approaching exhaustion. A financial incentive program was introduced to reward high performing CRSPs.
Member's failure to engage: no-shows, cancellations, rescheduling, and refusal of appointments.	Annual reviews began examining CRSPs' notes, this tool is used for chart auditing by the **DWIHN** Quality Department, and results are discussed with the providers. The PIHP's UM department will attempt to reach members prior to discharge to identify any barriers to keeping follow-up appointments.
Lack of coordination and continuity of care between inpatient and outpatient follow-up services.	The PIHP's complex case management (CCM) [staff] will attempt to assist with care coordination with Black/African American members prior to discharge and enroll [them] in CCM. Members are educated on the importance of keeping their appointments and addressing any barriers.
Lack of transportation for members.	Transportation payment was provided to outpatient providers to assist in providing transportation for members in need. CRSPs continued to offer telehealth appointments for behavioral health services to members.
Member's view on the importance of the appointment.	Anti-Stigma brochures indicating the importance of members seeking mental health services were developed and placed on the PIHP's website and will be provided to members during the hospital discharge process.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DWIHN initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: DWIHN did not achieve the state-defined goals for the PIP with the disparate performance indicator demonstrating a non-statistically significant decline in performance as compared to the baseline. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While it is unclear why the goals were not achieved or why the performance indicators declined, the data suggest that barriers exist for the disparate population for receiving a follow-up visit following a hospital discharge.

Recommendation: HSAG recommends that **DWIHN** revisit its causal/barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **DWIHN**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **DWIHN** works directly with service providers and the Medicaid population. As a result, oversight of affiliated CMHSPs was not applicable to the PIHP's PMV.

DWIHN received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **DWIHN** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-56 presents **DWIHN**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **DWIHN** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-56—Performance Measure Results for DWIHN

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	99.24%	99.44%	+0.20%
Adults—Indicator #1b	98.12%	96.55%	-1.57%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	28.81%	30.21%	+1.40%
MI–Adults—Indicator #2b	54.33%	57.36%	+3.03%
I/DD–Children—Indicator #2c	28.71%	21.78%	-6.93%
I/DD–Adults—Indicator #2d	43.55%	58.41%	+14.86%
Total—Indicator #2	45.15%	47.64%	+2.49%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	61.45%	64.73%	+3.28%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	85.36%	79.70%	-5.66%
MI–Adults—Indicator #3b	88.80%	90.49%	+1.69%
I/DD–Children—Indicator #3c	84.78%	66.35%	-18.43%
I/DD–Adults—Indicator #3d	77.05%	81.82%	+4.77%
Total—Indicator #3	87.24%	**85.22%**	-2.02%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	100%	97.78%	-2.22%
Adults	98.14%	98.67%	+0.53%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	100%	97.25%	-2.75%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	5.86%	5.83%	-0.03%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	93.54%	95.77%	+2.23%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	17.44%	18.69%	+1.25%
DD–Adults—Indicator #8b	8.79%	8.56%	-0.23%
MI and DD–Adults—Indicator #8c	7.52%	8.06%	+0.54%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.84%	99.81%	-0.03%
DD–Adults—Indicator #9b	94.35%	66.46%	-27.89%
MI and DD–Adults—Indicator #9c	98.70%	80.00%	-18.70%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	7.51%	8.62%	+1.11%
Adults—Indicator #10b	14.69%	17.58%	+2.89%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	21.08%	20.12%	-0.96%
MI and DD–Adults	29.11%	23.01%	-6.10%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	39.44%	39.62%	+0.18%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DWIHN meets with its clinically responsible service providers every 45 days to review provider-specific rates on the performance indicators and discuss potential interventions to support meeting the required standards. **DWIHN** also created a full time BH-TEDS coordinator within its Clinical Operations team who oversees data collection and supports providers in data entry and correction. [**Quality**]

Strength #2: DWIHN's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #3: DWIHN's SFY 2024 indicator #3 total rate exceeded the 75th percentile benchmark, suggesting that new persons were receiving timely ongoing covered services following completion of a non-emergent biopsychosocial assessment most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: DWIHN's reported rates for SFY 2023 and SFY 2024 for indicator #4a for both the child and adult populations exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that both children and adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days). [**Quality**, **Timeliness**, and **Access**]

Strength #5: DWIHN's reported rate for indicator #4b exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #6: DWIHN's reported rate for indicator #10a met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: The member-level detail file **DWIHN** submitted to HSAG as part of the audit activity did not list exception reasons for 39 cases reported for indicator #4a. [**Quality**]

Why the weakness exists: DWIHN discharge coordinators or call center staff were not fully completing documentation in MH-WIN when consumers refused appointments within seven days of discharge, did not show for scheduled appointments, or canceled scheduled appointments.

Recommendation: HSAG recommends that **DWIHN** try to use the 39 identified cases that are missing exception reasons to isolate process-related issues or staff training needs. HSAG also recommends that **DWIHN** audit a larger sample of exceptions prior to quarterly rate submissions to MDHHS to ensure they are appropriate and there is documentation in MH-WIN to verify the exception. In addition, **DWIHN** should perform a visual validation of the member-level detail file prior to HSAG submission for the annual audit to ensure that all exceptions have documented reasons in the file.

Weakness #2: DWIHN's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: DWIHN's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service. Some barriers noted by **DWIHN** include lack of available appointments, staffing shortages, and increased demand for services.

Recommendation: HSAG recommends that **DWIHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning. **DWIHN** is encouraged to continue with and expand upon its initiatives currently in place, such as its revised financial structure, to continue to address staffing shortages and encourage participation from providers. **DWIHN** is also encouraged to utilize telehealth as option for assessment completion or follow-up care.

Weakness #4: DWIHN's reported rate for indicator #10b for the adult population increased by nearly 3 percentage points and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: DWIHN's reported rate for indicator #10b for the adult population increased by nearly 3 percentage points and fell below the established performance standard for SFY 2024, suggesting an increase in readmissions for adults to an inpatient psychiatric unit within 30 days of discharge and that adults may have been prematurely discharged or follow-up was not timely following discharge.

Recommendation: HSAG recommends that **DWIHN** focus its efforts on reducing the number of inpatient psychiatric unit readmissions for adults by working with providers on adequate discharge planning, patient education, and coordination of services post-discharge. In addition, HSAG recommends that **DWIHN** also consider the root cause of the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as educating providers on the potential of telemedicine as an option for providing post-discharge follow-up care and providing encouragement to members to access follow-up services via telemedicine where possible.

Compliance Review

Performance Results

Table 3-57 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **DWIHN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **DWIHN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-57—Summary of Standard Compliance Scores for DWIHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	22	18	4	2	**82%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	17	5	1	**77%**
Total	**94**	**86**	**76**	**10**	**8**	**88%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DWIHN received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Strength #2: DWIHN received a score of 100 percent in the Coordination and Continuity of Care program area, demonstrating the PIHP has adequate processes for coordinating care and services; conducting initial and ongoing assessments; developing and implementing person-centered service plans; and integrating physical and behavioral health care. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: DWIHN received a score of 82 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: DWIHN received a *Not Met* score for four elements, indicating gaps in the PIHP's processes related to including taglines in the provider directory; writing all member materials in the minimum 12-point font size and at or below the 6.9 reading grade level; including specific provider accessibility accommodations and independent facilitators in all versions of the PIHP's provider directories; sorting the provider directory by county; and updating the paper directory monthly.

Recommendation: As **DWIHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: DWIHN received a score of 77 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: DWIHN received a *Not Met* score for five elements, indicating gaps in the PIHP's processes related to the content of ABD notices; timely service authorization decisions; correct reporting of service authorization data; inappropriate application of extensions to concurrent reviews; and service authorization decisions not reached timely.

Recommendation: As **DWIHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the

procedures in place to process service authorizations and send ABD notices to members. The PIHP should evaluate the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-58.

Table 3-58—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **DWIHN** met the time and distance standard requirements for 100 percent of its members for one indicator. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-59. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-59—DWIHN Network Adequacy Compliance

	DWIHN Urban	DWIHN Rural	DWIHN Frontier
Adult Assertive Community Treatment—H0039	97.00%	NA	NA
Adult Crisis Residential Programs—H0018	86.00%	NA	NA
Adult Opioid Treatment Programs—H0020	99.00%	NA	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	100%	NA	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	70.00%	NA	NA
Pediatric Crisis Residential Programs—H0018	77.00%	NA	NA
Pediatric Home-Based Services—H0036, H2033	92.00%	NA	NA
Pediatric Wraparound Services—H2021, H2022	92.00%	NA	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	97.00%	NA	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DWIHN demonstrated the ability to maintain accurate and complete provider information through its quarterly provider validation process. [**Access**]

Weaknesses and Recommendations

Weakness #1: DWIHN's method of calculating time and distance indicators used the location where member services were provided. [**Access**]

Why the weakness exists: DWIHN did not have the necessary software in place to calculate driving time and distance. **DWIHN** did not have formal guidance detailing its expectations for how the PIHPs should calculate time and distance to applicable providers.

Recommendation: HSAG recommends that **DWIHN** align with the MDHHS PIHP Network Adequacy Reporting Template instructions, which indicate: "Please include only enrollees that received services between 10.1.2022 - 9.30.2023. Please include only providers that provided services between 10.1.2022 - 9.30.2023." Therefore, **DWIHN** should consider providers who provide services within the defined reporting time frame, and not base the time and distance standard calculations upon the actual member utilization of a specific provider location.

Encounter Data Validation

Performance Results

Representatives from **DWIHN** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-60 outlines the key findings for **DWIHN** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-60—Key Findings for DWIHN

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **56.5 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Diagnosis Code* and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **24.7 percent** and **20.7 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates, with *Procedure Code Modifier* having the highest encounter data omission rate at **5.7 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **100 percent** of instances where codes were present in both the medical records and encounter data.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **98.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **99.5 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **56.2 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.9 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, and *Procedure Code* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 3.4 percent, 4.6 percent, and 3.8 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.9 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 24.0 percent of the *Diagnosis Code* and more than 20.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rates of unsupported *Diagnosis Code* and *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **DWIHN** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers.

Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **DWIHN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **DWIHN**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-61 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **DWIHN**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-61—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**DWIHN** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✓ CQS Objective 1.1—**DWIHN** achieved the 75th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. ✗ CQS Objective 1.1—**DWIHN** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	☒ Quality ☒ Timeliness ☐ Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 8—Oakland Community Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **OCHN**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-62 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-62—Overall Validation Rating for OCHN

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Improving Antidepressant Medication Management—Acute Phase	*High Confidence*	*No Confidence*	The rate for White adult members who maintained antidepressant medication management for 84 days.	63.9%	64.3% ⇔	—	Yes
			The rate for African-American adult members who maintained antidepressant medication management for 84 days.	43.2%	46.7% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

The goals for **OCHN**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American adult members) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White adult members). Table 3-63 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-63—Barriers and Interventions for OCHN

Barriers	Interventions
Lack of meaningful medication psychoeducation between the clinician, prescribers, and the individual-served/member. Low or limited organizational health literacy of providers.	Educated providers on the World Health Organization's technical report on medication safety in polypharmacy which highlights guidelines and best practices.
Lack of mental health literacy of provider staff and members.	Improve health literacy knowledge of members and network staff through education on depression, screening, evidence-based practices, adherence strategies, and supportive intervention.
Individuals discharged from acute care settings are at-risk for medication nonadherence and require medication psychoeducation and support.	Improving medication adherence by updating the Acute Care Discharge (ACD) protocol and audit tool. Provider staff are educated on the updated protocol annually by assigned supervisors/managers at the provider level.
Improving the complexity of the medication regimen and encouraging prescribers to utilize shared decision making.	Educated and encouraged providers to use shared decision-making skills to support adherence.
Members lack transportation to pick-up prescriptions/refills. Members may be unaware of medication benefits/delivery services.	The PIHP and providers encourage medication delivery enrollment, with participating pharmacies and services, to improve antidepressant medication adherence.
Lack of psychotropic and antidepressant medication adherence.	The PIHP's pharmacology partner, Genoa Pharmacy, provides system education on integrated pharmacy services, adherence strategies, and pharmacy collaboration to support psychotropic medication adherence.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: OCHN initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: OCHN did not achieve the state-defined goals of eliminating the existing disparity in the first remeasurement period and achieving statistically significant improvement for the disparate population. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Although **OCHN** made progress in improving performance for both populations, the PIHP did not develop intervention strategies specific to the disparate population in order to drive significant improvement and eliminate the disparity.

Recommendation: HSAG recommends that **OCHN** revisit its causal barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **OCHN**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **OCHN** works directly with service providers and the Medicaid population. As a result, oversight of affiliated CMHSPs was not applicable to the PIHP's PMV.

OCHN received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **OCHN** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-64 presents **OCHN**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **OCHN** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-64—Performance Measure Results for OCHN

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	94.56%	100%	+5.44%
Adults—Indicator #1b	91.61%	97.99%	+6.38%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	30.89%	37.18%	+6.29%
MI–Adults—Indicator #2b	53.53%	53.75%	+0.22%
I/DD–Children—Indicator #2c	21.74%	11.11%	-10.63%
I/DD–Adults—Indicator #2d	24.24%	20.45%	-3.79%
Total—Indicator #2	44.97%	46.94%	+1.97%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	81.71%	79.96%	-1.75%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	99.62%	88.26%	-11.36%
MI–Adults—Indicator #3b	98.91%	99.11%	+0.20%
I/DD–Children—Indicator #3c	100%	100%	+/-0.00%
I/DD–Adults—Indicator #3d	97.22%	97.56%	+0.34%
Total—Indicator #3	99.09%	**95.54%**	-3.55%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	96.15%	84.62%	-11.53%
Adults	95.73%	93.29%	-2.44%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	100%	99.28%	-0.72%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	7.31%	7.48%	+0.17%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	93.46%	95.98%	+2.52%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	24.21%	26.80%	+2.59%
DD–Adults—Indicator #8b	14.19%	15.11%	+0.92%
MI and DD–Adults—Indicator #8c	11.01%	11.07%	+0.06%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	100%	99.85%	-0.15%
DD–Adults—Indicator #9b	83.51%	73.19%	-10.32%
MI and DD–Adults—Indicator #9c	80.00%	65.43%	-14.57%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	0.00%	5.88%	+5.88%
Adults—Indicator #10b	9.83%	8.62%	-1.21%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	19.53%	19.51%	-0.02%
MI and DD–Adults	26.88%	26.92%	+0.04%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	33.64%	33.80%	+0.16%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: OCHN implemented process changes to address challenges that impacted performance for indicators #1 and #2. To address challenges impacting indicator #1, **OCHN** updated its programming logic to establish the pre-admission screening start time as the time when the member is at **OCHN**'s receiving center. To address challenges impacting indicator #2, **OCHN** improved pay and benefits for staff members and implemented several changes to its family outreach process within its access department to try to obtain eligibility paperwork from families in a timely manner. **[Quality**, **Timeliness**, and **Access]**

Strength #2: OCHN's reported rate for indicator #1a was 100 percent, and the rates for indicators #1a and #1b increased by over 5 percentage points from SFY 2023 to SFY 2024. Additionally, both rates exceeded the established performance standard for SFY 2024, demonstrating improvement and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #3: OCHN's SFY 2024 indicator #3 total rate exceeded the 75th percentile benchmark, suggesting that new persons were receiving timely ongoing covered services following completion of a non-emergent biopsychosocial assessment most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: OCHN's reported rate for indicator #4b exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating consistency in performance, and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #5: OCHN's reported rates for indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: OCHN's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: OCHN's SFY 2024 indicator #2 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **OCHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #2: OCHN's reported rates for indicator #4a for the child and adult populations decreased by over 11 percentage points and 2 percentage points, respectively, from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: OCHN's reported rates for indicator #4a for the child and adult populations decreased by over 11 percentage points and 2 percentage points, respectively, from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. The decrease in performance suggests that some children and adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **OCHN** continue to focus its efforts on increasing timely follow-up care for children and adults following discharge from a psychiatric inpatient unit. **OCHN** should continue to monitor the decrease in performance and implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-65 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **OCHN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **OCHN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-65—Summary of Standard Compliance Scores for OCHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	17	4	3	**81%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	13	2	1	**87%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VI—Coverage and Authorization of Services	23	22	17	5	1	**77%**
Total	**94**	**85**	**74**	**11**	**9**	**87%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: OCHN received a score of 100 percent in the Availability of Services program area, demonstrating that the PIHP has adequate processes for monitoring its access system and the timeliness of access to detoxification, methadone, and residential services for its SUD priority populations. [**Access** and **Timeliness**]

Strength #2: OCHN received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: OCHN received a score of 81 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: OCHN received a *Not Met* score for four elements, indicating gaps in the PIHP's processes related to using all of MDHHS-required model member handbook language; including taglines in the provider directory; writing all member materials in the minimum 12-point font size and at or below the 6.9 reading grade level; including specific provider accessibility

accommodations, independent facilitators, URLs, and full addresses in all versions of the PIHP's provider directories; and sorting the provider directory by county.

Recommendation: As **OCHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: OCHN received a score of 77 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: OCHN received a *Not Met* score for five elements, indicating gaps in the PIHP's processes related to the content of ABD notices; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; notice of extension time frames; and service authorization decisions not reached timely.

Recommendation: As **OCHN** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the procedures in place to process service authorizations and send ABD notices to members. The PIHP should evaluate the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-66.

Table 3-66—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **OCHN** did not meet the time and distance standard requirements for 100 percent of its members across any indicators, which were reported as results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-67. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-67—OCHN Network Adequacy Compliance

	OCHN Urban	OCHN Rural	OCHN Frontier
Adult Assertive Community Treatment—H0039	96.13%	NA	NA
Adult Crisis Residential Programs—H0018	79.24%	NA	NA
Adult Opioid Treatment Programs—H0020	95.87%	NA	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	94.94%	NA	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	93.49%	NA	NA
Pediatric Crisis Residential Programs—H0018	76.92%	NA	NA
Pediatric Home-Based Services—H0036, H2033	98.98%	NA	NA
Pediatric Wraparound Services—H2021, H2022	98.72%	NA	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	99.54%	NA	NA

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: OCHN indicated strong methodology for calculating time and distance indicators. [**Access**]

Weaknesses and Recommendations

Weakness #1: OCHN indicated that its process for geocoding and calculating time and distance was costly. [**Access**]

Why the weakness exists: At the time of reporting, **OCHN** did not have a cost-effective method to accurately evaluate time and distance standards.

Recommendation: HSAG recommends that **OCHN** work with MDHHS to explore alternative methodologies for calculating the time and distance standard.

Weakness #2: OCHN indicated having limited validation practices in place for the calculation of the time and distance standard. [**Access**]

Why the weakness exists: OCHN lacked a full understanding of the expectations for PIHP network adequacy reporting, which hindered the implementation of monitoring efforts.

Recommendation: HSAG recommends that **OCHN** develop validation procedures for the time and distance results, including peer evaluation and leadership review.

Weakness #3: OCHN's method of calculating time and distance indicators used the location where member services were provided. [**Access**]

Why the weakness exists: OCHN did not have formal guidance detailing its expectations for how the PIHPs should calculate time and distance to applicable providers.

Recommendation: HSAG recommends that **OCHN** align with the MDHHS PIHP Network Adequacy Reporting Template instructions, which indicate: "Please include only enrollees that received services between 10.1.2022 - 9.30.2023. Please include only providers that provided services between 10.1.2022 - 9.30.2023." Therefore, **OCHN** should consider providers who provide services within the defined reporting time frame, and not base the time and distance standard calculations upon the actual member utilization of a specific provider location.

Encounter Data Validation

Performance Results

Representatives from **OCHN** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-68 outlines the key findings for **OCHN** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-68—Key Findings for OCHN

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **72.4 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **40.0 percent, 12.4 percent, and 18.6 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Procedure Code Modifier* having the highest omission rate at **4.7 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.3 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.2 percent** of instances where codes were present in both the medical records and encounter data, with errors related to inaccurate

Analysis	Key Findings
	coding **(66.7 percent)** and procedure codes submitted in the encounter data that reflected higher levels of service than those supported in the medical records **(33.3 percent).**
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **98.4 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **41.5 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.0 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 3.3 percent, 4.5 percent, 4.0 percent, and 4.7 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.4 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A high rate of the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values (40.0 percent, 12.4 percent, and 18.6 percent, respectively) identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rates of unsupported *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as

incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **OCHN** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **OCHN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **OCHN**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-69 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **OCHN**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-69—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**OCHN** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.* ✓ CQS Objective 1.1—**OCHN** achieved the 75th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	✗ CQS Objective 1.1—**OCHN** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.* NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	request for service and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 9—Macomb County Community Mental Health

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MCCMH**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-70 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-70—Overall Validation Rating for MCCMH

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations	*High Confidence*	*No Confidence*	The percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.	41.0%	35.3% ↓	—	Yes
			The percentage of African-American adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.	31.9%	33.0% ⇔	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ Designates a statistically significant decrease over the baseline measurement period (p value < 0.05).

The goals for **MCCMH**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup

(Caucasian). Table 3-71 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-71—Barriers and Interventions for MCCMH

Barriers	Interventions
Limited appointment availability with directly operated and contract service providers.	**MCCMH** North and East locations for individuals discharging from inpatient hospital settings.
	Update electronic medical record (EMR) calendar to accurately represent available appointments within the network.
Outdated formalized processes for hospital discharges.	The PIHP Hospital Liaison Team updated formal processes to improve communication with members after discharge to provide support for attending their follow-up appointment.
	Managed Care Operations staff will improve coordination with the PIHP Hospital Liaison Team for discharging members.
Lack of communication with network on performance measure standards.	Issued a memorandum to the provider network to remind providers of the required standard and detail MDHHS/PIHP standards.
	Meet with providers to reiterate the importance of follow-up after an inpatient stay and provide space to further discuss challenges providers may be facing.
Unidentified trends and barriers related to follow-up care.	Conducted a provider survey to identify network-wide barriers related to care coordination.
	Use dashboards to trend out-of-compliance cases and identify trends and patterns specific to race and ethnicity.
Limited data visibility with network regarding MDHHS performance measures.	Develop dashboards for providers on compliance rates with MDHHS performance measures.
	Develop formalized processes with providers to review their current compliance rates.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCCMH initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: MCCMH did not achieve the state-defined goals for the PIP with the comparison performance indicator demonstrating a statistically significant decline in performance as compared to the baseline. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Although **MCCMH** made progress in improving performance for both populations, the PIHP did not develop intervention strategies specific to the disparate population in order to drive significant improvement and eliminate the disparity.

Recommendation: HSAG recommends that **MCCMH** revisit its causal barrier analysis to determine if any new barriers exist for the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **MCCMH**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), or BH-TEDS data production. **MCCMH** works directly with service providers and the Medicaid population. As a result, oversight of affiliated CMHSPs was not applicable to the PIHP's PMV.

MCCMH received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **MCCMH** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-72 presents **MCCMH**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **MCCMH** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-72—Performance Measure Results for MCCMH

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	99.01%	99.33%	+0.32%
Adults—Indicator #1b	99.01%	98.36%	-0.65%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	15.08%	39.52%	+24.44%
MI–Adults—Indicator #2b	17.09%	46.90%	+29.81%
I/DD–Children—Indicator #2c	17.95%	23.47%	+5.52%
I/DD–Adults—Indicator #2d	23.81%	30.00%	+6.19%
Total—Indicator #2	16.86%	41.98%	+25.12%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	82.52%	75.47%	-7.05%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	66.20%	61.21%	-4.96%
MI–Adults—Indicator #3b	72.40%	86.23%	+13.83%
I/DD–Children—Indicator #3c	80.68%	77.36%	-3.32%
I/DD–Adults—Indicator #3d	55.56%	65.63%	+10.07%
Total—Indicator #3	71.45%	**77.27%**	+5.82%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	51.47%	64.84%	+13.37%
Adults	38.93%	56.53%	+17.60%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	92.88%	100%	+7.12%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	4.56%	4.77%	+0.21%
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	94.92%	92.38%	-2.54%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	21.71%	24.17%	+2.46%
DD–Adults—Indicator #8b	5.94%	6.23%	+0.29%
MI and DD–Adults—Indicator #8c	6.81%	7.70%	+0.89%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	100%	99.94%	-0.06%
DD–Adults—Indicator #9b	94.35%	35.28%	-59.07%
MI and DD–Adults—Indicator #9c	92.96%	49.67%	-43.29%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	4.23%	10.68%	+6.45%
Adults—Indicator #10b	15.36%	13.96%	-1.40%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	15.50%	14.34%	-1.16%
MI and DD–Adults	20.22%	21.23%	+1.01%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	46.59%	47.30%	+0.71%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.
SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.
* A lower rate indicates better performance.
[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.
[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.
[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCCMH explained efforts to decrease the readmission rate of individuals discharged from the ED for alcohol and other drug use. **MCCMH**'s County Office of Substance Abuse (MCOSA), which is a division of **MCCMH**, initiated the Alcohol and Substance Use Services, Education, and Referral to Treatment (Project ASSERT), an evidence-based, peer-led intervention program co-located at several area hospitals that provides peer recovery coach services in the EDs for individuals who present under the influence of alcohol or other drugs. Peer recovery coach activities include conducting screenings, supporting the ED staff members in reaching and engaging individuals, aiding individuals in accessing ongoing treatment and recovery services, coordinating medical care transportation, assisting in addressing barriers to treatment, and connecting individuals to resources and the recovery community. These efforts relate to indicator #10 and are within the scope of the PMV activity. [**Quality**, **Timeliness**, and **Access**]

Strength #2: MCCMH's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #3: MCCMH's reported rate for indicator #4b significantly increased by more than 7 percentage points from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2023 and SFY 2024, demonstrating improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: MCCMH's reported rates for indicators #10a and #10b met the established performance standard for SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upon review of **MCCMH**'s member-level detail file, HSAG identified that the data counts received on the initial member-level detail file did not match the data counts that were reported to MDHHS for Q1 SFY 2024 for indicator #4b: *The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days.* While there was no difference noted in the rate reported for indicator #4b (i.e., it remained 100 percent) between the original member-level detail file and what was reported to MDHHS for Q1 SFY 2024, the number of

net discharges and the number of discharges followed up on by CMHSP/PIHP within seven days between the member-level detail file and the Q1 SFY 2024 data reported to MDHHS did not match. [**Quality**]

Why the weakness exists: **MCCMH** researched the data count mismatch further and explained the reason the counts were different was due to three providers adding their discharges after the first submission to MDHHS.

Recommendation: Prior to submitting member-level detail file data to HSAG, HSAG recommends that **MCCMH** conduct a data count check across all reported performance indicators to ensure alignment with the final reported counts to MDHHS. Additionally, HSAG recommends that **MCCMH** continue to collaborate with providers to submit their discharge dates promptly as suggested.

Weakness #2: One case reported in indicator #4b was reported as "in-compliance" without a follow-up service documented in the member-level detail file. [**Quality**]

Why the weakness exists: **MCCMH** researched further and reported that this case was reviewed and overridden because the consumer was scheduled for detox and residential at the same provider; that is, there was an open admission layer for residential with approved authorizations because the provider did not bill residential due to staff member turnover. **MCCMH** confirmed that the claim has been submitted and provided a revised member-level detail file with the indicator #4b issue corrected.

Recommendation: HSAG recommends that **MCCMH** review the member-level detail file prior to submission to HSAG to ensure that cases marked as "in-compliance" have accurate follow-up service dates documented in the member-level detail file. Further, HSAG recommends that **MCCMH** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks can add value, especially when data are being integrated from multiple sources.

Weakness #3: While **MCCMH**'s SFY 2024 indicator #2 total rate significantly increased from SFY 2023 to SFY 2024, it fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: While **MCCMH**'s SFY 2024 indicator #2 total rate significantly increased from SFY 2023 to SFY 2024, it fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **MCCMH** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #4: While **MCCMH**'s SFY 2024 indicator #3 total rate significantly increased from SFY 2023 to SFY 2024, it fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: While **MCCMH**'s SFY 2024 indicator #3 total rate significantly increased from SFY 2023 to SFY 2024, it fell below the 75th percentile benchmark, suggesting that

some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

Recommendation: HSAG recommends that **MCCMH** continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

Compliance Review

Performance Results

Table 3-73 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **MCCMH**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MCCMH** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-73—Summary of Standard Compliance Scores for MCCMH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	17	4	3	**81%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	14	8	1	**64%**
Total	**94**	**85**	**71**	**14**	**9**	**84%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCCMH received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: MCCMH received a score of 81 percent in the Member Rights and Member Information program area. The PIHP's member materials must meet language and content requirements to ensure members are receiving the necessary information on their rights, the benefits they are entitled to, and how to access those services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MCCMH received a *Not Met* score for four elements, indicating gaps in the PIHP's processes related to including taglines in the provider directory; writing all member materials in the minimum 12-point font size; sorting the provider directory by county; and updating the electronic provider directory timely.

Recommendation: As **MCCMH** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. HSAG also recommends that the PIHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify if additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: MCCMH received a score of 64 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MCCMH received a *Not Met* score for eight elements, indicating gaps in the PIHP's processes related to the content of ABD notices; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; implementation of extension requirements; processes for when a member no longer wishes to receive services; ABD notices for claim payment denials; and service authorization decisions not reached timely.

Recommendation: As **MCCMH** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the

findings from the compliance review, the PIHP's current UM/service authorization policies, and the procedures in place to process service authorizations and send ABD notices to members. The PIHP should evaluate the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-74.

Table 3-74—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **MCCMH** met the time and distance standard requirements for 100 percent of its members across all indicators. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-75. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-75—MCCMH Network Adequacy Compliance

	MCCMH Urban	MCCMH Rural	MCCMH Frontier
Adult Assertive Community Treatment—H0039	100%	NA	NA
Adult Crisis Residential Programs—H0018	100%	NA	NA
Adult Opioid Treatment Programs—H0020	100%	100%*	NA
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	100%	NA	NA
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	100%	NA	NA
Pediatric Crisis Residential Programs—H0018	100%	NA	NA
Pediatric Home-Based Services—H0036, H2033	100%	NA	NA
Pediatric Wraparound Services—H2021, H2022	100%	NA	NA
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	100%	NA	NA

*MCCMH reported having an OTP in a rural area due to the provider being located in the city of Richmond, where a significant portion of the land is used for agricultural purposes. This characteristic led to the center being classified as rural.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCCMH demonstrated strength in maintaining accurate provider data by requiring provider data be updated annually. [**Access**]

Weaknesses and Recommendations

Weakness #1: MCCMH used a methodology that did not utilize member demographic data when calculating time and distance. [**Access**]

Why the weakness exists: MCCMH did not have formal guidance detailing its expectations for how the PIHPs should calculate time and distance to applicable providers.

Recommendation: HSAG recommends that **MCCMH** align with the MDHHS PIHP Network Adequacy Reporting Template instructions, which indicate: "Enter the percentage of enrollees who met Time and Distance Standards in SFY 2024. Numerator is number of enrollees in the program who met the time and distance standard. Denominator is the total enrollees in the program." Therefore, **MCCMH** should use member demographic data when calculating time and distance indicators.

Weakness #2: MCCMH indicated limited validation processes were in place when calculating network adequacy indicators. [**Access**]

Why the weakness exists: MCCMH lacked a full understanding of the expectations for PIHP network adequacy reporting, which hindered the implementation of monitoring efforts.

Recommendation: HSAG recommends that **MCCMH** develop processes for validating data and time and distance results when reporting network adequacy indicators.

Encounter Data Validation

Performance Results

Representatives from **MCCMH** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-76 outlines the key findings for **MCCMH** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-76—Key Findings for MCCMH

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **99.7 percent**, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **65.8 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Diagnosis Code* and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **45.1 percent** and **28.8 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• The *Procedure Code Modifier* data element had a moderately high encounter data omission rate at **11.8 percent**. This indicates that the procedure codes modifiers in the members' medical records were only moderately supported by the encounter data.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **100 percent** of instances where codes were present in both the medical records and encounter data.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **98.4 percent** of instances where codes were present in both the medical

Analysis	Key Findings
	records and encounter data, with errors related to inaccurate coding **(46.7 percent)** and procedure codes submitted in the encounter data that reflected higher levels of service than those supported in the medical records **(53.3 percent)**.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **99.6 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **34.6 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 1.2 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, and *Procedure Code* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.2 percent, 2.4 percent, and 3.1 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.4 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 45.0 percent of the *Diagnosis Code* and more than 28.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rate of unsupported *Diagnosis Code* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly

documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **MCCMH** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submission protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Weakness #2: Nearly 12.0 percent of the *Procedure Code Modifier* data element values identified in the medical records were not found in the encounter data. [**Quality**]

Why the weakness exists: The *Procedure Code Modifier* data element values not found in the encounter data likely arises from several interrelated factors. One possible reason is incomplete data submission practices, where providers or coders may not consistently include procedure code modifiers in encounter data submissions, particularly if these modifiers are perceived as less critical for reimbursement or reporting. Another contributing factor is a lack of awareness or training among behavioral health providers and coding staff, who may not fully understand the importance of accurately submitting modifiers to reflect the complexity, scope, or unique circumstances of the services provided. Additionally, modifiers may be omitted during payer adjudication or data aggregation processes if they are not required for reimbursement, leading to discrepancies between the medical records and encounter data. Finally, the fragmented nature of behavioral health services, which often involve multiple providers or systems, increases the likelihood of incomplete or inconsistent data submissions.

Recommendation: To address missing *Procedure Code Modifier* data element values in the encounter data, **MCCMH** should enhance provider and coder training, and standardize documentation and coding practices. Regular audits with feedback and collaboration with payers to avoid data loss during adjudication, are also essential. Hosting workshops and pilot initiatives, such as automated validations, can further promote accurate and complete reporting of the *Procedure Code Modifier* data element.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **MCCMH**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MCCMH**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-77 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MCCMH**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-77—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**MCCMH** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✓ CQS Objective 1.1—**MCCMH** achieved the 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. The total rate also increased by approximately 6 percentage points. ✓ CQS Objective 1.1—The total rate for indicator #2: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* increased by approximately 25 percentage points. ✗ CQS Objective 1.1—**MCCMH** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.* NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Region 10 PIHP

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Region 10**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-78 displays the validation ratings and baseline and Remeasurement 1 results for the performance indicators.

Table 3-78—Overall Validation Rating for Region 10

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing Racial/Ethnic Disparities in Access to SUD Services	*High Confidence*	*Low Confidence*	The percentage of new persons (Black/African American) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.	68.1%	78.0% ↑	—	Yes
			The percentage of new persons (White) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.	73.2%	82.0% ↑	—	

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R2) results during SFY 2024.
↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).

The goals for **Region 10**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-79 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-79—Barriers and Interventions for Region 10

Barriers	Interventions
Members are not sufficiently engaged in or committed to the Access screening and referral process.	Create/strengthen caller engagement and commitment during the Access screening.
Members experience lack of transportation	Expand transportation resources.
Members experience a delay or extended duration between the point of Access screening and the program first contact.	Improve SUD program appointments' scheduling capacity and processes.
Members feel discouraged by the number and range of tasks to complete the program intake.	Support SUD program intake and service provision innovations.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality** and **Timeliness**]

Strength #2: Region 10 achieved statistically significant improvement over the baseline performance for both performance indicators. [**Quality**, **Timeliness**, and **Access]**

Weaknesses and Recommendations

Weakness #1: Region 10 did not achieve the state-defined goal of eliminating the existing disparity in the first remeasurement period. [**Quality**]

Why the weakness exists: Although **Region 10** made significant progress in improving performance for both populations, the PIHP did not develop intervention strategies specific to the disparate population in order to eliminate the disparity.

Recommendation: HSAG recommends that **Region 10** revisit its causal barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

HSAG evaluated **Region 10**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, or oversight of affiliated CMHSPs.

Region 10 received an indicator designation of *Reportable* for all indicators except indicator #2e, which received an indicator designation of *Not Applicable*. The PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2024 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Region 10** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-80 presents **Region 10**'s performance measure results and SFY 2023 and SFY 2024 comparison. For indicators with corresponding performance standards, when a performance standard was established by MDHHS, rates shaded in yellow indicate that **Region 10** met or exceeded the performance standard. For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

Table 3-80—Performance Measure Results for Region 10

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	100%	99.29%	-0.71%
Adults—Indicator #1b	99.77%	98.57%	-1.20%
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	58.48%	48.24%	-10.24%
MI–Adults—Indicator #2b	53.64%	49.46%	-4.18%
I/DD–Children—Indicator #2c	50.00%	45.95%	-4.05%
I/DD–Adults—Indicator #2d	61.64%	50.00%	-11.64%
Total—Indicator #2	54.99%	48.76%	-6.23%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	72.21%	**74.15%**	+1.94%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	78.59%	78.64%	+0.05%
MI–Adults—Indicator #3b	80.16%	75.58%	-4.58%
I/DD–Children—Indicator #3c	85.82%	87.71%	+1.89%
I/DD–Adults—Indicator #3d	81.97%	80.00%	-1.97%
Total—Indicator #3	80.30%	**78.01%**	-2.29%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	97.30%	91.43%	-5.87%
Adults	94.64%	93.61%	-1.03%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	94.95%	96.10%	+1.15%
#5: The percent of Medicaid recipients having received PIHP managed services.			
The percentage of Medicaid recipients having received PIHP managed services.	6.82%	7.19%	+0.37%

Performance Indicator	SFY 2023 Rate	SFY 2024 Rate	SFY 2023–SFY 2024 Comparison
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
The percentage of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.55%	97.18%	+0.63%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	17.52%	20.58%	+3.06%
DD–Adults—Indicator #8b	6.63%	6.72%	+0.09%
MI and DD–Adults—Indicator #8c	8.56%	9.73%	+1.17%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.94%	99.32%	-0.62%
DD–Adults—Indicator #9b	94.07%	63.08%	-30.99%
MI and DD–Adults—Indicator #9c	94.40%	78.77%	-15.63%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	8.57%	5.45%	-3.12%
Adults—Indicator #10b	10.62%	13.77%	+3.15%
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	16.74%	15.54%	-1.20%
MI and DD–Adults	24.49%	24.35%	-0.14%
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	46.36%	43.75%	-2.61%

Indicates that the reported rate met or exceeded the performance standard.
Indicates a rate increase of 5 percentage points or more from SFY 2023 to SFY 2024.
Indicates a rate decrease of 5 percentage points or more from SFY 2023 to SFY 2024.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 continued to hold Quality Management Committee and Quality Improvement Committee meetings monthly to discuss performance indicators and quarterly to review performance indicator reports. If improvement opportunities were identified regarding a particular indicator rate, **Region 10** referred the identified opportunity to one or more **Region 10** QAPIP standing committees, such as the Improving Practices Leadership Team (IPLT), for further discussion, analysis, and improvement efforts. Further, **Region 10**'s quality and data department staff members continued to hold monthly meetings with the CMHSP provider and data staff members to review performance indicator trends using its internal quarterly performance indicator report to review performance indicator numerator and denominator counts with each CMHSP for each performance indicator. [**Quality**]

Strength #2: For the performance indicators with newly set performance standards (i.e., performance indicators #2 and #3), **Region 10** updated its contract language to require that the CMHSP affiliates and SUD providers perform root cause analyses and develop performance improvement plans regardless of performance. SUD providers were also asked to submit appointment detail information to support efforts to identify and address access barriers for SUD services. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Region 10's reported rates for both SFY 2023 and SFY 2024 for indicators #1a and #1b exceeded the established performance standard, demonstrating consistency in timeliness of care and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Region 10's reported rate for indicator #4b increased by over 1 percentage point from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2024, demonstrating improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #5: Region 10's reported rates for indicators #10a and #10b met the established performance standard for SFY 2023 and SFY 2024, suggesting that there continued to be a small percentage of readmissions for children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, HSAG identified seven cases in which the service data specific to the performance indicator reported in the member-level detail file did not match the system documentation. [**Quality**]

Why the weakness exists: One case for indicator #4a for Lapeer was marked as "in compliance" without a follow-up visit documented in the initial member-level detail file. One case for indicator #1 for Sanilac had inaccurate pre-admission screening start and stop times reported in the member-level detail file compared to what was reported in the proof-of-service files. One case for indicator #3 for Sanilac did not have the accurate follow-up service date reported. Three cases were categorized as an exception for indicator #4b without an exception reason populated in the member-level detail file. One case for indicator #1 for St. Clair had an inaccurate pre-admission screening start and stop time reported in the member-level detail file compared to what was reported in the proof-of-service files.

Recommendation: HSAG recommends that **Region 10** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter. Data validation is a crucial step in ensuring accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources. Further, HSAG recommends for future reporting that **Region 10** enhance its validation process by conducting a quality check prior to submission of data for cases listed as compliant with blank follow-up service dates.

Weakness #2: During PSV, HSAG identified one case for indicator #1 in which the member had a pre-admission screening done outside of the reporting period. [**Quality**]

Why the weakness exists: **Region 10** further researched the issue and found one additional case that was reported outside the reporting period, and it removed the two members. Sanilac explained that the crisis screening date that was input by access center staff was used for reporting and not the date the event took place. **Region 10** submitted an updated member-level detail file.

Recommendation: HSAG recommends that **Region 10** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter. Data validation is a crucial step in ensuring accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources. Further, HSAG recommends that **Region 10** meet with CMHSP staff members to provide additional training when these or similar errors occur, in addition to reviewing a statistically significant sample of cases from each category to check CMHSP reporting accuracy before submission.

Weakness #3: During PSV, HSAG identified one individual's screening was duplicated for Sanilac's indicator #1 data in the member-level detail file. [**Quality**]

Why the weakness exists: Sanilac further researched the issue and found five individuals with either the same date for the "Request Date" or the same time in the "Start Time" column, one individual with multiple events and pre-admission screenings, one individual with screenings called in on the same day, one individual whose screening was duplicated, one individual who was seen

two different times by two different providers, and one individual who was screened by the hospital then by the CMHSP.

Recommendation: While **Region 10** worked with Sanilac to remove the duplicate member and submit a revised member-level detail file, HSAG recommends that **Region 10** meet with CMHSP staff members to provide further training when these and similar errors occur and review a statistically significant sample of cases from each category to check CMHSP reporting accuracy before submission.

Weakness #4: Region 10's SFY 2024 indicator #2 total rate declined by more than 5 percentage points and fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: Region 10's SFY 2024 indicator #2 total rate declined by more than 5 percentage points and fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **Region 10** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #5: Region 10's SFY 2024 indicator #3 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: Region 10's SFY 2024 indicator #3 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergency biopsychosocial assessment.

Recommendation: HSAG recommends that **Region 10** continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

Weakness #6: Region 10's reported rate for indicator #4a for the child population decreased by over 5 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Region 10's reported rate for indicator #4a for the child population decreased by over 5 percentage points from SFY 2023 to SFY 2024 and fell below the established performance standard for SFY 2024. The decrease in performance suggests that some children were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **Region 10** continue to focus its efforts on increasing timely follow-up care for children following discharge from a psychiatric inpatient unit. **Region 10** should continue to monitor the decrease in performance and implement appropriate interventions to

improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-81 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **Region 10**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **Region 10** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards.

Table 3-81—Summary of Standard Compliance Scores for Region 10

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	20	1	3	**95%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	16	6	1	**73%**
Total	**94**	**85**	**76**	**9**	**9**	**89%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 received a score of 100 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the PIHP has adequate processes for monitoring the adequacy of its provider network and identifying opportunities for improving its network capacity and enhancing timely access to services for its membership. [**Access** and **Timeliness**]

Weaknesses and Recommendations

Weakness #2: Region 10 received a score of 73 percent in the Coverage and Authorization of Services program area. The PIHP demonstrated several challenges in implementing all service authorization requirements, which is imperative for members to receive timely medically necessary services and their rights when services are denied. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Region 10 received a *Not Met* score for six elements, indicating gaps in the PIHP's processes related to the content of ABD notices; accurate reporting of service authorization data; timely service authorization decisions; accurate categorization and reporting of expedited service authorizations; application of extension provisions; process for when a member no longer wishes to receive services; and service authorization decisions not reached timely.

Recommendation: As **Region 10** submitted a CAP which was approved by HSAG and MDHHS, HSAG recommends that the PIHP ensure full implementation of its action plans to address each deficiency. Additionally, HSAG recommends that the PIHP conduct an extensive review of the findings from the compliance review, the PIHP's current UM/service authorization policies, and the PIHP's delegated arrangements. The PIHP should evaluate the risks and the benefits of delegating service authorization functions and the overall strengths and weaknesses of its program. From the evaluation, HSAG recommends that the PIHP implement necessary revisions to its UM program, as applicable. Further, HSAG recommends that the PIHP begin preparations to implement the new seven calendar day service authorization time frame effective in 2026, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PIHP according to Table 3-82.

Table 3-82—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **Region 10** met the time and distance standard requirements for 100 percent of its members for 16 indicators. All remaining indicators had results below 100 percent. Adequacy was determined based on the PIHPs' compliance with MDHHS' time and distance standards, with assessment conducted for each provider type according to urbanicity. Reporting for SFY 2024 was purely informational and intended to establish baseline data for future reporting years. Results are presented by provider type and urbanicity in Table 3-83. "NA," as used throughout the PIHP's performance results, means "Not Applicable." This designation was applied in cases where a PIHP had no members to serve, had no available service providers in the area, and/or when the concept of urbanicity did not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Table 3-83—Region 10 Network Adequacy Compliance

	Region 10 Urban	Region 10 Rural	Region 10 Frontier
Adult Assertive Community Treatment—H0039	NA	100%	100%
Adult Crisis Residential Programs—H0018	NA	99.00%	100%
Adult Opioid Treatment Programs—H0020	NA	100%	100%
Adult Psychosocial Rehabilitation Programs (Clubhouses)—H2030	NA	99.00%	100%
Adult Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	100%	100%
Pediatric Crisis Residential Programs—H0018	NA	100%	100%
Pediatric Home-Based Services—H0036, H2033	NA	100%	100%
Pediatric Wraparound Services—H2021, H2022	NA	100%	100%
Pediatric Inpatient Psychiatric Services—0100, 0114, 0124, 0134, 0154	NA	100%	100%

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Region 10 had sufficient policies and control processes in place to ensure reporting accuracy for measures in scope of review. [**Access**]

Weaknesses and Recommendations

Weakness #1: Region 10 reported not having internal backups for programmers for network adequacy reports. [**Access**]

Why the weakness exists: Region 10 lacked a full understanding of the expectations for how the PIHPs should calculate time and distance to applicable providers, which hindered the ability to train additional staff members effectively.

Recommendation: HSAG recommends that **Region 10** explore the capabilities of training additional staff members on supporting network adequacy reporting activities to ensure reporting continuity.

Encounter Data Validation

Performance Results

Representatives from **Region 10** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-84 outlines the key findings for **Region 10** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-84—Key Findings for Region 10

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **99.7 percent**, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **74.6 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code* and *Procedure Code Modifier* data elements had relatively high medical record omission rates at **11.1 percent** and **21.8 percent**, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Procedure Code* having the highest omission rate at **3.0 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.9 percent** of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **98.0 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **66.1 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of the *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 0.2 percent. [**Quality**]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code,* and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 1.3 percent, 1.3 percent, 3.0 percent, and 1.5 percent, respectively. [**Quality**]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.0 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: More than 11.0 percent of the *Procedure Code* and more than 21.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [**Quality**]

Why the weakness exists: The high rate of unsupported *Procedure Code* data element values identified in the encounter data can likely be attributed to several factors. These include inconsistent provider documentation practices, where not all aspects of the services performed are thoroughly documented. Data submission issues, such as incorrect coding during submission or data entry errors, also contribute to the discrepancies. Additionally, gaps in provider training may play a role, as behavioral health providers and staff may not fully understand the importance of aligning medical record documentation with the codes submitted in the encounter data.

Recommendation: To address the discrepancies, **Region 10** should focus on improving provider documentation practices by enhancing provider training to strengthen understanding of documentation and coding alignment, standardizing documentation processes to ensure all services performed are accurately recorded and conducting regular audits to identify and resolve discrepancies. Additionally, data submission processes should be improved by implementing validation checks and minimizing data entry errors. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions protocols, medical record documentation requirements, and proper coding practices to reduce future omissions and improve data accuracy.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Region10**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region 10**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives for the populations managed by SBHS and BCCHPS. Table 3-85 displays each MDHHS CQS goal and the EQR activity results that indicate whether the PIHP positively (✓) or negatively (✗) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **Region 10**'s Medicaid members. Not applicable (**NA**) was used if a CQS goal did not include any quality measures for the SBHS or BCCHPS programs or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-85—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care	✓ CQS Objective 1.1—**Region 10** achieved MDHHS' standard for the child and adult populations for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. ✓ CQS Objective 1.1—**Region 10** achieved the 50th percentile for the total population for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*. ✗ CQS Objective 1.1—**Region 10** did not achieve the 50th percentile for the total population for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.* The total rate also decreased by approximately 6 percentage points. NA CQS Objective 1.3—The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #2: Strengthen person and family-centered approaches	NA The CQS not does include quality measures for the SBHS program under Goal #2. NA CQS Objective 2.1—The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under this objective.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	NA CQS Objective 3.1—The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under this objective. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new measures in year one of MDHHS' behavioral health quality measure overhaul. Performance of these measures will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 3.2—The EQR activities do not produce data to assess the impact of the two quality measures of the BCCHPS program under this objective.	☒ Quality ☒ Timeliness ☒ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes	NA CQS Objective 4.1—The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under this objective. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity. NA CQS Objective 4.1—The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under this objective. Of note, while indicator #2*: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data are not stratified by persons of color.	☒ Quality ☒ Timeliness ☐ Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform	NA The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access

4. Follow-Up on Prior External Quality Review Recommendations for Prepaid Inpatient Health Plans

From the findings of each PIHP's performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Michigan Behavioral Health Managed Care program. The recommendations provided to each PIHP for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 4-1 through Table 4-10. The PIHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-10.

Region 1—NorthCare Network

Table 4-1—Prior Year Recommendations and Responses for NCN

1. Prior Year Recommendations From the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **NCN** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For the Co-Occurring treatment PIP, **NCN** is seeking to increase the percentage of individuals receiving cooccurring treatment that have cooccurring disorders. Interventions have focused on staff training. Causal/Barrier analysis and outcomes were limited as various staff attended numerous different trainings sponsored by multiple entities. **NCN** was the funder for said trainings and encouraged training but did not present the training to assess understanding pre/post training. Requests for training reimbursement were submitted to **NCN** after the training occurred. Going forward, **NCN** will complete pre/post tests for any trainings coordinated by **NCN** and a survey is being sent to all staff to assess their satisfaction with any training they have attended. Preliminary results of this survey suggest that training is still a need. There have been proposed adjustments to the EMR to better track situations where a person chooses not to have an integrated plan although such a plan was offered. This has not yet been developed in the EMR.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA

1. Prior Year Recommendations From the EQR Technical Report for Validation of Performance Improvement Projects
c. Identify any barriers to implementing initiatives: • NCN is not hosting/providing the training, so ability to assess for pre/post training understanding is limited. Ability to assess staff's effectiveness working with consumers pre/post training is also limited.
HSAG Assessment: HSAG has determined that NCN addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and revised its barriers and interventions as appropriate, evaluating the effectiveness of each effort.

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During primary source verification (PSV), for indicator #4b, HSAG identified one case that was categorized as "In-Compliance"; however, the performance indicator event screen showed the case was overridden to be an exception. NCN further researched the issue, reviewed all reported cases per HSAG's request, and identified an additional case with the wrong discharge date noted that was incorrectly categorized. While these findings did not have a significant impact on the rate, HSAG recommends that NCN implement quality assurance steps to ensure it captures accurate discharge dates and categorization of members for future reporting. • Upon review of NCN's member-level detail file submission, HSAG identified one "NorthCare Dual" member incorrectly reported in indicator #2. NCN indicated that it is working with Peter Chang Enterprises, Inc. (PCE) and has submitted a ticket to update its system logic to identify and remove members admitted to the access center with a mild/moderate radio button selection within the system. While this finding did not have a significant rate impact, HSAG recommends that NCN continue its efforts toward working with PCE on the system logic updates. HSAG also recommends that additional validation checks be incorporated to ensure appropriate populations are included in future performance indicator reporting.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • During primary source verification (PSV), for indicator #4b, HSAG identified one case that was categorized as "In-Compliance"; however, the performance indicator event screen showed the case was overridden to be an exception. NCN further researched the issue, reviewed all reported cases per HSAG's request, and identified an additional case with the wrong discharge date noted that was incorrectly categorized. While these findings did not have a significant impact on the rate, HSAG recommends that NCN implement quality assurance steps to ensure it captures accurate discharge dates and categorization of members for future reporting. • Upon review of NCN's member-level detail file submission, HSAG identified one "NorthCare Dual" member incorrectly reported in indicator #2. NCN indicated that it is working with Peter Chang Enterprises, Inc. (PCE) and has submitted a ticket to update its system logic to identify and remove members admitted to the access center with a mild/moderate radio button selection within the system. While this finding did not have a significant rate impact, HSAG recommends that NCN continue its

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
efforts toward working with PCE on the system logic updates. HSAG also recommends that additional validation checks be incorporated to ensure appropriate populations are included in future performance indicator reporting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA
c. Identify any barriers to implementing initiatives: • NA
HSAG Assessment: HSAG has determined that NCN fully addressed the prior year's recommendations. NCN fully addressed the prior year's recommendation for indicator #4b to implement quality assurance steps to ensure it captured accurate discharge dates and categorization of members. NCN provided education on the use of discharge dates. Additionally, during the SFY 2024 audit, NCN indicated that the detox discharge date was an identified system weakness in SFY 2023 due to a system glitch. NCN confirmed that this was fixed, and it did not experience further errors in its reporting due to that system glitch. NCN fully addressed the prior year's recommendation for system logic updates for indicator #2 to identify and remove members admitted to the access center with a mild/moderate radio button selection within the system as well as incorporating additional validation checks to ensure appropriate populations were included in performance indicator reporting. During the SFY 2024 audit, NCN indicated the ELMER logic was updated to remove mild or moderate "NorthCare Dual" consumers via the access screening in October 2023. NCN confirmed this was fixed and did not experience any mild or moderate "NorthCare Dual" consumers reported for indicator #2.

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • NCN did not remediate two of the four elements for the Provider Selection standard, indicating continued gaps in the PIHP's credentialing processes. Timely credentialing activities verify education, training, practice history, liability history, licensing, and certification to ensure providers are qualified to perform the services for which the providers are seeking to be paid. HSAG required NCN to submit an action plan to address these findings. Specifically, HSAG recommended that NCN revise its credentialing policy and onboarding checklist to identify the acceptable sources of PSV for education, as well as the time frame for calculating timely credentialing to comply with, and ensure delegates performing credentialing activities comply with, all initial credentialing requirements as outlined in its contract with MDHHS. Additionally, NCN should continue to strengthen oversight and monitoring of the credentialing processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with the Provider Selection standard requirements. • NCN did not remediate the two elements for the Health Information Systems standard. NCN has not made the Patient Access API accessible to its members in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, NCN has not made its entire provider directory publicly accessible via the Provider Directory API in accordance with 42 CFR §431.70. Having provider directory information

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **NCN** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **NCN** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **NCN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **NCN** completed a corrective action plan and worked with specific providers that were struggling with the credentialing process. Forms and procedures were updated and the EMR was adjusted to better be able to track due dates and changes in the credentialing status of individual staff. • A Provider Directory API standard operating procedure was implemented and operationalized regionally in May of 2024 to ensure that **NCN** Provider Network Management staff and CMHSP Contract Management staff are accurately and completely maintaining provider data exposed by the publicly available Provider Directory API. • **NCN** is also working through a project to redesign our organization's website. Among the activities that are to be completed as part of this project is to design an electronic, printable, and machine-readable provider directory which utilizes the Provider Directory API as its data source while also meeting other state and federal requirements. Additionally, location of the Patient Access API documentation on the website will be among the many considerations in the redesign.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Completeness and accuracy of information available via the Provider Directory API has improved drastically since implementation of the standard operating procedure above.
c. Identify any barriers to implementing initiatives: • [no response provided by the PIHP]
HSAG Assessment: HSAG has determined that **NCN** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. While **NCN** implemented actions to address the recommendations related to credentialing and the Provider Directory application programming interface (API), it is unknown if the PIHP implemented actions to ensure the Patient Access API is made available to its members and that it meets all federal requirements. As such, HSAG recommends that **NCN** ensure that all API requirements are fully executed. As it is unclear if **NCN** has any registered third-party applications. HSAG continues to recommend that **NCN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **NCN** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **NCN** did not indicate claim volume or timeliness quality checks performed for claims/encounters from its subcontractors' data. **NCN** should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness and timeliness of encounter data. By implementing such measures, **NCN** can enhance the overall quality and reliability of the encounter data that it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time. • While several PIHPs recognized the labor- and resource-intensive nature of medical record review (MRR) as a method for conducting data quality checks and reported its usage, **NCN** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **NCN** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 96.8 percent and 95.7 percent, respectively. Additionally, 97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **NCN**'s enrollment data may not be complete. **NCN** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **NCN** is working on an encounter monitoring report to address volume and timeliness trended over time. The data quality process is reviewed annually during CMHSP site reviews. In FY25, there will be an improvement process to incorporate system edits and manual checks in the data quality process. As this process is working in tandem with EHR updates and regional committees, it is anticipated that full data quality assessment of subcontractor data will take a couple of years. **NCN** will continue to discuss the components best considered pertinent for the quality assessment, including MRR, satisfaction results, site review results, etc.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Current EHR capabilities and various demands for changes in an EHR.
HSAG Assessment: HSAG has determined that **NCN** has partially addressed the prior year's recommendations. **NCN** is currently developing an encounter monitoring report to track claim volume and timeliness trends over time, with plans to enhance data quality processes in SFY 2025 through the incorporation of system edits and manual checks. While **NCN** has outlined plans for improvement, full implementation will take time, and tangible progress has not been reported. Regarding MRR, while it has been identified as a potential component for data quality assessment, no concrete steps have been taken toward implementation. Additionally, **NCN** has not addressed the recommendation related to enrollment data

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
completeness, and collaborative efforts with MDHHS are needed to validate and improve enrollment data accuracy. In conclusion, **NCN** has made progress in identifying the need for enhanced monitoring processes and data quality improvements but has not fully implemented solutions to address HSAG's recommendations. Significant gaps remain in establishing timeliness checks, incorporating MRR, and reconciling enrollment data. To strengthen compliance with HSAG's recommendations, **NCN** should: • Accelerate the development and deployment of encounter monitoring reports and implement interim manual processes. • Pilot MRR to evaluate its feasibility and effectiveness for subcontractor data quality checks. • Collaborate with MDHHS to reconcile enrollment data discrepancies and address gaps in member ID validity. • Enhance internal data validation processes to ensure ongoing data quality improvements. These steps will help **NCN** address barriers, improve data reliability, and align more closely with HSAG's recommendations.

Region 2—Northern Michigan Regional Entity

Table 4-2—Prior Year Recommendations and Responses for NMRE

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **NMRE** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **NMRE** revisits its causal/barrier analysis annually and continues to evaluate interventions to determine the effectiveness of each effort.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • No Barriers were found in implementation.
HSAG Assessment: HSAG has determined that **NMRE** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and revised barriers and interventions as appropriate. Intervention efforts were evaluated to determine effectiveness.
2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During PSV, for indicator #3, HSAG identified that one CMHSP was counting pre-planning meetings as medically necessary, ongoing covered services within 14 days, while another CMHSP was not counting pre-planning meetings as medically necessary, ongoing covered services. HSAG recommends that **NMRE** continue to hold collaborative meetings with its CMHSPs to provide guidance on interpretation of the measure specifications. Additionally, HSAG recommends that **NMRE** reach out to MDHHS for guidance on interpretation of the specifications whenever necessary to ensure consistency in reporting among the CMHSPs. • During review of the member-level detail file, HSAG noted that multiple dates of birth did not match for indicators #4a, #4b, and #10. Additionally, the "Compliant" column was not properly formatted, which led to HSAG asking additional questions regarding data validation. HSAG recommends that **NMRE** perform additional spot checks prior to submitting data to HSAG. Data validation is a crucial step in ensuring accurate submission. Incorporating additional spot checks can add value, especially when data are being integrated from multiple sources. • During PSV, HSAG identified for indicator #1 that Northern Lakes Community Mental Health Authority was allowing providers to enter a reason for dispositions not being completed within three

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
hours, even if the disposition was in fact completed within three hours for indicator #1. HSAG recommends that providers only be prompted to enter an explanation if a member is noncompliant. If the disposition is completed within the required time frame, then an explanation prompt should not be necessary. • **NMRE**'s reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **NMRE** focus its efforts on increasing timely follow-up care for adults following discharge from a psychiatric inpatient unit. **NMRE** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge. • **NMRE**'s reported rate for indicator #4b decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **NMRE** focus its efforts on increasing timely follow-up care for members following discharge from a substance abuse detox unit. **NMRE** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **NMRE** continues to hold collaborative meetings with its CMHSPs to provide guidance on the interpretation of the Performance Measure specifications. • **NMRE** continues to reach out to MDHHS for clarification on the interpretation of the Performance Measure specifications. • **NMRE** now performs additional spot checks before submitting data to HSAG. • **NMRE** identified a need for indicator #1 system logic changes. These changes haven't been implemented at this time. However, **NMRE** has it as an item on the Business Intelligence Committee's Regional Programming Changes IT Request list. • **NMRE** has reviewed the data for Performance Indicator 4a. There are fluctuations from quarter to quarter, however, we've maintained an average above the 95% benchmark for 4a. **NMRE** continues to monitor quarterly. • **NMRE** has reviewed the data for Performance Indicator 4b. There was one quarter (FY2023Q1) that had a statistically significant drop. Outside that quarter, we've maintained an average above the 95% benchmark for 4b. **NMRE** continues to monitor quarterly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
c. Identify any barriers to implementing initiatives: • Due to multiple demands from HSAG and MDHHS for system changes, prioritization has delayed a few changes. Implementation is expected by 12/31/2024.
HSAG Assessment: NMRE fully addressed the prior year's recommendation for indicator #3 related to ensuring CMHSPs consistently interpret the measure specifications, including whether pre-planning meetings were considered as medically necessary, ongoing covered services. NMRE held collaborative meetings with its CMHSPs to provide guidance on the interpretation of the measure specifications, as well as reached out to MDHHS for guidance on interpretation of the specifications, whenever necessary, to ensure consistency in reporting among the CMHSPs. In addition, during the SFY 2024 audit, NMRE discussed that it had confirmed with MDHHS that pre-planning meetings were being correctly reported as ongoing covered services for indicator #3. NMRE fully addressed the prior year's recommendation for indicators #4a, #4b, and #10 related to ensuring that dates of birth match and that column formatting in the member-level detail file is consistent. While NMRE did not indicate any changes resulted from HSAG's prior year recommendation, during the SFY 2024 audit, HSAG did not identify the same type of issue. Therefore, the recommendation is considered fully addressed. NMRE partially addressed the prior year's recommendation for indicator #1 related to only allowing providers to enter a reason for dispositions not being completed within three hours (i.e., if the member is noncompliant). NMRE identified system logic changes necessary for indicator #1, however, it has not implemented the changes for the SFY 2024 audit period. As such, HSAG recommends that NMRE implement the system logic changes for indicator #1 as well as provide guidance to providers on only entering an explanation for noncompliant members in indicator #1 to further ensure the consistency and accuracy of reported data. NMRE has made an effort to improve its performance for indicator #4a for the adult population by continuously monitoring performance for each quarter. However, there is still opportunity for improvement, as NMRE's reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2023 to SFY 2024 and continued to fall below the established performance standard for SFY 2024. HSAG therefore recommends that NMRE continue to focus its efforts on increasing timely follow-up care for members discharged from a psychiatric inpatient unit and expand upon any interventions currently in place in order to prevent the rate from further declining. NMRE fully addressed the prior year's recommendation for indicator #4b, as the reported rate for indicator #4b increased from SFY 2023 to SFY 2024 and exceeded the established performance standard for SFY 2024.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • NMRE did not remediate two of the three elements for the Practice Guidelines standard, indicating continued gaps in the PIHP's processes related to the adoption of clinical practice guidelines (CPGs). CPGs assist providers in applying up-to-date, evidence-based practice to clinical care. HSAG required NMRE to submit an action plan to address these findings. Specifically, HSAG recommended NMRE develop a procedure for obtaining input from network providers prior to adopting CPGs; formally adopting CPGs; and reviewing CPGs periodically, including how often CPGs will be reviewed.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review

Additionally, HSAG recommended that the PIHP document the input from network providers in committee meeting minutes, a notes format, or other format that clearly indicates which network providers provided the input and their specialty, if applicable. Further, HSAG recommended that the PIHP formally document in committee meeting minutes what CPGs were adopted and the developer of the guidelines; who was present at the meeting adopting the CPGs, along with each person's title, organization, and/or provider specialty; and when CPGs were adopted. Lastly, **NMRE** should continue to strengthen oversight and monitoring of the adoption of CPG processes to ensure continued remediation and compliance with the Practice Guidelines standard requirements.

- **NMRE** did not remediate the two elements for the Health Information Systems standard. **NMRE** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **NMRE** has not made its Provider Directory API publicly accessible. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **NMRE** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **NMRE** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **NMRE** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
- **NMRE** did not remediate two of the nine elements for the Quality Assessment and Performance Improvement Program standard, indicating continued gaps in the PIHP's implementation of its quality assessment and performance improvement (QAPI) program. QAPI programs provide the foundation for Medicaid MCEs to continually monitor for and identify opportunities for performance improvement with the goal of improving quality of care and member outcomes. HSAG required **NMRE** to submit an action plan to address these findings. Specifically, HSAG recommended that **NMRE** designate or develop a field in its system to track when a critical incident is determined to be sentinel and create reports that allow it to track these time frames in real time. Additionally, related to the assessment of member experience, HSAG recommended that **NMRE** develop a procedure to include the processes to take specific action on individual cases (when appropriate), identify and investigate sources of dissatisfaction, outline systemic action steps to follow up on the findings, and evaluate the effects of activities implemented to improve satisfaction. **NMRE** could also develop a comprehensive member experience report (separate from its QAPI evaluation) that includes all activities to assess member experience with services and notify members when the results of member experience activities are available on the website. Lastly, **NMRE** should continue to strengthen oversight and monitoring of its QAPI program to ensure continued remediation and compliance with the Quality Assessment and Performance Improvement Program standard requirements.
- **NMRE** did not remediate one of the four elements for the Coverage and Authorization of Services standard, indicating continued gaps in the PIHP's processes related to providing members with appropriate notices of adverse benefit determination (NABDs). NABDs for the denial of payment are

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
an important protection as they may be the only notification members receive alerting them that a claim has been submitted on their behalf. HSAG required **NMRE** to submit an action plan to address these findings. Specifically, HSAG recommended **NMRE** update its denial of payment procedures to include the business rules that will trigger a denial of payment NABD and to specify the process for ensuring the denial of payment NABD will be sent to members at the time of the action affecting the claim; and update its annual audit tool to specifically review denial of payment procedures and NABDs. Additionally, **NMRE** should continue to strengthen oversight and monitoring of the utilization management processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with the Coverage and Authorization of Services standard requirements.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The **NMRE** revised its Practice Guideline policy and procedures to specify the dissemination, adoption, and monitoring of Clinical Practice Guidelines (CPG). The **NMRE** Quality Assessment and Performance Improvement Plan (QAPIP) for FY 2024 outlines that the **NMRE**, in collaboration with its network providers, will review and adopt practice guidelines established by the American Psychiatric Association (APA) and Michigan Department of Community Health (MDHHS). The CPGs were reviewed and approved by the Clinical Leadership Committee and Quality and Compliance Oversight Committee in FY 2024 and documented in meeting minutes. The guidelines are scheduled to be reviewed with the Provider Network Managers Committee at their next meeting. The guidelines are posted on the NMRE.org website and an email with a link to the guidelines was sent out to committee members prior to the meeting for review. • Both the Provider Directory and Patient Access APIs are active and available on NMRE.org website currently. Notice of the availability of these APIs will be going out in our informational mailer to our beneficiaries during the next mailing cycle. • **NMRE** requested the addition of a field in PCE to track when a critical incident was determined to be a sentinel event. This was implemented in FY 2024 and is being used by the entire **NMRE** region. The **NMRE** continues to enhance its mechanisms to assess member satisfaction through satisfaction surveys. Satisfaction surveys cover topics such as LTSS services, home and community-based services, SUD services, and other CMHSP services. The satisfaction surveys have ample possibilities for a recipient to report dissatisfaction, including a question that specifically asks if a recipient would like to discuss their satisfaction with customer service. If a name and number are listed, the appropriate provider is given the information to then reach out to the recipient. If a comment is left that could be a Recipient Rights Violation, then the provider's Office of Recipient Rights is contacted. If a violation seems to be against licensing rules, a report is made to the Licensing and Regulatory Affairs. At the end of the survey cycle, a comparison of the current year is made against the previous years. From there, an action plan is made to increase satisfaction in deficient areas or an action plan to at least keep status quo with the goal of increasing satisfaction. Survey results are shared with network providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operations Committee (IOC), Board of Directors, the Regional Consumer Council, and posted on the NMRE.org website. The **NMRE** has developed a process for updating member service experiences on NMRE.org website and has developed an informational mailer that will be sent out to beneficiaries advising them how they

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
can access this information. The **NMRE** continues to provide updates to the regional Quality and Compliance Oversight Committee (QOC), network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities are shared with consumers through the regional Consumer Council and other stakeholders through committees and postings to the NMRE.org website. The **NMRE** Quality Oversight Committee, which meets monthly, is responsible for the oversight and monitoring of the QAPIP. • The **NMRE** has created the Denial of Payment Policy, to address the deficiency. This policy was shared with the local CMHSPs, and their policies were updated for accuracy. The site review tool has also been updated to include review of denial of payment NABDs. Along with monitoring the denial of payment NABD at time of site review, the **NMRE** monitors payment NABD for appropriateness on a quarterly basis by reviewing the MDHHS quarterly denials report. Still underway, the **NMRE** is creating a training for technical requirements regarding NABD. This training will be created, provided, and taught by the **NMRE**.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During review of the quarterly denial reports, the **NMRE** has been able to catch a couple NABDs given for payment denial that were incorrect. The CMHSP then corrected the human error and an updated NABD was provided.
c. Identify any barriers to implementing initiatives: • As a region, the **NMRE** has very few payment denial NABDs. This is a barrier in the sense that without the NABDs to monitor, it's difficult to fully implement a process for improvement of this deficiency.
HSAG Assessment: HSAG has determined that **NMRE** addressed the prior year's recommendations based on the PIHP's reported initiatives. However, while **NMRE** reported that the Provider Directory and Patient Access API are active and accessible via the PIHP's website, it is unclear if **NMRE** has any registered third-party applications. HSAG continues to recommend that **NMRE** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **NMRE** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **NMRE** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **NMRE** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process. • **NMRE** did not submit institutional encounters timely, where 40.4 percent of institutional encounters were submitted within 60 days of payment, and 65.1 percent of encounters were submitted within 360 days. **NMRE** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
• The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 96.0 percent and 92.2 percent, respectively. Additionally, 95.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **NMRE**'s enrollment data may not be complete. **NMRE** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **NMRE** utilizes the Medical Record Review (MRR) in several of our review processes including Encounter Data Validation, Performance Measure Validation, and Medicaid Encounter Verification audits. In addition to MRR, we have implemented built-in system checks to ensure that valid and accurate member data is consistently submitted to MDHHS. These measures help **NMRE** to maintain high data quality standards and ensure compliance with reporting requirements. • **NMRE** research of the delayed submission of institutional and professional claims was due to MDHHS requesting a massive resubmission of 837I claims due to missing data that CHAMPS was not flagging as an error. **NMRE** had to work with CMHSPs to update encounters and resubmit data. **NMRE** continues to monitor data submissions to ensure that encounters are being submitted timely after payment occurs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **NMRE** has worked with PCE add additional system validations to help prevent data errors from occurring.
c. Identify any barriers to implementing initiatives: • Not applicable
HSAG Assessment: HSAG has determined that **NMRE** has partially addressed the prior year's recommendations. **NMRE** has confirmed the use of MRR in multiple processes, including Encounter Data Validation (EDV), Performance Measure Validation, and Medicaid Encounter Verification audits. By effectively incorporating MRR into its review processes, **NMRE** has demonstrated a strong commitment to ensuring data quality. Regarding the timeliness of institutional encounter submissions, **NMRE** attributed delays to a large-scale resubmission of 837I claims requested by MDHHS due to missing data. **NMRE** collaborated with CMHSPs to update and resubmit the data and continues to monitor submissions for timeliness. While **NMRE** has addressed this specific instance of delayed submissions, consistent and proactive timeliness monitoring remains necessary to prevent future issues. For enrollment data completeness, **NMRE**'s implementation of system checks to improve the validity of member data is a positive step. However, **NMRE** has not indicated any collaborative efforts with MDHHS to comprehensively reconcile and validate enrollment data, leaving this recommendation only partially addressed.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
In conclusion, **NMRE** has made progress, particularly in incorporating MRR into its processes and addressing the root cause of delayed institutional submissions. However, gaps remain in ensuring consistent timeliness and comprehensively addressing enrollment data completeness. To strengthen compliance with HSAG's recommendations, **NMRE** should: • Develop automated tracking mechanisms and proactive strategies to prevent late submissions. • Formalize collaboration with MDHHS to reconcile enrollment discrepancies and validate member data. • Expand MRR efforts to target subcontractor-specific challenges. These steps will enhance **NMRE**'s data quality processes, address barriers, and ensure alignment with HSAG's recommendations.

Region 3—Lakeshore Regional Entity

Table 4-3—Prior Year Recommendations and Responses for LRE

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **LRE** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of African American/Black members attending follow-up appointments after hospitalization for mental illness, **LRE** should identify the barriers of care that are specific to the African American/Black population and implement interventions that are tailored to the needs of the African American/Black community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **LRE** reviews its Follow-up after Hospitalization Racial Disparity Performance Improvement Project (FUH PIP) amongst its FUH PIP Workgroup. **LRE** identified barriers and interventions specific to FUH PIP's overall success. **LRE** FUH PIP Workgroup continues to periodically review the FUH PIP progress, barriers, and intervention implementation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Given the lag in FUH data availability, it is too soon to evaluate **LRE**'s interventions
c. Identify any barriers to implementing initiatives: • The lag in FUH data availability
HSAG Assessment: HSAG has determined that **LRE** partially addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and initiated interventions that were reasonably linked to their corresponding barriers. The PIHP did not provide intervention evaluation results for the efforts initiated to determine effectiveness. The PIHP did not identify barriers to care that are specific to the African American/Black population or implement interventions that are tailored to their needs.
2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • Upon review of HealthWest's member-level detail file, HSAG identified three cases with completed biopsychosocial assessment dates that occurred prior to the non-emergency request for service dates for indicator #2. As a result of this finding, HealthWest has since added an extra layer of data validation as part of its data cleanup process prior to submission. This process is intended to ensure that all dates are in proper chronological order and that they match the records in the chart. HealthWest is also enhancing the logic for its performance indicator report and clinical documentation workflows so that fewer charts must be reviewed manually. Additionally, **LRE** instructed PCE to deploy programming logic for edits that will

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
reject submitted CMHSP data if the request date is later than the assessment date and if the assessment date is later than the ongoing covered service date. While the incorrect dates did not impact the rate, HSAG recommends that **LRE** continue to monitor the remediation plans and work with the CMHSP to expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data. This should include a reduction of manual entry processes, wherever possible. • Upon review of OnPoint's member-level detail file, HSAG identified one case with a completed biopsychosocial assessment date that occurred prior to the non-emergency request for service date for indicator #2. As a result of this finding, **LRE** instructed PCE to deploy programming logic for edits that will reject submitted CMHSP data if the request date is later than the assessment date and if the assessment date is later than the ongoing covered service date. While the incorrect dates did not impact the rate, HSAG recommends that **LRE** continue to monitor the remediation plan and expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data. • Upon review of West Michigan Community Mental Health's proof of service documentation provided, HSAG identified one case with an incorrect request date documented for indicator #2. West Michigan Community Mental Health noted that the correct request date reflected a greater-than-14-day difference between the non-emergency request date and completed biopsychosocial assessment date, which implies that this case should have received an out-of-compliance disposition instead of an in-compliance disposition. At HSAG's request, all reported cases were reviewed, and an additional five cases contained the same errors and should have been reported as out of compliance. West Michigan Community Mental Health indicated that new staff began processing the performance indicators as of Q2 SFY 2023. These staff have been trained on existing procedures, and every screening within the 60-day window is now being reviewed in detail to ensure the correct request date is reported. West Michigan Community Mental Health is also in the process of implementing a new module into its electronic health record (EHR) that will provide a simpler way of tracking multiple requests for services and attempts to screen members, thus reducing the potential for human error. HSAG recommends that **LRE** monitor the remediation plan and work with the CMHSP to expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data. This should include a reduction of manual entry processes, wherever possible. • **LRE**'s reported rate for indicator #4a for the child population decreased by more than 2 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **LRE** focus its efforts on increasing timely follow-up care for children following discharge from a psychiatric inpatient unit. **LRE** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • At the direction of **LRE**, **LRE** and its Member CMHSPs directed their electronic health record (EHR) vendors to implement chronological edits related to request, assessment, and service dates immediately upon discovery of the chronological inaccuracies found by HSAG. **LRE** reviews all Member

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
Community Mental Health Service Programs (CMHSPs) indicator 2a and 3 data ensuring chronological accuracy prior to submission. • West Michigan Community Mental Health (WMCMH) ensures correct request dates are reported by reviewing every screening within a 60-day window from the most recent request date for each member requesting services. • LRE considered the root cause for the decline in indicator 4a for the child population and implemented interventions to improve performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Since implementation of the chronological edits, LRE found no chronological inaccuracies in its indicator 2a and 3 data prior to submission. • For the last five out of six quarters, LRE met indicator 4a for the children population.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: LRE fully addressed the prior year's recommendations for indicator #2 related to cases identified with biopsychosocial assessment dates that occurred prior to non-emergency request for service dates. HSAG recommended that LRE monitor remediation plans in place and that LRE work with HealthWest and OnPoint to expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data. LRE confirmed that since implementation of the chronological edits, LRE found no chronological inaccuracies in its indicator #2a and #3 data prior to submission. During the SFY 2024 audit, LRE also discussed that, for a couple of quarters, when the CMHSPs sent their data to LRE, the data were checked to ensure that the issue was fixed. The CMHSPs were also asked to review their data specifically related to this issue, and training was provided by LRE for double-checking any manual data entries. LRE fully addressed the prior year's recommendation related to incorrect proof-of-service documentation (i.e., containing incorrect request dates) received from WMCHM for multiple cases for indicator #2. WMCHM conducted staff training and took action to implement a new module into its EHR in order to provide a simpler way of tracking multiple requests for services and attempts to screen members, thus reducing the potential for human error. LRE monitored the remediation plan and confirmed that WMCHM ensures correct request dates are reported by reviewing every screening within a 60-day window from the most recent request date for each member requesting services. During the SFY 2024 audit, LRE also confirmed that the module was implemented into WMCHM's EHR, and that it had been effective in addressing the issue. LRE fully addressed the prior year's recommendation related to the decrease in its reported rate from SFY 2022 to SFY 2023 for indicator #4a for the child population. LRE's consideration of the root cause and implementation of interventions to improve performance have been successful, resulting in an increase to the reported rate as well as again meeting the established minimum performance standard (MPS) for SFY 2024.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • LRE did not remediate the two elements for the Health Information Systems standard. LRE has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g.,

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **LRE** has not made its Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **LRE** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **LRE** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **LRE** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **LRE** continues to collaborate with other Pre-paid Inpatient Health Plans (PIHPs) via a state-wide workgroup to help move forward data sharing projects and prepare for future interoperability requirements. **LRE** continues to work with its EHR vendor to enable the Patient Access API, which remains under construction. **LRE**'s Provider Data API is live within **LRE**'s EHR vendor. • **LRE** posts information regarding data sharing on its public facing website: https://www.lsre.org/what-is-data-sharing.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • It is too soon to evaluate **LRE**'s initiatives.
c. Identify any barriers to implementing initiatives: • Published Federal API data sharing template specifications and the most current provider directory requirements may be out of sync, which may cause implementation delays. • Lack of interest by third-party application developers.
HSAG Assessment: HSAG has determined that **LRE** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. While **LRE** has indicated that its Provider Directory API is live within its EHR vendor, it is unclear if the Provider Directory API was made publicly accessible via a digital end-point on its website. **LRE** has also confirmed that the Patient Access API has yet to be implemented. As **LRE** has been noncompliant for several years, HSAG recommends that **LRE** prioritize full implementation of the Patient Access API and consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Further, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **LRE** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements. Lastly, with CMS increasing the interoperability requirements, this should stress the importance to **LRE** of not delaying implementation of the Patient Access API any further.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **LRE** modified encounters from its subcontractors before submitting them to MDHHS. **LRE** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors. • **LRE** did not submit professional encounters timely, where 60.9 percent of professional encounters were submitted within 60 days of payment, and not reaching greater than 90 percent of professional encounters submitted until within 360 days of payment. **LRE** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.3 percent and 93.5 percent, respectively. Additionally, 97 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **LRE**'s enrollment data may not be complete. **LRE** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • Although not required to be populated, 62.4 percent and 26.9 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. **LRE** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **LRE** collaborated with MDHHS to confirm that the identified encounter changes do not require adjustments to be sent back to the subcontractors. MDHHS confirmed that **LRE** need not send adjustments back to the subcontractors given that the subcontractors directed **LRE** to modify the encounters. • **LRE** monitors encounter timeliness by way of its Volume and Timeliness Power BI® Dashboard and, when necessary, brings deficiencies to the attention of the **LRE** Provider Network Manager and **LRE** CEO for resolution/remediation. • **LRE** is confident in the completeness and accuracy of its 834-enrollment data in its system. MDHHS requires **LRE** to submit encounters and BHTEDS for both Medicaid and Non-Medicaid eligible individuals served by our CMHSPs, which may be considered "pass through encounters" due to funding sources. Also, Region 3 hosts several CCBHC Demonstration sites, which, due to the service delivery model, are serving a higher number of non-Medicaid individuals thereby increasing the number of individuals and encounters that do not have a Medicaid ID number. **LRE** follows the MDHHS Reporting Requirements regarding the data submitted in the Subscriber Number field on encounters for non-Medicaid eligible individuals. • **LRE** continues its work with its EHR vendor to improve reconciliation and reporting of provider NPI numbers for both billing and rendering providers. Upon completion, **LRE** anticipates it will be able to validate provider NPI data, as well as other provider data, on inbound encounters from its Member CMSHPs via front-end edits.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None noted at this time.
c. Identify any barriers to implementing initiatives: • LRE's EHR vendor serves all but less than a handful of Michigan PIHPs and Member CMHSPs as well as MDHHS. As such, the EHR vendor's bandwidth has been limited due to multiple, competing implementation projects, such as MichiCANS, CCBHC Demonstration changes, Electronic Visit Verification, OnPoint EHR conversion, etc.
HSAG Assessment: HSAG has determined that LRE has partially addressed the prior year's recommendations. LRE confirmed with MDHHS that adjustments to subcontractor encounters do not need to be sent back, as subcontractors directed LRE to make the modifications. This collaboration with MDHHS ensured clarity and compliance regarding encounter modifications. For the timeliness of professional encounter submissions, while monitoring is in place, no performance improvements were identified. LRE should enhance its monitoring processes and implement proactive measures to address timeliness issues systematically. Regarding enrollment data completeness, LRE expressed confidence in its 834 enrollment data and attributed discrepancies to non-Medicaid encounters and unique regional challenges, such as Certified Community Behavioral Health Clinic (CCBHC) Demonstration sites serving non-Medicaid individuals. However, no evidence of collaborative efforts with MDHHS to reconcile and validate enrollment data was provided. In terms of provider data completeness, LRE reported that it is working with its EHR vendor to improve reconciliation and reporting of provider National Provider Identifier (NPI) numbers. Upon completion, LRE plans to implement front-end validation edits for inbound encounters. While progress is being made, barriers related to the EHR vendor's limited capacity have delayed full implementation. In conclusion, LRE has made progress in addressing HSAG's recommendations, particularly in collaborating with MDHHS on encounter modifications. However, gaps remain in improving encounter timeliness, validating enrollment data, and ensuring provider NPI completeness due to systemic barriers and resource constraints. To strengthen compliance with HSAG's recommendations, LRE should: • Enhance encounter timeliness monitoring by implementing proactive measures and accountability mechanisms. • Formalize collaboration with MDHHS to reconcile enrollment data and address discrepancies. • Implement interim NPI quality checks while waiting for EHR system updates. • Work with its EHR vendor to prioritize updates and set clear milestones for completion. These steps will improve data quality, address barriers, and ensure alignment with HSAG's recommendations.

Region 4—Southwest Michigan Behavioral Health

Table 4-4—Prior Year Recommendations and Responses for SWMBH

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **SWMBH** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of African American/Black members attending follow-up appointments after an ED visit for alcohol or other drug abuse or dependence, **SWMBH** should identify the barriers of care that are specific to the African-American/Black population and implement interventions that are tailored to the needs of the African-American/Black community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Some of the work of this project has been supported and guided by another project led by the CEO of The Synergy Health Center, who has a Michigan Health Endowment Fund grant to decrease disparities within the African American population on FUA and the Follow Up after Emergency Department Visits for Mental Illness (FUM) metric in Kalamazoo County. • A 2022 report entitled, "Racial Disparities in Behavioral Health Follow Up Care for African Americans" identified contributing factors to African American disparities in substance use Emergency Department (ED) follow up including stigma, a lack of treatment options, a lack of African American clinicians, and disparities in referrals to follow up treatment. To assist in decreasing African American healthcare disparities, the CEO of The Synergy Health Center has developed a registry of African American healthcare professionals, the Black Wellness Network. She supports a network of youth behavioral health ambassadors who assist other youth in crisis (the Mind Health Ambassadors program). They host an annual African American Mental Health Symposium and is working to increase the number of African American students entering behavioral health careers. • **SWMBH** used the "Racial Disparities in Behavioral Health Follow Up Care for African Americans" report in our causal-barrier analysis. Our interventions target stigma, workforce training, and improving communication between EDs and community mental health providers to ensure linkage to and continuity of care. We also contracted with Michigan Public Health Institute to complete interviews with peer professionals, including individuals of color, to better understand barriers to behavioral health treatment in the local PIHP/CMH system. Some prominent themes mentioned included limitations in treatment options, transportation challenges, differential treatment, and jargony or stigmatizing language from staff. Our causal-barrier analysis was updated to integrate these findings. • Our interventions include meeting with EDs and peers to facilitate communication, share data, and increase awareness of the follow up disparity, beginning in 2022. A marketing campaign implemented across the region to decrease mental health and substance use disorder stigma (directed toward non-white populations) began in 2023, along with a series of trainings for behavioral health providers

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
focused on increasing health equity. We added a new provider of Project ASSERT ED follow up in Van Buren County in 2024 and have implemented encounter reporting for Project ASSERT services in Kalamazoo County.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Currently aggregating data for the first set of cases reviewed. Performance data will be reviewed for increase in performance during subsequent quarterly audits. • Our stigma reduction and clinician training interventions were successful in meeting marketing goals, training attendance, and effectiveness of training but we have not yet seen an impact on our project goal of eliminating the disparity in African American / Black and White rates of follow up after ED visits for AOD. • We continue to see gaps in ED follow up, which appear to be due to a combination of Project ASSERT provider availability and inconsistent referral practices from ED's.
c. Identify any barriers to implementing initiatives: • The appeal resolution letter has been updated; however, a delay occurred in uploading the template into the electronic health record (EHR). Staff members manually generate appeal resolution letters until the letters can be auto generated. Full implementation is scheduled for October 31, 2024. • It has been very difficult to impact referral processes between EDs and Project ASSERT programs. Neither **SWMBH** nor the Project ASSERT programs have formal relationships with the ED's. In one County, the ED has refused permission for peers to intervene on site. • Some of the barriers will take years of intervention to change, such as stigma, provider biases, and an insufficient proportion of African American clinicians.
HSAG Assessment: HSAG has determined that **SWMBH** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and revised its barriers and interventions as appropriate, evaluating the effectiveness of each effort. The PIHP identified barriers and developed strategies specific to the disparate population.

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During the PSV session of the virtual review, in an Integrated Services of Kalamazoo County case reviewed for indicator #1, the start time and disposition time were the same. HSAG recommends that **SWMBH** ensure that Integrated Services of Kalamazoo County provide targeted training to clinical staff to ensure they understand that dates and times entered need to match clinical documentation for the pre-screening. Additionally, HSAG recommends that **SWMBH** ensure that Integrated Services of Kalamazoo County perform a visual validation of all dates and times entered for indicator #1 prior to submission to **SWMBH** to ensure the dates and times match clinical documentation for the pre-screening. • During HSAG's initial review of the member-level file detail provided, it was noted that for indicator #4b, **SWMBH** reported one exception with the reason "Exclude - Other." **SWMBH** researched the case and found that the record was for short-term residential rehabilitation services, had been erroneously marked as a sub-acute detoxification discharge, and should not have been included in indicator #4b. HSAG recommends that **SWMBH** carry out its proposed CAP to provide targeted training to SUD providers

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
regarding which services qualify for the indicator #4b denominator, as well as explore report logic as a fail-safe to prevent errors. • During the PSV session of the virtual review, an SUD case reviewed for indicator #2e was determined to be for an existing client and not a new request for services. HSAG recommends that **SWMBH** carry out its proposed CAP to update the report logic to require a match between requests for services and BH-TEDS admission records. HSAG further recommends that **SWMBH** notify MDHHS when duplicate Social Security numbers are identified within the enrollment data, as twin members should have unique Social Security numbers assigned to them. • During the PSV session of the virtual review, in an SUD case reviewed for indicator #4b, the dates reported did not match the service dates in the EMR. HSAG recommends that **SWMBH** carry out its proposed CAP and also consider providing targeted training to SUD providers on how to update BH-TEDS records for members who transfer directly from inpatient care to residential treatment. • **SWMBH**'s reported rates for indicator #4a for the child and adult populations decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **SWMBH** focus its efforts on increasing timely follow-up care for children and adults following discharge from a psychiatric inpatient unit. **SWMBH** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing member and provider education or improving upon coordination of care following discharge.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For Indicator #1- Integrated Services of Kalamazoo County completed staff retraining and are completing manual quality reviews. Conditional formatting was also added to the reporting template used by all CMHSPs to assist in the visual validation process. • For Indicator #2e- **SWMBH** added additional columns to the report to assist in validation of the request for service to the claims/encounters, and with the identification of errors in the BH-TEDS admissions associated with the first SUD service. **SWMBH** identified that the issue was not with twin members but was instead with a single member with multiple Master PIHP IDs, which resulted in the failure to match the BH-TEDS record and the request for first service for that member. **SWMBH** continues to work with providers on properly entering records into SmartCare to avoid the creation of two Master PIHP IDs for one individual. • For Indicator #4a- CMHSPs that missed the benchmark in FY23 Q1 were asked to identify the root cause(s) and develop corrective action plans. **SWMBH** also discussed best practices in the Regional Quality Management Committee in April of 2023. • For Indicator #4b- **SWMBH** provided training to the SUD providers related to transferring from one facility to the next and/or transferring from detox to residential programs. **SWMBH** also updated the report logic to ensure data only includes discharges from detox services.

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For Indicator #1- following the implementation of the initiatives fewer errors have been identified in the documentation for this indicator in FY24 Q2 and Q3, and identified errors were corrected prior to submission to MDHHS. • For Indicator #2e- the number of expired requests decreased from FY24 Q1 to Q2, which has improved outcomes. • For Indicator #4a- the benchmark was met for the remaining quarters in FY23 and have been met for Q1-Q3 in FY24. • For Indicator #4b- following the training that was provided to the SUD providers, less errors have been identified.
c. Identify any barriers to implementing initiatives: • No barriers were identified related to the implementation of initiative for Indicators #1, #4a, or #4b. • For Indicator #2e- validation efforts require an extensive amount of manual data review.
HSAG Assessment: **SWMBH** fully addressed the prior year's recommendation for indicator #1 related to a case in which the start time and disposition time were the same. HSAG recommended that **SWMBH** ensure that Integrated Services of Kalamazoo County (Kalamazoo) provide targeted training to clinical staff to ensure they understand that dates and times entered need to match clinical documentation for the pre-screening and that Kalamazoo perform a visual validation of all dates and times entered for indicator #1 prior to submission to **SWMBH**. To address these recommendations, **SWMBH** applied conditional formatting to the reporting template used by all CMHSPs to assist with the visual validation process. Additionally, during the SFY 2024 virtual review, **SWMBH** reported that it provided targeted training, as recommended, and required Kalamazoo to conduct visual validation of indicator #1 dates and times to confirm their accuracy. During PSV, Kalamazoo also provided pre-admission screening documentation, and it aligned with the dates and times reported for indicator #1. **SWMBH** fully addressed the prior year's recommendation for indicator #4b related to providing targeted training to SUD providers regarding which services qualify for the indicator denominator and exploring report logic updates as a fail-safe to prevent errors, as **SWMBH** had inadvertently included an exclusion case in indicator #4b. During the SFY 2024 virtual review, **SWMBH** reported that individual case findings were immediately remedied following the prior year's virtual review, and that **SWMBH** also conducted additional training for providers who entered EHR data. **SWMBH**'s Quality Department now also attends provider meetings and provides resources to offices about how to correctly document SUD detoxification discharges. **SWMBH** also shared the indicator #4b statuses in more detail with provider groups so that providers can better understand the rationale for the PIHP's case-specific follow-up based on its quarterly audits. Lastly, **SWMBH** indicated it has updated the report logic to ensure data only includes discharges from detox services. **SWMBH** partially addressed the prior year's recommendation for indicator #2e for **SWMBH** to update its reporting logic to require a match between requests for services and BH-TEDS admission records and for unique Social Security numbers to be assigned, as a case was identified that was determined to be for an existing client and not a new request for services. During the SFY 2024 virtual review, **SWMBH** reported that it began engaging the CMHSPs in expired request reviews during fall 2023. **SWMBH** indicated it added data to its internal expired request report to help validate whether the BH-TEDS record was active without having to manually confirm accuracy in the system. **SWMBH** further noted that it identified a significant decline in

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
expired requests from Q1 to Q2 and that Q3 was trending to reflect similar improvement as noted in Q2. However, HSAG continues to recommend that **SWMBH** notify MDHHS when duplicate Social Security numbers are identified within the enrollment data, as twin members should have unique Social Security numbers assigned to them. **SWMBH** fully addressed the prior year's recommendation for indicator #4b to consider providing targeted training to SUD providers on how to update BH-TEDS records for members who transfer directly from inpatient care to residential treatment, as a case was identified in which the dates reported did not match the service dates in the EMR. **SWMBH** provided training to the SUD providers related to transferring from one facility to the next and/or transferring from detox to residential programs. **SWMBH** also updated the report logic to ensure data only include discharges from detox services. **SWMBH** fully addressed the prior year's recommendation related to the decrease in its reported rate from SFY 2022 to SFY 2023 for indicator #4a for the child population. **SWMBH** asked applicable CMHSPs to identify the root cause and implemented CAPs. In addition, **SWMBH** discussed best practices in its Regional Quality Management Committee in April of 2023. **SWMBH**'s actions to improve performance have been successful, resulting in an increase to the reported rate as well as again meeting the established MPS for SFY 2024.

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **SWMBH** did not remediate the one of the two elements for the Health Information Systems standard. **SWMBH** has not implemented the Patient Access API in accordance with the requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. HSAG continues to recommend that **SWMBH** thoroughly review the requirements of 42 CFR §431.60 and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access API. **SWMBH** must ensure its API meets all federally required provisions and is prominently accessible on its website. Further, HSAG continues to recommend that **SWMBH** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **SWMBH** IT team thoroughly reviewed the CMS requirements. • **SWMBH** contacted our MCIS vendor, Streamline, to discuss the possibility of using their API which was still under development for Member Access and would not have included claims for mental health, only substance use disorder (SUD) claims.

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
• **SWMBH** interviewed and received quotes from two vendors Intersystems and Acentra who both had excellent but cost prohibitive solutions. These systems were designed for Managed Care Organizations with 250,000 or more members. While **SWMBH** has approximately 200,000 Medicaid beneficiaries in our region's catchment area, we only serve approximately 25,000 Medicaid beneficiaries and would never fully utilize the capacity of these systems. • The decision was made to develop the API in house using our own Software Engineer. • A Member Access API plan was created, and development began in 2023. • **SWMBH** Software Engineer completed setup of Microsoft Azure FHIR service to store, secure and present FHIR data through an API. • **SWMBH** Software Engineer completed development of extract, transform and load (ETL) process that maps our existing data to the FHIR resource. • **SWMBH** Software Engineer is currently working on patient account sign-up/sign-in functionality using Azure Business to Customer (B2C) that will enable consumers to create a login to their account and connect to their FHIR data. This step is required for third party applications to be able to authenticate consumers using SMART on FHIR as required by CMS and the Implementation Guide. • **SWMBH** Software Engineer is currently using the DaVinci Payer Data Exchange Implementation Guide to develop an ETL process that maps our existing data to the FHIR resource. Data that exists in our system will then be available to the consumer through their selected third-party application. • **SWMBH** Programmer/Analyst researched Open ID and Oauth specifications and is in the process of creating a C# application that will allow us to test our ability to pull data from the data source to the FHIR API and query via a third-party application. • Next steps will be to select and onboard third party application developers whose tools are likely to be chosen by consumers for accessing their healthcare information. We will also have to publish the API and include usage instructions on our public website.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • Data is stored in multiple data warehouses and not simple to aggregate. • Cost to hire outside solution provider is prohibitive - close to $1Million and no funding was provided for this initiative. • Most solutions require use of a patient portal for authentication of consumers. **SWMBH** has up until this point not needed to implement a patient portal because we do not directly serve consumers. Have instead used the Azure B2C for this purpose which has required time to research and implement. • Cost of Azure has already doubled and will continue to increase significantly as more data is stored in the cloud solution
HSAG Assessment: HSAG has determined that **SWMBH** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. HSAG recommends that **SWMBH** continue with its action plan to ensure full implementation of the Patient Access API. Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **SWMBH** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **SWMBH** did not submit professional or institutional encounters timely, where within 120 days of payment, 87.2 percent of professional encounters were submitted, and 90.6 percent of institutional encounters were submitted. **SWMBH** reached over a 99 percent professional encounter submission rate within 330 days and after 360 days for institutional encounters. **SWMBH** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 94.2 percent and 93 percent, respectively. Additionally, 97.3 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **SWMBH**'s enrollment data may not be complete. **SWMBH** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • Although not required to be populated, 43.8 percent and 17.4 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. **SWMBH** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Encounter Timeliness** – **SWMBH** identified an issue with the method CMHSPs who use PCE as an EMR use to correct encounters and the impact that method has on tracking encounter timeliness. In short, when a claim changes, PCE will void the encounter, assign a new Encounter ID (Claim Reference Number) and submit the encounter as new (not a replacement). This causes timeliness for corrections to appear much worse than they are. We have worked with PCE to switch to a persistent, service level identifier, which now allows us to accurately differentiate between the initial encounter submission and subsequent corrections. We are using this to monitor both the MDHHS defined timeliness metric and stricter PIHP timeliness metrics. Our current FY2024 timeliness for the MDHHS metric is 99.2% for Professional and 97.3% for Institutional encounters. • **Member ID Completeness** – Some portion of our encounters reported to MDHHS are funded by General Fund, Block Grant, or other grants. Some of these consumers may never have been eligible for Medicaid and will not have a Medicaid ID available. The PIHP has processes in place to identify encounters submitted by CMHSPs without a Medicaid ID, but where the Medicaid is known. The Medicaid ID is added to the encounters submitted to MDHHS. • **Billing and Rendering Provider Completeness** – For FY2023, **SWMBH** included a Billing Provider NPI for 97.5% of encounters and a Rendering Provider for 42.3% of encounters. Some providers are required to register their NPI(s) in MDHHS CHAMPS. When processing encounters, CHAMPS attempts to lookup the NPI used in the encounter against the registered provider. If a provider has not registered the NPI at that point, a blank value for NPI is written to the CHAMPS Claim. It was our understanding that MDHHS encounter analysts had the ability to re-link the NPI the PIHP supplied in the encounter to the encounter in the data warehouse. This large variation could be caused by this re-linking step being skipped in the encounter dataset pull provided to HSAG.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Encounter Timeliness** – Increased insight into the differences in timeliness between lines of business, transaction types, CMHSPs, and billing patterns.
c. Identify any barriers to implementing initiatives: • **Encounter Timeliness** – Our internal method of tracking unique service level identifiers is not accessible by MDHHS. We need to discuss this issue with them. • **Member ID Completeness** – We are limited to the 834 enrollment records that MDHHS provides to us. • **Billing and Rendering Provider Completeness** – As a PIHP, we have no control over MDHHS CHAMPS processing or their encounter data warehouse.
HSAG Assessment: HSAG has determined that **SWMBH** has partially addressed the prior year's recommendations. Regarding encounter timeliness, **SWMBH** identified and addressed an issue with how CMHSPs using PCE as an EMR corrected encounters, which caused delays in timeliness tracking. To resolve this, **SWMBH** implemented a persistent service-level identifier to accurately track both initial and corrected encounters. **SWMBH** reported that its FY 2024 timeliness metrics show improvements, with 99.2 percent for professional encounters and 97.3 percent for institutional encounters, meeting MDHHS standards. However, while significant progress has been made, the internal tracking method is not accessible to MDHHS, limiting full transparency. For member ID completeness, **SWMBH** noted that encounters funded by General Fund or other grants may lack Medicaid IDs because some consumers are not Medicaid-eligible. **SWMBH** has processes in place to identify and add Medicaid IDs where known. Despite these efforts, reliance on MDHHS-provided 834 enrollment records constrains **SWMBH**'s ability to comprehensively address data gaps. Regarding billing and rendering provider completeness, **SWMBH** reported a billing provider NPI on 97.5 percent of encounters and a rendering provider NPI on 42.3 percent of encounters. Variations stem from providers not registering NPIs in MDHHS CHAMPS and limitations in MDHHS systems for linking NPIs to claims. While **SWMBH** has made improvements, external barriers such as CHAMPS system limitations and provider noncompliance continue to hinder full resolution. In conclusion, **SWMBH** has made progress, particularly in improving encounter timeliness tracking and processes to address member ID and provider data completeness. However, systemic barriers related to MDHHS systems and external factors such as provider compliance hinder full implementation. Moving forward, **SWMBH** should focus on: • Collaborating with MDHHS to align tracking methods and improve data validation. • Establishing regular data reconciliation efforts with MDHHS for enrollment data. • Enhancing provider education and exploring interim solutions to address NPI gaps. These steps will help strengthen data quality processes and ensure compliance with HSAG's recommendations.

Region 5—Mid-State Health Network

Table 4-5—Prior Year Recommendations and Responses for MSHN

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **MSHN** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of Black/African-American members receiving a medically necessary service within 14 days of completing a biopsychosocial assessment, **MSHN** should continue to focus its efforts on identifying the barriers of care that are specific to the Black/African-American population and implement interventions that are tailored to the needs of the Black/African-American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
• **MSHN** Performance Improvement Project (PIP) Quality Improvement (QI) Team was expanded to include consultants for additional data analysis. Brainstorming was used to review the fishbone diagram developed for Calendar Year (CY) 21 and CY23. Updates to the fishbone included revised key areas and new barriers. Once the barriers were identified an impact analysis was completed to identify what barriers had the greatest impact on the outcome. A driver diagram was completed to categorize the key drivers linking them to corresponding interventions. Interventions were prioritized based on those that were expected to impact the largest number of individuals within the denominator, thereby achieving the desired outcome.
• **MSHN** is made up of 21 counties and twelve Community Mental Health Service Programs (CMHSP). All CMHSP participants engage in interventions to improve access to services. Approximately 85% of new individuals included in the black/African American population and have received an assessment belong to three CMHSP participants (six counties) which include Clinton-Eaton-Ingham (CEI), Saginaw County Community Mental Health Authority (SCCMHA), and Lifeways. The remaining 15% is split between nine CMHSP participants (15 counties). Interventions developed were primarily focused on the barriers where the majority (85%) of the Black/African American population reside. Additional data analysis was completed to identify trends and focus areas about those that did not receive an assessment within the 14 days as required. In addition to the focus on reducing the disparity, an additional focus on increasing the rate will be applied for the next measurement period to address the decrease in the Index (White) rate. Initiatives include:
  • Increasing the workforce to ensure appointments are available within the required timeframe.
  o Provide financial incentives for obtaining retaining staff.
  • Increasing attendance of appointments within the required timeframe.
  o Implement appointment reminder systems.
  o Modify the coordination process between providers for assessment and treatment.

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
• Engaging with organizations within communities of color to develop relationships and identify barriers to treatment. • Distribute educational materials to communities of color for treatment options available to increase engagement in services when needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increasing the workforce to ensure appointments are available within the required timeframe. The rate of appointments scheduled outside of the 14 days due to "no available appointment" increased for the region CY21Q4 6%-CY23 14%. However, one of the CMHSPs was successful in obtaining additional staff and decreasing the rate of "no appointments available" CY21 Q4 29.73% - CY23 18.11%. • Increasing attendance of appointments within the required timeframe. o Implement appointment reminder systems-Decreased the no show rate from 34% to 30%. o Modify the coordination process between providers for assessment and treatment. Decreased the performance rate 68% to 63%. • Engaging with organizations within communities of color to develop relationships and identify barriers to treatment. This will continue as it was not able to be evaluated. • Providing education to communities of color for treatment options available to increase engagement in services when needed. This will continue as it was not able to be evaluated.
c. Identify any barriers to implementing initiatives: • There are no barriers that are not accounted for within the improvement strategies.
HSAG Assessment: HSAG has determined that **MSHN** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and evaluated the effectiveness of each effort. The PIHP identified a barrier and developed an intervention strategy specific to the disparate population.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During Community Mental Health Authority of Clinton, Eaton, & Ingham Counties' PSV, while reviewing cases for indicator #1, HSAG found a data entry error for one case which led to documenting an incorrect wait time. **MSHN** further researched the issue and reported an additional seven cases with similar documentation errors that needed correction. While this finding did not significantly impact the rate, HSAG recommends that **MSHN** complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check. HSAG also recommends and supports **MSHN**'s efforts in continuing to meet with staff members to provide further training when errors occur, in addition to the **MSHN**'s proposed corrective action to have the quality improvement team review all indicator #1 "out-of-compliance" items and check with the CMHSP for accuracy before submission. • During Lifeways' PSV, HSAG identified one case for indicator #1 that should have been reported as in compliance instead of out of compliance. HSAG recommends that **MSHN** continue its efforts to meet with CMHSP staff members to provide further training when these and similar errors occur, in addition to having the quality improvement team review all indicator #1 out-of-compliance items to check CMHSP reporting accuracy before submission.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
• During Saginaw County Community Mental Health Authority's PSV, HSAG found zero elapsed minutes documented and reported for one indicator #1 case. While **MSHN** has since worked with PCE to develop a system update to help capture cases with zero elapsed minutes, HSAG recommends and supports **MSHN**'s efforts in monitoring for this particular issue until the PCE system update is in place. Additionally, HSAG recommends that **MSHN** continue to monitor for cases with unusual, elapsed times after implementing the system update to further ensure the system edits are working as expected. • After reviewing Bay-Arenac Behavioral Health's proof-of-service documentation, HSAG found that one indicator #3 case was reported as in compliance when no valid follow-up service was documented. While PCE completed a logic update in June 2023 to prevent the specific CPT code from being billed twice in the same day, HSAG recommends that **MSHN** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV on a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly identifying valid ongoing services. • After reviewing Huron Behavioral Health's proof-of-service documentation, HSAG found that one case should have been counted as an exception rather than as compliant for indicator #4a. While this finding did not significantly impact the rate, HSAG recommends that **MSHN** and the CMHSP employ additional enhancements to **MSHN**'s validation process to ensure appropriate categorization of compliant cases and capture of exceptions. • After reviewing Shiawassee Health & Wellness' proof-of-service documentation, HSAG found that one member for indicator #3 had an incorrect medically necessary ongoing service date documented and pulled for reporting. While **MSHN** provided evidence reflecting the correct date of the ongoing service that matched the reported date, HSAG recommends that **MSHN** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV on a statistically significant sample of cases for indicator #3 each quarter to ensure that only correct services are reported as ongoing services.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Each CMHSP is required to submit the Performance Indicator (PI) data by uploading the detail file to **MSHN**. Once uploaded, validation checks are completed based on the Michigan Mission Based Performance Indicator System (MMBPIS) Code Book requirements and basic business rules. If any field in the detail data file does not successfully complete the validation process the entire file is rejected. The CMHSP is able to review the rejected records and errors associated with the file. All errors are required to be corrected in order for the file to be accepted. Once the data has been received by the Pre-Paid Inpatient Health Plan (PIHP), the specifications and methodology consistent with the MDHHS MMBPIS Codebook, including Medicaid eligibility verification for the reporting period, are applied to the regional data. The **MSHN** designee reviews each indicator for face validity to ensure it meets the MDHHS specifications for data submission. • The **MSHN** designee selects a sample of records from those providers that were unable to be validated during a previous review, for primary source verification prior to submission. The sample selection includes a review of all indicators and focuses on those areas that were unable to be validated. Any

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
files selected that are unable to be validated against what the CMHSP/Provider submitted will require an additional improvement strategy. In addition to the regional systemic process changes the following specific actions implemented based on the primary source review: o Bay Arenac Behavioral Health (BABH) Logic was changed to exclude 90791 as a follow up service. o Clinton-Eaton-Ingham (CEI) incorporated a validation check to review all abnormal disposition completed dates and times to allow for improvements and to eliminate data entry errors. o Saginaw County Community Mental Health Authority (SCCMHA)-Edits have been put in place to flag if there is zero minutes between start and stop times.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MSHN** and HSAG reviewed a total of 310 records. Of the records reviewed there were no repeat findings for five of the six recommendations/findings listed by HSAG above. There were records that did have a zero elapsed time from start to stop, however, flagging this did eliminate the occurrence for SCCMHA's. This will be applied throughout the other CMHSPs during the upcoming year.
c. Identify any barriers to implementing initiatives: • Not all the interventions required to ensure accuracy are able to be fully automated. This results in additional follow-up by a staff person. Staff resources have been limited. Additional efficiencies are explored ongoing to reduce or eliminate this barrier.
HSAG Assessment: **MSHN** fully addressed the prior year's recommendation for indicator #1 related to discrepancies found in the way multiple CMHSPs were reporting data for this indicator. HSAG recommended that **MSHN** complete its proposed corrective action to review all abnormal disposition completed dates and times, review all out-of-compliance items as part of validation, and continue meeting with staff to provide further training as errors occur. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had completed the corrective actions and incorporated the improvement efforts as outlined by HSAG. **MSHN** has stated that such corrective actions include performing additional validation checks, staff training, and working with PCE to update system logic appropriate to each CMHSP impacted by the discrepancies. During the SFY 2024 audit, HSAG did not identify these issues. **MSHN** fully addressed the prior year's recommendation for indicator #3 to perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases, as discrepancies were identified in the way some CMHSPs were reporting data for the indicator. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had completed the corrective actions and incorporated the improvement efforts as outlined by HSAG. **MSHN** also stated that such corrective actions include performing additional validation checks, staff training, and working with PCE to update system logic appropriate to each CMHSP impacted by the discrepancies. During the SFY 2024 audit, HSAG did not identify these issues. **MSHN** put forth effort toward addressing the prior year's recommendation related to indicator #4a to perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting, as an incorrect medically necessary ongoing covered service date was documented by a CMHSP and pulled for reporting. During the SFY 2024 audit, HSAG followed up on the prior year's recommendations, and **MSHN** indicated that it had incorporated the enhancements outlined by HSAG. However, upon further review, HSAG identified one similar case that should have been reported as an exception rather than in compliance. As

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
such, HSAG continues to recommend that **MSHN** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV on a statistically significant sample of cases for indicator #3 each quarter to ensure that only correct services are reported as ongoing services.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **MSHN** did not remediate the one element for the Health Information Systems standard. **MSHN** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **MSHN** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **MSHN** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **MSHN** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **MSHN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MSHN** has implemented both APIs. • **MSHN** is in the process of implementing the REMI Client Portal. Clients are not likely to find this useful because **MSHN** does not store much clinical information of value or data that fits the elements identified in these requirements. Some of our CMHSPs have client portals with much more meaningful clinical information and they have very low usage.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • **MSHN** recently made major changes to the midstatehealthnetwork.org website. **MSHN** still needs to add a page to the website that explains the available APIs and the steps required to access information via this option. **MSHN** also needs to find developers that will sign up to use these features within their software and will follow all the privacy and security rules. Finally, **MSHN** will need to find clients that desire to have access to their data from one of these vendors. This last item will be difficult because **MSHN** does not store much clinical information of value or data that fits the elements identified in these requirements.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG has determined that **MSHN** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. HSAG recommends that **MSHN** continue with its action plan to ensure full implementation of the Patient Access API (i.e., member-facing website for the available APIs and findings developers). Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **MSHN** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements. Lastly, while **MSHN** has indicated that it stores limited clinical information, if **MSHN** has implemented the Patient Access API in accordance with CMS' implementation guidance, the PIHP has met its obligation. However, HSAG recommends that the PIHP consider ways it may be able to enhance the clinical information that can be shared with members through the API.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **MSHN** modified encounters from its subcontractors before submitting them to MDHHS. **MSHN** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors. • While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **MSHN** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **MSHN** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process. • **MSHN** did not submit institutional encounters timely, where 55.6 percent of institutional encounters were submitted within 120 days of payment and did not reach greater than 90 percent of professional encounters submitted until after 360 days of payment. **MSHN** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97.1 percent and 92.4 percent, respectively. Additionally, 95.9 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **MSHN**'s enrollment data may not be complete. **MSHN** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • Although not required to be populated, 55.8 percent and 27.9 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. **MSHN** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The items that **MSHN** updates were planned during implementation of the MCO software that collects the data from the region's CMHSPs and sends the data to MDHHS and vice-versa. The appropriate

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
conversions to allow the data to meaningfully go back to the CMHSP and be automatically handled by the EHR systems are already in place. There is no need to involve MDHHS staff or systems in this process. **MSHN** converts the CMHSP specific case number to a unique PIHP case number and the CMH claim ID to a unique PIHP claim ID. • **MSHN** attempts to keep the administrative burdens as low as possible. Since **MSHN** already does medical record reviews as part of other processes identified below it seems too burdensome to add another medical record review for this purpose especially when there has been no specific area of concern. • **MSHN** does conduct Encounter Data reviews and BH-TEDS reviews of CMHSPs as part of the Delegated Managed Care review process. The review included verifying that the 837 data matches either 1) the data in the system or 2) the data in the system as translated by the 837 processes. This includes diagnosis, procedure or revenue code, procedure modifier code, quantity of services, facility code for institutional encounters, LARA license and rendering provider. • In addition, **MSHN** conducts Medicaid Event Verification reviews bi-annually for CMHSPs and annually for substance use disorder providers. Data elements tested during the review include the following 1) Code submitted for billing is approved under the contract, 2) Eligibility of the beneficiary on the date of service, 3) For CMHSP Participants, the service provided is part of the beneficiary's individualized plan of service (and provided in the authorized amount, scope and duration); For SUD Providers, the service provided was provided as authorized and included in the treatment plan, 4) The date and time of the service, 5) Services were provided by a qualified individual and falls within the scope of the code billed and paid, 6) The amount billed does not exceed the provider's standard/customary rate 7) The amount paid does not exceed the contracted amount, and 8) Modifiers are used following the HCPCS and MDHHS guidelines. • It does not appear that the timeliness of institutional encounters is accurate. Every encounter in REMI is submitted weekly (nothing is withheld). Some encounters might get rejected by MDHHS, but they get reviewed and resubmitted every week as well. The CMHSPs within the mid-state region are contractually required to submit encounter data on a monthly basis matching the State requirement of the PIHP. This requirement is reviewed quarterly through our balance score card reporting and it has consistently shown that more than 90% of encounters are received within the 30 days of adjudication. There are some encounters that are not received from the hospital for several months after the service date but that is mostly due to issues with third party billing. It would be helpful if we could get the specifications for how these calculations were made. • **MSHN** views collaboration very favorably. If MDHHS agrees that there should be a review of the enrollment data being shared by MDHHS with **MSHN** we are very open to participating in the process. A first step that could be helpful is to define what the member ID field is and how to determine a valid value and what is meant by a "medical encounter". The encounter companion guide indicates that the NM109 should be populated with the Medicaid ID when there is one (active or not) and if there is not one, use the PIHP unique consumer ID. All **MSHN** encounters follow this rule, so there should be no invalid Member ID values. • NPI values are not required in many cases and providing extraneous data can often cause confusion, so **MSHN** has chosen to only report this data when it is required.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
c. Identify any barriers to implementing initiatives: • The inability to confirm/verify the results provided in this report is mostly due to not having any definitions or specific rules to follow.

HSAG Assessment: HSAG has determined that **MSHN** has partially addressed the prior year's recommendations. **MSHN** provided clarification regarding encounter modifications, ensuring compliance without requiring additional input from MDHHS. For the timeliness of institutional encounter submissions, **MSHN** reported that all encounters are submitted weekly through REMI, with rejections reviewed and resubmitted weekly. **MSHN** also highlighted CMHSP contractual requirements for monthly data submissions and quarterly balance scorecard reviews, demonstrating over 90 percent compliance within 30 days of adjudication. However, delays related to third-party billing issues from hospitals remain a challenge. While **MSHN** has monitoring systems in place, discrepancies between its reported timeliness and HSAG's findings require further clarification.

Regarding MRR, **MSHN** indicated that adding an additional MRR process would be overly burdensome, particularly in the absence of specific areas of concern. Current reviews, including Medicaid Event Verification and Encounter Data reviews, already assess data quality. However, **MSHN** has not evaluated the feasibility of implementing MRR specifically for subcontractor data quality checks as recommended. Piloting an MRR process could help determine its value and cost-effectiveness in improving data accuracy and completeness.

For member ID completeness, **MSHN** reported compliance with MDHHS guidelines but raised concerns about unclear definitions of "member ID validity" and "medical encounter," as well as the criteria used in HSAG's EDV analysis. **MSHN** should work with MDHHS to define key terms and establish a collaborative process for reconciling enrollment data discrepancies.

Regarding billing and rendering provider NPI completeness, **MSHN** reported including NPIs only when required, noting that unnecessary data could lead to confusion. While this aligns with MDHHS guidelines, additional quality checks have not been implemented to improve NPI data completeness.

In conclusion, **MSHN** has made progress, particularly in clarifying encounter modifications and maintaining monitoring processes. However, challenges persist in timeliness reporting, member ID completeness, and provider NPI validation. To strengthen compliance with HSAG's recommendations, **MSHN** should:

- Collaborate with MDHHS to align definitions and methodologies for member ID and timeliness metrics.
- Address third-party billing delays with targeted solutions.
- Evaluate the feasibility of piloting MRR to enhance subcontractor data quality.
- Implement additional quality checks to improve NPI completeness without introducing unnecessary confusion.

These steps will enhance data quality, address existing barriers, and ensure compliance with HSAG's recommendations.

Region 6—Community Mental Health Partnership of Southeast Michigan

Table 4-6—Prior Year Recommendations and Responses for CMHPSM

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **CMHPSM** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and decrease the prevalence of no-show appointments for the African American population, **CMHPSM** should identify the barriers of care that are specific to the African-American population and implement interventions that are tailored to the needs of the African-American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • A casual/barrier analysis has been completed annually during the project, including identifying barriers of care and evaluating interventions to determine the effectiveness of each effort specific to the African American population.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • While there was a decrease in racial disparity for one county, it did not result in a statistically significant reduction for the region, and overall, there was no significant change in disparity. Data did show a higher performance rate when assessments are offered within a specific timeframe from the initial request.
c. Identify any barriers to implementing initiatives: • The state ending the allowance to bill for audio-only telehealth services after the end of the public health emergency. Staffing resources as long-term effect of pandemic.
HSAG Assessment: HSAG has determined that **CMHPSM** partially addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and initiated interventions that were reasonably linked to their corresponding barriers. The PIHP developed a training intervention strategy specific to the disparate population. The PIHP did not provide intervention evaluation results for the efforts initiated to determine effectiveness.
2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • The rates for indicator #2 decreased from SFY 2022 to SFY 2023 for MI children, MI adults, and I/DD children (indicators #2a, #2b, and #2c). HSAG recommends that **CMHPSM** continue its improvement efforts and oversight of the CMHSPs, including providing education, expanding appointment options, and ensuring staff coverage to improve performance related to indicator #2 and to further ensure timely and

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning. • **CMHPSM**'s reported rate for indicator #4a for the adult population decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **CMHPSM** focus its efforts on increasing timely follow-up care for adults following discharge from a psychiatric inpatient unit. **CMHPSM** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The activities and/or interventions that were implemented during State fiscal year (SFY) 2024 in follow-up to the recommendations made in the SFY 2023 EQR Technical Report for each EQR activity. • Indicators #2a, #2b, and #2c: Improvements were made to access barriers at screening, offer more options of types of appointments (walk in, telehealth, times of day), provide call backs for appointments and reminders, assist with transportation needs, increase staffing, and provide more staff training. • Indicator #4a: Improvements were made to provide more staff training, offer appointments closer to discharge, improve coordination with hospitals on admissions/discharges and seek access to other data sources for those not known to the Community Mental Health Service Providers (CMHSP).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Indicators #2a, #2b, and #2c: Overall improvement but did not meet state threshold set for FY24. • Indicator #4a: Overall improvement for adults but did not meet state standard. Overall improvements for children and met state standard as of FYQ2.
c. Identify any barriers to implementing initiatives: • Indicators #2a, #2b, and #2c: Majority of cases were result of no show/no reschedule by consumer, consumer sought alternate option, or wanted an appointment outside of timeframe. • Indicator #4a: A continued barrier of those who were admitted to an inpatient psychiatric unit that were not known to CMHSPs (not enrolled in CMHSP prior to hospitalization), lack of care coordination from hospitals
HSAG Assessment: **CMHPSM** partially addressed the prior year's recommendation for indicator #2 related to improving performance for indicator #2 and further ensuring timely and accessible treatments and supports for individuals. During the SFY 2024 virtual review, **CMHPSM** stated the CMHSPs increased same-day and walk-in appointment availability, transportation assistance, and customer service to assist with making appointments. The end of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) added an additional barrier to improvement because offering a biopsychosocial assessment over the phone was no longer an option. **CMHPSM** also completed a process improvement plan and continued to conduct data analysis for additional quality improvement initiatives, as the rates continue to trend downward. While **CMHPSM** put forth

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
effort to toward improving its indicator #2 rates, the rates decreased by over 5 percentage points for all indicators for SFY 2024. As such, HSAG recommends **CMHPSM** conduct additional data analysis for its improvement efforts and continue monitoring to help ensure that any root causes are identified and addressed in a timely manner. **CMHPSM** is encouraged to update its performance improvement plan, as applicable, based on any findings. **CMHPSM** put forth effort in addressing the prior year's recommendation related to the rate decline for indicator #4a for the adult population from SFY 2022 to SFY 2023 by providing additional staff training, offering appointments closer to discharge, improving coordination with hospitals on admissions and discharges, and seeking access to other data sources for those not known to the CMHSPs. HSAG commends **CMHPSM** for the efforts made toward improving timely follow-up care; however, rates have continued to decline for SFY 2024. HSAG recommends that **CMHPSM** continue with the interventions put in place and consider additional efforts needed to further address the decrease in performance and care coordination barriers.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **CMHPSM** did not remediate the two elements for the Health Information Systems standard. **CMHPSM** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **CMHPSM** has not made its entire provider directory publicly accessible via the Provider Directory API in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **CMHPSM** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **CMHPSM** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **CMHPSM** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • <u>Patient Access API:</u> **CMHPSM** completed prior steps of roll-out and implementation of our patient portal Consumer Electronic Health Record (CEHR) by PCE Systems; Explore third party vendors and our current electronic health record (HER) vendor that could implement a forward-facing consumer information feed related to claims, benefits, and encounters, build out a separate page within our **CMHPSM** website that will house implementation information and instructions on utilization of CEHR.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
• Provider Directory API: The Provider directory was updated in FY23 and FY24 to further comply 42 CFR §431.70. Details were included in the FY24 **CMHPSM** PMV/NAV ISCAT submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Patient Access API: There was not a feasible way to acquire third party vendor integration. There is a structure in place and written guidance by which consumers can request access to the portal and a means by which staff provide them access through our current EHR system. PIHP Chief Information Officers (CIOs) continue to address this matter with the state in the need for state guidance or a state-wide system with no resolution. • Provider Directory API: Increase in public accessibility; ability to search and sort directory for specific information/categories.
c. Identify any barriers to implementing initiatives: • Patient Access API: Need for state guidance/structure. • Provider Directory API: None in completing updates
HSAG Assessment: HSAG was unable to determine if **CMHPSM** addressed HSAG's recommendations. Based on **CMHPSM**'s responses, it appears the PIHP has not fully implemented the Patient Access API, and it is unclear if the PIHP has an appropriate plan to proceed with implementing the API. It is unclear why **CMHPSM** has indicated that there is a need for MDHHS guidance and a statewide resolution as the federal Medicaid managed care rule requires the PIHP to implement the provisions of the Patient Access API. HSAG recommends that **CMHPSM** proceed with fully executing the Patient Access API and consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. While the PIHP reported that its provider directory was updated to further comply with 42 CFR §431.70 and that details were included in the PMV/NAV ISCAT submission, there was no reference to the Provider Directory API or the requirements under 42 CFR §431.70. If **CMHPSM** has not yet fully implemented the Provider Directory API, the PIHP must proceed with doing so. Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **CMHPSM** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **CMHPSM** did not indicate claim volume quality checks performed for claims/encounters from its subcontractors' data. **CMHPSM** should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness of encounter data. By implementing such measures, **CMHPSM** can enhance the overall quality and reliability of the encounter data it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
• While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **CMHPSM** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **CMHPSM** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.2 percent and 90.7 percent, respectively. Additionally, 95.3 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **CMHPSM**'s enrollment data may not be complete. **CMHPSM** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • **CMHPSM** had a relatively high percentage of duplicates for professional encounters (4.1 percent). HSAG recommends that **CMHPSM** examine its internal process of identifying duplicates.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • With real time reports available in the EHR for the **CMHSPs** and PIHP that allow for claim volume quality checks performed for claims/encounters from its subcontractors' data, the level of checks that occur in the EHR prior to subcontract provider being able to submit a claim, and the preauthorization process held by the **CMHSPs** with subcontractors, the feasibility of integrating MRR further into our data quality checks beyond current practices outweighs any potential benefits. This is based on current activities of at least quarterly reviews of Behavioral Health Treatment Episode Data Set (BH-TEDS) data, with monthly checks of outliers, and MRR auditing already conducted by the region resulting in low rates of any error findings. A detailed process of ensuring the accuracy and completeness of claims/encounters was included in the **CMHPSM** FY24 PMV/NAV ISCAT under III. Data Acquisition Capabilities (BH-TEDS Data and Provider Data System). • Medical Record Reviews (MRR) in the form of annual audits of subcontract providers are conducted through the year, PIHP Medicaid service verification reviews included claim quality checks using a statistically significant formulary for sample size, and a claim volume quality review was piloted for a SUD provider with high volume dosing claims. Quarterly reports to the state Office of Inspector General (OIG) include quarterly volume claims data mining review related to high-cost high volume services such as community living support (CLS). A review of this data shows a low threshold of errors that further did not support additional claim volume quality checks or MRR. • **CMHPSM** enhanced internal processes and worked with the state to increase validity rates of BH-TEDS encounter data and review duplicates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **CMHPSM** participated in a state project to resolve encounter BH-TEDS data with open admission and discharges, without an update since 11/30/2022 resulting in an 83% statewide reduction, with **CMHPSM** reducing specific outstanding issues to below 3%.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
c. Identify any barriers to implementing initiatives: • None other than the labor and resource cost not supporting sufficient benefits to increasing MRR activities.

HSAG Assessment: HSAG has determined that **CMHPSM** has partially addressed the prior year's recommendations. Regarding claim volume quality checks, **CMHPSM** reported that real-time reports in the EHR, preauthorization processes, and checks within the CMHSPs help ensure sufficient data quality. Quarterly BH-TEDS reviews and monthly outlier checks are conducted. While these processes are in place, HSAG's concerns about comprehensive claim volume monitoring remain unaddressed.

For MRR, **CMHPSM** noted that it conducts MRR through annual subcontract provider audits and Medicaid service verification reviews, using statistically significant sampling for claim quality checks. However, **CMHPSM** determined that the labor and resource requirements of expanding MRR outweigh the potential benefits, given the low error thresholds identified in its current processes.

Regarding enrollment data completeness, **CMHPSM** participated in a statewide project to resolve outstanding BH-TEDS data, successfully reducing open admissions and discharges to below 3 percent. Internal processes were enhanced to increase validity rates and address duplicates. While these efforts improved internal processes and engaged the state on BH-TEDS data, the response does not confirm active collaboration with MDHHS on reconciling member enrollment records.

For duplicate professional encounters, **CMHPSM** indicated that it has enhanced internal processes and conducted duplicate reviews, which identified low error thresholds. While this demonstrates efforts to address duplicates, the response lacks detailed outcomes or evidence of long-term solutions.

In conclusion, **CMHPSM** has made progress in addressing HSAG's recommendations, particularly in reducing BH-TEDS data issues and implementing some MRR and duplicate review processes. However, gaps remain in comprehensive claim volume monitoring, MRR feasibility studies, and active collaboration with MDHHS on enrollment data reconciliation. To strengthen compliance with HSAG's recommendations, **CMHPSM** should:

- Standardize and expand claim volume monitoring processes across subcontractors.
- Reassess the cost benefit of expanded MRR for high-risk subcontractors and explore automated solutions.
- Formalize collaboration with MDHHS to reconcile enrollment data comprehensively.
- Enhance duplicate monitoring with routine reporting and corrective measures.

These steps will improve data quality, ensure compliance, and address identified barriers effectively.

Region 7—Detroit Wayne Integrated Health Network

Table 4-7—Prior Year Recommendations and Responses for DWIHN

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **DWIH** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of Black or African American members accessing follow-up care after discharge from psychiatric hospitalization, **DWIH** should identify the barriers of care that are specific to the Black or African-American population and implement interventions that are tailored to the needs of the Black or African-American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DWIH** has taken proactive steps to address the needs of the Black or African American population. As part of these efforts, the Complex Case Management (CCM) department reaches out with personalized phone calls to African American members who have missed their follow-up appointments within 7 days of being discharged from an inpatient psychiatric hospitalization. This personalized approach demonstrates our commitment to providing tailored support and ensuring that every individual admitted to inpatient psychiatric unit receives the ongoing care and services needed. • **DWIHN's** Customer Service department conducted a phone survey to contact members who missed their follow-up appointment within 7 days. They asked questions about the reasons for missing the appointment and based on the survey, they conducted other activities and interventions. Other initiatives include: • **DWIHN** aims to enhance education and awareness about mental health and reduce stigma through public education campaigns and community presentations. • The **DWIHN** Substance Use Department (SUD) organized a Celebrate Recovery event in 2023, which included stigma-related events such as testimonials and speakers. The event was attended by 763 people. • Education about stigma was also included in the SUD's Narcan trainings, which were held in various community settings such as meetings, schools, corporations, churches, health fairs, and law enforcement agencies. In 2023, a total of 6,004 individuals participated in these trainings. • Additionally, meetings are held every 45 days with the top 6 Clinically Responsible Service Providers (CRSP's) who have the highest racial disparity percentage and/or who serve the most African American members. The purpose of these meetings is to discuss barriers, interventions, and progress being made.

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **DWIHN's** racial disparity percentage has shown progress from 2022 (8.73%) to 2023 (7.57%). Preliminary data for calendar year 2024, has shown good improvement at 5.40% from January to September 2024.
c. Identify any barriers to implementing initiatives: • The barriers to implementing initiatives include incorrect contact information when CRSPs are trying to re-engage members in services. Although a CRSP can update contact information in their Electronic Health Record (EHR), that updated information is not carried over to **DWIHN's** EHR, MH_WIN system. **DWIHN** is currently working with our internal IT department to resolve this barrier. • There is a stigma surrounding mental illness/substance use disorders and receiving assistance. • There has also been a decrease in telehealth services due to the ending of the COVID-19 Public Health Emergency (PHE) Declaration, which is the primary contributing factor to the decline in performance compared to the baseline.
HSAG Assessment: HSAG has determined that **DWIHN** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and evaluated the effectiveness of each effort. The PIHP developed a care coordination intervention strategy specific to the disparate population.

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • Although improvement efforts were discussed related to indicator #2, the rates for MI and I/DD children (i.e., indicators #2a and #2c) and I/DD adults (i.e., indicator #2d) significantly decreased from SFY 2022 to SFY 2023. HSAG recommends that **DWIH** continue with its improvement efforts (i.e., provider outreach, monitoring, and financial incentives) related to indicator #2 to further ensure timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DWIH** has been actively working on improving our outcomes for Performance Indicator (PI) #2. We've been reaching out to providers, monitoring their performance, and offering financial incentives. • **DWIHN** has also revised the financial incentive structure to increase the amount dispersed each quarter in the hope that this will address challenges reported in FY 2024. • Additionally, various departments within **DWIHN** have been meeting with providers every 45 days to discuss compliance rates, barriers, interventions, appointment availability, and capacity plans related to PI#2. • To address staffing shortages for children's populations, **DWIHN** issued a Request for Proposal for new providers at the end of FY2023.

2. Prior Year Recommendations From the EQR Technical Report for Performance Measure Validation
• Finally, we've been requesting Performance Improvement Plans from providers who do not meet the 57% threshold at the end of each quarter.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **DWIHN** has made significant progress in addressing the challenges faced by individuals with Intellectual and Developmental Disabilities (IDD). In the 1st Quarter of 2024, **DWIHN** achieved its lowest rate in years at 21.78%. Although there have been slight increases in the 2nd and 3rd Quarters, early data for the 4th Quarter indicates a rate of approximately 50%. Notably, the rates for IDD Adults have surpassed those of FY2023 and FY2022. **DWIHN**'s successful implementation of interventions has resulted in remarkable improvements, with rates for the 1st Quarter of 2024 at 58.41%, the 2nd Quarter at 63.64%, and the preliminary 3rd Quarter at 60.77%.
c. Identify any barriers to implementing initiatives: • The largest challenge since 2020 has been lack of available appointments, staff shortages, and increased demand for services. • The CRSP's providers report that the paperwork demands, salaries, and hours are noted as reasons why it is difficult to recruit and retain staff. • Staff from the CRSP's are joining private practice agencies, who can employ limited licensed staff. These agencies can offer flexibility in hours, higher pay, and little paperwork requirements. • Another system providers have reported losing many staff members to schools. Schools also have increased salaries and offer summers off. • Lastly, **DWIHN** continues to see rates fluctuate from quarter to quarter and from indicator to indicator. Sometimes, it is due to changes within a provider's structure or changes from another provider that is affecting the demand of another provider's services.
HSAG Assessment: HSAG has determined that **DWIHN** partially addressed the prior year's recommendation for indicator #2, and HSAG commends **DWIHN** for the efforts it put forth toward improving its rates for indicator #2. During the SFY 2024 audit, **DWIHN** indicated that it had tried to boost hiring efforts by organizing career fairs, offering sign-on bonuses, and providing exam prep classes to help new clinicians pass the licensure exam. Additionally, some providers started contracting with staffing companies to attract and hire master's-level clinicians. Lastly, **DWIHN**'s finance department continued to offer financial incentives for high performance on the indicators. While rates did improve for most of the indicator #2 populations, indicator #2c for I/DD children continued to significantly decline. Therefore, HSAG recommends that **DWIHN** continue with its improvement efforts, especially with a focus on I/DD children, to further ensure timely assessments. **DWIHN** is encouraged to update its performance improvement plans or interventions, as applicable, as additional factors/barriers are identified related to indicator #2 and I/DD children.
3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **DWIHN** did not remediate the two elements for the Health Information Systems standard. **DWIHN** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **DWIHN** has not made the Provider Directory API publicly accessible in

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **DWIHN** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **DWIHN** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **DWIHN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Both APIs are fully completed and available to the public in MH-Win. We are currently in discussions with our vendor PCE to determine if any additional implementation steps are required. Moreover, we are engaging with the Chief Information Officer (CIO) forum to gain insights into how other PIHPs are addressing the 42 CFR requirements and to explore opportunities for further enhancement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • None identified at this time.
HSAG Assessment: HSAG has determined that **DWIHN** addressed the prior year's recommendations based on the PIHP's reported initiatives. However, while **DWIHN** reported that the Provider Directory and Patient Access APIs are fully implemented, it is unclear if **DWIHN** has any registered third-party applications. HSAG continues to recommend that **DWIHN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Additionally, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **DWIHN** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **DWIH** modified encounters from its subcontractors before submitting them to MDHHS. **DWIH** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors. • **DWIH** did not indicate claim volume, accuracy, or timeliness quality checks performed for claims/encounters from its subcontractors' data. **DWIH** should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness, accuracy, and timeliness of encounter data. By implementing such measures, **DWIH** can enhance the overall quality and reliability of the encounter data that it submits, aligning with industry standards and improving data usability for all

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97 percent and 94 percent, respectively. Additionally, 97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **DWIH**'s enrollment data may not be complete. **DWIH** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • **DWIH** had a relatively high percentage of duplicates for professional encounters (7.9 percent). HSAG recommends that **DWIH** examine its internal process of identifying duplicates.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • This matter will be discussed at the upcoming CIO forum meeting scheduled for Friday, September 27, 2024. Bullet 1: Identifying contact at MDHHS appropriate for this collaboration. Bullet 2: We need to identify existing reports and processes that ensure the completeness, accuracy, and timeliness of encounter data. There are ongoing activities in use that may not have been reflected in our reporting. For example, **DWIHN's** Finance Department is reviewing the claims cube to monitor utilization. Bullet 3: We need to identify a contact at MDHHS for collaboration. We require technical assistance to clearly define how certain percentages were calculated, as this information is crucial for our understanding and decision-making. Bullet 4: **DWIHN** is working to identify the sources of duplicates referred to by HSAG. We are seeking technical assistance to address this issue.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None at this time.
c. Identify any barriers to implementing initiatives: • **DWIHN** is requesting HSAG technical assistance with regards to bullets #3 and #4 mentioned above.
HSAG Assessment: HSAG has determined that **DWIHN** has partially addressed the prior year's recommendations. Regarding encounter modifications, while plans for collaboration have been outlined, no specific actions or outcomes have been reported. For claim volume, accuracy, and timeliness checks, **DWIHN** indicated ongoing activities, such as Finance Department reviews of claims data, but did not provide detailed information about specific monitoring reports or processes. While these activities are acknowledged, they appear incomplete or insufficient to fully address HSAG's recommendations. For enrollment data completeness, **DWIHN** has recognized the need for collaboration with MDHHS and identified a requirement for technical assistance to understand the calculations used in HSAG's findings. However, no progress or specific actions have been reported to date.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
Regarding duplicate professional encounters, **DWIHN** noted that it is working to identify the sources of duplicates and has requested technical assistance from HSAG. While initial efforts are underway, no concrete steps or outcomes have been provided. In conclusion, **DWIHN** has taken initial steps to address HSAG's recommendations, including plans for collaboration with MDHHS and ongoing internal reviews. However, significant gaps remain in implementing comprehensive solutions for encounter data quality checks, enrollment data reconciliation, and duplicate monitoring. To strengthen compliance with HSAG's recommendations, **DWIHN** should: • Expedite collaboration with MDHHS by identifying a point of contact and formalizing joint activities. • Develop and refine data monitoring reports for claim volume, accuracy, and timeliness. • Conduct a detailed analysis of duplicates and implement routine checks for long-term resolution. • Request and integrate technical assistance from HSAG to address identified barriers effectively. These steps will enhance data quality, address existing barriers, and ensure alignment with HSAG's recommendations.

Region 8—Oakland Community Health Network

Table 4-8—Prior Year Recommendations and Responses for OCHN

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **OCHN** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and improve antidepressant medication management for its African-American members, **OCHN** should identify the barriers of care that are specific to the African-American population and implement interventions that are tailored to the needs of the African-American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Encourage member's enrollment in pharmacy delivery services to address transportation barriers to medication pick-up. • To improve health literacy, **OCHN** continues to promote the MyStrength mobile application during the quarterly IHC meetings. **OCHN** monitors enrolled, active, and returning users, reassessment scores, and improved outcomes. • **OCHN** and Providers encourage medication delivery enrollment, with participating pharmacies and services, to improve antidepressant medication adherence. **OCHN** hired a transportation manager during 2024 to further address transportation barriers and improve transportation needs of individuals served.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • After reviewing population sub-group performance, 64.33% (or 963 adults) of the Caucasian/White population maintained their antidepressant medication regimen for 84 days, while 46.71% (or 291 adults) of African American/Black subgroup population continued their antidepressant medications for 12 weeks. The African American adherence rate improved by 3.56% from the baseline phase, and there was a -3.08% disparity change. • MyStrength Mobile App- As of December 2023, there were 1,495 active enrolled members and 258 returning members. Membership increased by 3.4% in 2023.
c. Identify any barriers to implementing initiatives: • Lack of meaningful medication psychoeducation between the clinician, prescribers, and the individual-served/member • Low/limited health literacy of members, impacting understanding for taking and continuing antidepressant medications. • Members lack transportation to pick-up prescriptions/refills. Members may be unaware of medication benefits/delivery services.

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG Assessment: HSAG has determined that **OCHN** partially addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and initiated interventions that were reasonably linked to their corresponding barriers. The PIHP provided intervention evaluation results for the efforts initiated to determine effectiveness. The PIHP did not identify barriers to care that are specific to the African-American population or implement interventions that are tailored to their needs.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During PSV, the disposition time of one case for indicator #1 was marked as "a.m." when it should have been documented as "p.m." HSAG recommends that **OCHN** require the provider group to deploy additional quality assurance steps to more readily detect and correct employees' manual documentation errors. These mechanisms may include additional audit review of noncompliant cases wherein the disposition time has a different a.m./p.m. designation than the start time. • During PSV, for indicator #4a, a partial hospitalization service was incorrectly reported in the indicator report module of ODIN as the discharge date for one case. Additionally, the same service was missed as an appropriate follow-up service. While **OCHN** had a review process in place, frequent manual edits may result in discrepancies and a reduction in time efficiency. Therefore, HSAG recommends that **OCHN** ensure that programming code is identifying the correct services for the performance indicator. Additionally, HSAG recommends that **OCHN** continue its review process prior to submitting data to the State. • During member-level detail file review, HSAG identified blank fields across the performance indicators for the numerator and denominator data. HSAG recommends that **OCHN** employ additional validation steps to the performance indicator review process to ensure all corrected data are captured in the member-level detail file, and that no fields are blank. • **OCHN**'s reported rates for indicators #1a and #1b decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. Although **OCHN** has demonstrated efforts toward improving its indicator #1 rates by offering signing bonuses, employee referral plans, and incentives for late shift applicants, and has been working with PCE to address issues noted with the logic to ensure cases are accurately assessed as compliant, there is still opportunity for improvement. Therefore, HSAG recommends that **OCHN** continue to focus its efforts on increasing timely dispositions and expand upon interventions currently in place.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Indicator 1: Expectations have been communicated to providers to review the PI 1 PBI dashboard ongoing, as well as participate in weekly reviews of the data with **OCHN** staff. With the goal of checking for errors in the data (which includes discrepancies between am/pm). **OCHN** staff is also reviewing any outliers in the data.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
• Indicator 4a: The logic has been updated to include partial hospitalizations as a qualifying follow-up service. Internal procedures have been updated to eliminate the need for manually overriding these cases. • Blank Fields: The blank fields on the Member Level Detail file were attributed to the cases that were manually overridden in ODIN during the validation process. During preparation for the FY24 PMV submission, all manually overridden cases were identified and the appropriate numerator/denominator was included in the Detail file. • Decreased Rates: The logic was updated for Performance Indicator 1 to reflect the experience of those more accurately in the ER or directly admitted to the hospital. There has also been the addition of 2 children's providers and additional staff hired at Common Ground, to improve rates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Indicator 1: No findings related to AM/PM errors were found in FY24 • Indicator 4a: **OCHN** logic aligned with MDHHS logic in FY24. • Blank Fields: No findings related to blank fields were found in FY24 • Decreased Rates: Indicator 1 has been above the standard for the last 5 quarters, for both adults and children. • FY23 Q1: 91.2% Adults and 94.95% Child. FY24 Q1: 97.2% Adults and 99.7% Child.
c. Identify any barriers to implementing initiatives: • Indicator 1: N/A • Indicator 4a: N/A • Blank Fields: N/A • Decreased Rates: N/A
HSAG Assessment: HSAG has determined that **OCHN** fully addressed the prior year's recommendations. **OCHN** fully addressed the prior year's recommendation for indicator #1 to implement additional quality assurance steps as there was one case that had a disposition time marked as "a.m." instead of "p.m." **OCHN** communicated the expectation to providers that they review the Power BI dashboard on an ongoing basis and also participate in weekly reviews of the data, also checking for any outliers in the data. In addition, during the SFY 2024 audit, HSAG did not identify this issue. **OCHN** fully addressed the prior year's recommendation for indicator #4a to ensure programming identified correct services for performance indicator data and that **OCHN** continue its review process prior to submitting data to the State. This recommendation was due to partial hospitalization services being incorrectly reported for the indicator as a discharge date. **OCHN** updated its logic to include partial hospitalizations as a qualifying follow-up service. Internal procedures were also updated to eliminate the need for manually overriding these cases. Additionally, during the SFY 2024 audit, HSAG did not identify this issue. **OCHN** fully addressed the prior year's recommendation to employ additional validation steps to ensure that all corrected data were captured in the member-level detail file, as HSAG identified blank fields across performance indicators within the member-level data. **OCHN** clarified that the blank fields on the member-level detail file were attributed to manually overridden cases from its validation process and that during the

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
SFY 2024 audit prep, it had reviewed all manually overridden cases for accuracy. Additionally, during the SFY 2024 audit, HSAG did not identify this issue. **OCHN** fully addressed the prior year's recommendation for indicators #1a and #1b to focus its efforts on increasing timely dispositions and expand upon interventions currently in place, as the rates decrease from SFY 2022 to SFY 2023. **OCHN** updated its logic to reflect the experience of those more accurately in the emergency room or when they were directly admitted to the hospital. Two additional children's providers and additional staff were also hired at Common Ground to help improve rates. **OCHN** has also improved its reported rates for both indicators, which again meet the minimum performance standard for SFY 2024, with the indicator for #1a improving to 100 percent.

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **OCHN** did not remediate one of the two elements for the Member Rights and Member Information standard. **OCHN** has not included specific accessibility accommodations offered by provider locations in its provider directory. Providing accessibility information is critical, particularly as the number of managed LTSS programs increase. MCEs must present information in the directory with sufficient specificity to be useful to the readers. HSAG required **OCHN** to submit an action plan to address these findings. Specifically, HSAG recommended that **OCHN** update its online provider directory functionality to include specific accessibility accommodations for its provider network. Additionally, **OCHN** should continue to strengthen oversight and monitoring of its provider directory to ensure continued remediation and compliance with the Member Rights and Member Information standard requirements. • **OCHN** did not remediate the two elements for the Health Information Systems standard. **OCHN** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **OCHN** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **OCHN** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **OCHN** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **OCHN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

3. Prior Year Recommendations From the EQR Technical Report for Compliance Review
• Accessibility Information: **OCHN** has updated our online provider directory functionality to include specific accessibility accommodations for our provider network. Additionally, **OCHN** maintains the provider directory on a monthly basis by pulling PowerBI reports and uploading them to the directory on the last Monday of every month or upon request/as needed. Providers continue to be instructed on how to submit updated information via the existing Microsoft Forms sheet. QM Auditors assist with data maintenance during site visits by logging accessibility information in provider profiles in ODIN. Further communication with providers will be provided stating that each location in ODIN needs its own information added. • API: PCE developed the API in accordance with CMS' implementation guidelines and the Provider Directory API has been made publicly accessible. **OCHN** will continue to look at options in updating our website to include information related to the Provider and Patient Access Directory API.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Accessibility Information: Our current provider directory is available to all providers from our website. 31% of providers have accessibility accommodation information in the provider directory. • API: **OCHN** has implemented the use of the PCE Provider Directory API.
c. Identify any barriers to implementing initiatives: • Accessibility Information: Since **OCHN** had to build provider profiles in ODIN to house accessibility information, collecting the data from providers is an ongoing process. The percentage of providers with accessibility accommodation information in ODIN can be attributed to the fact that many of the providers have multiple locations in ODIN and are only entering accessibility information for one location. There were also delays in the provider directory update process that resulted from the 3rd party contracted to make these updates. • API: The continued barrier is that we are waiting on additional guidelines on the expectations of the API. We are continuing to work internally and with our vendor to meet these requirements.
HSAG Assessment: HSAG has determined that **OCHN** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. HSAG recommends PIHP proceed with updating its website to include educational information on the APIs. Additionally, it is unclear if **OCHN** has any registered third-party applications. HSAG continues to recommend that **OCHN** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Lastly, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **OCHN** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **OCHN** modified encounters from its subcontractors before submitting them to MDHHS. **OCHN** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors. • **OCHN** did not indicate claim volume or timeliness quality checks performed for claims/encounters from its subcontractors' data. **OCHN** should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness, accuracy, and timeliness of encounter data. By implementing such measures, **OCHN** can enhance the overall quality and reliability of the encounter data that it submits,

4. Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time. • **OCHN** did not submit professional or institutional encounters timely. For professional encounters, **OCHN** submitted 57.1 percent of encounters within 120 days, and within 360 days, submitted 81.3 percent of encounters. For institutional encounters, **OCHN** submitted 5.5 percent of encounters within 120 days, and within 360 days, submitted 68.6 percent of encounters. **OCHN** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.3 percent and 84.2 percent, respectively. Additionally, 90.8 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **OCHN**'s enrollment data may not be complete. **OCHN** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members. • Although not required to be populated, 44.0 percent and 23.6 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. **OCHN** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated. • **OCHN** had a relatively high percentage of duplicates for professional encounters (4.2 percent). HSAG recommends that **OCHN** examine its internal process of identifying duplicates.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Modified Encounters – **OCHN** verified the only modification that occurs on encounters is removing local modifiers that are sent to us from providers but are not needed at the state level. We do not alter any other information before submitting encounters to MDHHS. • Claim Volume or Timeliness Quality Checks-**OCHN** continues to improve existing dashboards to monitor volume and claim timeliness from providers. A new policy was also created to tighten down the time a document is signed, which will improve submission time to **OCHN**. • Timely Encounters-**OCHN** continues to send encounters weekly to MDHHS and monitors acceptance of those batches to ensure timely encounters. • Validity Rates-No changes were made in this area, since we would expect some individuals not to have a Medicaid ID but have an encounter. • Provider NPI-We continue to have internal edits to ensure the NPI numbers are being added to our provider records and are included on encounters and claims being sent to **OCHN** for submission to MDHHS. • Duplicates-We continue to look for new edits to help assist with stopping duplicates from entering the system. We also have an internal report for encounters that could be duplicates and that is reviewed for correction by the provider.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Claim Timeliness has improved based on FY23 numbers.

4. Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
○ Professional Encounters reported within 120 days is at 89.86% and over 120 is 10.14% ○ Institutional reported within 120 days is at 70.86% and over 120 is at 29.14%
c. Identify any barriers to implementing initiatives: • Modified Encounters- No barriers • Claim Volume or Timeliness Quality Checks-No barriers. • Timely Encounters-We process encounters on a weekly basis and claims are paid every 2 weeks, but providers do have 60 days to bill us professional claims so that can always be a barrier if they are billing towards the end of the 60 days. • Duplicates-We try to implement as many front-end edits as possible but at times some still come through and then we have to get those corrected once they have been submitted to us.
HSAG Assessment: HSAG has determined that **OCHN** has partially addressed the prior year's recommendations. Regarding encounter modifications, **OCHN** confirmed that its only modification involves removing unnecessary local modifiers, and no other encounter data are altered before submission to MDHHS. This explanation ensures compliance and clarity regarding encounter modifications. For claim volume and timeliness quality checks, **OCHN** noted improvements, including enhancements to dashboards to monitor volume and timeliness and the implementation of a policy to improve submission timelines. However, detailed evidence of comprehensive monitoring reports or measurable outcomes is lacking. Regarding timeliness of encounter submissions, **OCHN** processes encounters weekly and monitors acceptance. Timeliness metrics improved in FY 2023, with 89.86 percent of professional and 70.86 percent of institutional encounters submitted within 120 days. While progress has been made, **OCHN** should collaborate with providers to address delays caused by late billing and consider implementing incentives or penalties to ensure timely submissions. For enrollment data completeness, **OCHN** indicated no changes, noting that some individuals without Medicaid IDs are expected to have encounters. To address this, **OCHN** should collaborate with MDHHS to reconcile enrollment discrepancies and establish a clear process for managing invalid or missing member IDs. Regarding provider NPI completeness, **OCHN** continues to use internal edits to ensure NPIs are added to provider records and included in encounters submitted to MDHHS. However, no evidence of additional quality checks for rendering provider NPIs has been provided, indicating an area for further improvement. For duplicate professional encounters, **OCHN** utilizes front-end edits and an internal report to review potential duplicates, which are then corrected by providers. While these steps are helpful, ongoing issues with duplicates suggest the need for enhanced processes and automation to prevent recurrence. In conclusion, **OCHN** has made progress, particularly in encounter modifications, improving timeliness and addressing duplicates. However, gaps remain in implementing comprehensive monitoring tools, reconciling enrollment data, and enhancing provider NPI validation. To strengthen compliance with HSAG's recommendations, **OCHN** should: • Expand and refine dashboards to monitor claim quality comprehensively. • Address institutional encounter delays by collaborating with providers and establishing stricter timelines. • Formalize reconciliation efforts with MDHHS to improve enrollment data completeness.

4. Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
• Enhance validation processes for rendering provider NPIs and duplicate detection mechanisms. These steps will improve data quality, address barriers, and ensure alignment with HSAG's recommendations.

Region 9—Macomb County Community Mental Health

Table 4-9—Prior Year Recommendations and Responses for MCCMH

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **MCCMH** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the number of African American members discharged from a psychiatric inpatient unit who are seen for timely follow-up care, **MCCMH** should identify the barriers of care that are specific to the African American population and implement interventions that are tailored to the needs of the African American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **MCCMH** engaged in specific initiatives to address challenges and bridge barriers on racial disparity. Some of those initiatives include: • Integrated Outreach and Partnerships: **MCCMH** actively participates in community health fairs, workshops, and seminars to engage directly with underserved communities. These events serve as platforms for both disseminating information and forging partnerships with other organizations and community leaders. • Cultural Competency and Implicit Bias Training: All team members undergo mandatory cultural competency training during orientation and implicit bias training to ensure they are well-prepared to serve our diverse community respectfully and effectively. • Development of Culturally Tailored Resources: **MCCMH** is committed to continuously developing and updating educational materials and community guides that are culturally tailored. This is an ongoing process and **MCCMH** is making steady improvements to ensure that these resources meet the needs of the communities we serve. • Service Delivery Revisions: **MCCMH** continuously reviews and adjusts service delivery models to ensure they are inclusive and accessible to all community members. This includes adjusting appointment scheduling, language services, and physical accessibility, ensuring our services are accommodating to everyone. • **MCCMH** Leadership has started meeting with targeted providers to consider adjusting their service delivery models by opening more walk-in appointments to ease accessibility. • Lastly, **MCCMH** has been holding monthly Quality Provider meetings to discuss challenges that exist around racial disparity and some of the interventions that can be put in place to address those challenges.

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
b. Identify any noted performance improvement because of initiatives implemented (if applicable): • **MCCMH** leadership worked with the directly operated providers to increase walk-in appointment availability. There was an increase in the number of available walk - in appointments at **MCCMH** North and East locations for individuals discharged from inpatient psychiatric unit. This increase has slightly improved patient outcome however, **MCCMH** leadership continues to assess walk-in availabilities and find way to open more slots for walk–in appointments.
c. Identify any barriers to implementing initiatives: • Transportation and appointment availability have been the major barriers. However, **MCCMH** leadership continues to identify other options to break through these barriers.
HSAG Assessment: HSAG has determined that **MCCMH** partially addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and initiated interventions that were reasonably linked to their corresponding barriers. The PIHP provided intervention evaluation results for the efforts initiated to determine effectiveness. The PIHP did not identify barriers to care that are specific to the African-American population nor implement interventions that are tailored to their needs.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During PSV, in four of the five cases reviewed, the member presented for pre-screening at a date and/or time that was considerably different than the date/time reported for the indicator. **MCCMH** further researched the issue and reported an additional 28 cases in which the member presented for pre-screening at a date and/or time that differed from the date/time reported for indicator #1. Of those 28 cases, three additional cases were found that should have been marked as out of compliance. HSAG recommends that **MCCMH** complete its proposed corrective action for updating the report logic. Additionally, HSAG recommends that **MCCMH** perform PSV for a statistically significant sample of cases for indicator #1 each quarter to ensure that the corrected report logic prevents the issue from reoccurring. • During PSV, HSAG noted that one case reported in indicator #3 was for a member in the Omnibus Budget Reconciliation Act (OBRA) program, which should have been excluded from reporting. **MCCMH** further researched the issue and reported one additional OBRA member categorized as "in-compliance" for indicator #3 that should have been excluded. While **MCCMH** completed its proposed corrective action by updating the report logic in June 2023, HSAG recommends that **MCCMH** perform PSV for a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly excluding/omitting OBRA members from the appropriate performance indicators. • During PSV, HSAG found that report logic for indicator #3 incorrectly identified the first ongoing service for one case. **MCCMH** further researched the issue and reported an additional 36 members who had incorrect ongoing services identified for indicator #3. HSAG recommends that **MCCMH** complete its proposed corrective action for updating the report logic. Additionally, HSAG recommends that **MCCMH** perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV for a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly identifying valid ongoing services according to the MDHHS Codebook specifications.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
• During PSV, HSAG found that one case reported in indicator #3 was incorrectly excluded from reporting for indicator #3. While **MCCMH** completed its proposed corrective action by updating the report logic in May 2023 to correctly look for either a "triage call" and/or "assessment/screening" for this indicator, HSAG recommends that **MCCMH** perform validation checks on a statistically significant sample of omitted records to ensure appropriate members are being included in the performance indicators. • During PSV, HSAG found that one case reported in indicator #4b was incorrectly reported as "in-compliance" and should have been reported as "out-of-compliance" due to the member not being seen for an appropriate follow-up service within the seven-day time frame. HSAG recommends that **MCCMH** complete its proposed corrective action for updating the report logic. HSAG also recommends that **MCCMH** implement additional validation checks to further ensure data accuracy for future reporting periods. This additional level of validation could involve reviewing a statistically significant sample of compliant records listed in the member-level data to ensure appropriate follow-up services are being reported that align with MDHHS Codebook specifications of a valid follow-up service. • **MCCMH**'s reported rate for indicator #4b decreased by more than 7 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG recommends that **MCCMH** focus its efforts on increasing timely follow-up care for members following discharge from a substance abuse detox unit. **MCCMH** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The Certificate of Need (CON) document in **MCCMH's** FOCUS EMR has been updated to collect multiple dates/times when the CON is sent back and forth between the hospital and PIHP prior to disposition. **MCCMH's** PI Report logic to calculate disposition time has also been updated to account for the multiple dates/times. • Currently **MCCMH** through the IS Department runs sample cases each quarter for each indicator to ensure the logic is pulling accurately. • Indicator 4b has always pulled accurately at 100% and **MCCMH** did not have any discrepancies with this indicator.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Implementation is recent, **MCCMH** is still to observe improvements. • Any errors found with the logic are addressed real time to ensure more accurate data pull. • N/A
c. Identify any barriers to implementing initiatives: • N/A • Staff availability to complete this additional task. • N/A

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation

HSAG Assessment: HSAG has determined that **MCCMH** fully addressed the prior year's recommendations.

MCCMH fully addressed the prior year's recommendation for indicator #1 to update its report logic and perform PSV for a statistically significant sample of cases for indicator #1 each quarter, as discrepant pre-screening dates and/or times for the indicator were identified by HSAG. **MCCMH** has indicated that, through the IS Department, sample cases were run each quarter for each indicator to ensure the logic is pulling accurately. **MCCMH** has also improved its reported rate to 100 percent, again meeting the minimum performance standard for SFY 2024. During the SFY 2024 audit, **MCCMH** also discussed that the Certificate of Need (CON) programming changes had been completed and were pending implementation in the live FOCUS system, along with corresponding pending program changes. Additionally, during the SFY 2024 audit, HSAG did not identify this issue.

MCCMH fully addressed the prior year's recommendations for indicator #3 related to various reporting issues (i.e., an Omnibus Budget Reconciliation Act [OBRA] member was identified during PSV that should have been excluded, cases with incorrect ongoing services were captured for reporting, and cases that were incorrectly excluded from reporting). **MCCMH** initiated appropriate corrective actions and updated report logic, where needed. **MCCMH** also plans to expand the review process with its providers that has proved successful for other indicators to indicator #3 in Q1 SFY 2025, as well as begin using HSAG's PSV validation tool with providers to validate performance indicator event data. In addition, during the SFY 2024 audit, HSAG did not identify these data issues.

MCCMH fully addressed the prior year's recommendation for indicator #4b to implement additional validation checks to further ensure data accuracy, as a member was reported as "in-compliance" that should have been reported as "out-of-compliance." **MCCMH** has indicated that, through the IS Department, sample cases were run each quarter for each indicator to ensure the logic was pulling accurately. Additionally, during the SFY 2024 audit, **MCCMH** discussed that these logic updates were completed and implemented in FOCUS on May 20, 2024. Additionally, during the SFY 2024 audit, HSAG did not identify this issue.

MCCMH fully addressed the prior year's recommendation to focus its efforts on increasing timely follow-up care for members discharged from a SUD unit, as the indicator #4b rate decreased and fell below the performance standard for indicator #4b from SFY 2022 to SFY 2023. **MCCMH** performed quarterly monitoring and indicated that, through the IS Department, sample cases were run each quarter for each indicator to ensure the logic was pulling accurately. **MCCMH** has also improved its reported rate to 100 percent, again meeting the minimum performance standard for SFY 2024.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **MCCMH** did not remediate two of the three elements for the Health Information Systems standard. **MCCMH** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **MCCMH** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having this information available through an

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **MCCMH** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **MCCMH** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **MCCMH** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. • **MCCMH** did not remediate two of the eight elements for the Quality Assessment and Performance Improvement Program standard, indicating continued gaps in the PIHP's implementation of its QAPI program. QAPI programs provide the foundation for Medicaid MCEs to continually monitor for and identify opportunities for performance improvement with the goal of improving quality of care and member outcomes. HSAG required **MCCMH** to submit an action plan to address these findings. Specifically, HSAG recommended that **MCCMH** develop quarterly analyses of critical incidents, sentinel events, and risk events that includes both quantitative and qualitative analyses and document the review of the analyses in its CRMC minutes during which the review was completed. HSAG also recommended that **MCCMH** update its policy with the process to disseminate information on the effectiveness of the PIHP's QAPI program annually to network providers and to members upon request and develop plan to disseminate the QAPI program evaluation to network providers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MCCMH** continues to work with a subgroup of the Statewide CIO forum to develop standards for posting information about the Provider Directory API and Patient Access API publicly. o **MCCMH** is developing a page on the website to share information on how to access our Provider Directory API. Macomb developed a new Provider Directory application on their public website utilizing information from the Provider Directory API interface to our EMR. o **MCCMH** anticipates having information and instructions on accessing the Provider Directory and Patient Access APIs posted publicly by the next review. • **MCCMH** has implemented **MCCMH** Quality Policy 8-003 which provides guidelines for staff to ensure timely reporting and collection of required documentation when reviewing critical, risk and sentinel events. **MCCMH** has also developed a process to perform quarterly analyses of critical incidents, sentinel events, and risk events that includes both quantitative and qualitative analyses and document the review of the analyses in its CRMC minutes during which the review was completed. This report is shared and discussed at the Quality Committee and the Board. • A process to disseminate information on the effectiveness of the PIHP's QAPI program annually to network providers and to members upon request is now included in the QAPIP Description document.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
• Timely incident reporting has been an ongoing challenge. Continuous training and reminders to the network has been implemented to help mitigate the situation. • This process has created more QAPIP awareness in the community/Network and additional feedback on the program.
c. Identify any barriers to implementing initiatives: • No current partnerships with external healthcare application developers. Otherwise, none. • Staff turnover at the provider level. • N/A
HSAG Assessment: HSAG has determined that **MCCMH** partially addressed the prior year's recommendations based on the PIHP's reported initiatives. HSAG recommends the PIHP proceed with updating its website to include educational information on the APIs. Additionally, HSAG continues to recommend that **MCCMH** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Lastly, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **MCCMH** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.5 percent and 91.2 percent, respectively. Additionally, 94.6 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **MCCMH**'s enrollment data may not be complete. **MCCMH** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MCCMH** will continue to work with MDHHS to ensure both entities have an accurate and complete database of enrolled members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This initiative is new therefore, improvements are yet to be identified.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG has determined that **MCCMH** has partially addressed the prior year's recommendations. Regarding enrollment data completeness, **MCCMH** confirmed that it will continue working with MDHHS to improve enrollment data accuracy and completeness. While **MCCMH** has expressed commitment to collaboration, no specific actions or measurable progress have been detailed to demonstrate improvement in enrollment data validity.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
In conclusion, **MCCMH** has acknowledged the importance of collaborating with MDHHS and initiated efforts to address enrollment data completeness. However, the response lacks detailed actions, progress metrics, or outcomes to fully address HSAG's recommendation. To strengthen compliance, **MCCMH** should: • Formalize its collaboration process with MDHHS, including regular reconciliation and validation efforts. • Develop and document an internal monitoring plan to track enrollment data accuracy over time. • Provide updates on measurable progress or improvements in data validity rates as part of its response to HSAG's findings. These steps will ensure **MCCMH**'s enrollment data are accurate, complete, and aligned with HSAG's recommendations, improving overall data quality and reliability.

Region 10 PIHP

Table 4-10—Prior Year Recommendations and Responses for Region 10

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no identified weaknesses. Although there were no identified weaknesses, HSAG recommends that **Region 10** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and improve the timeliness of Black/African American members receiving a face-to-face SUD service after request, **Region 10** should identify the barriers of care that are specific to the Black/African American population and implement interventions that are tailored to the needs of the Black/African American community to mitigate those identified barriers.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The four significant barriers identified during calendar year 2023, and their respective interventions, were identified as relevant for calendar year 2024. It was recommended to continue all calendar year 2023 activities through calendar year 2024. • Quarterly implementation monitoring continues to take place. • The PIHP continues to facilitate discussions with representatives and subject matter experts from the substance use disorder (SUD) Provider Network regarding barriers and possible interventions to support Black/African American individuals with accessing SUD services. These discussions consist of in-person, on-site visits with each participating SUD Provider, as well as presentations and dialogue at PIHP SUD Provider Network Meetings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At the first remeasurement period, it was found that both racial/ethnic groups (Black/African American and White) demonstrated a significant increase in their rate of persons who received a face-to-face service for treatment or support from an SUD treatment program within 14 calendar days of a non-emergency request for service. • The Black/African American group Remeasurement 1 percentage (77.97%) was greater than the group's Baseline (68.12%) as well as its Remeasurement 1 target (76%). The White group Remeasurement 1 percentage (81.95%) was greater than the group's Baseline (73.18%) as well as its Remeasurement 1 target (76%).
c. Identify any barriers to implementing initiatives: • There were no identified barriers to revisiting the causal/barrier analysis annually and continuing to evaluate interventions to determine the effectiveness of each effort.

1. Prior Year Recommendations from the EQR Technical Report for Validation of Performance Improvement Projects
• Through the causal/barrier analyses conducted, the PIHP identified the same causes and barriers for both the White and Black/African American populations though marginal differences were noted in most of the identified barriers.
HSAG Assessment: HSAG has determined that **Region 10** partially addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and initiated interventions that were reasonably linked to their corresponding barriers. The PIHP provided intervention evaluation results for the efforts initiated to determine effectiveness. The PIHP did not identify barriers to care that are specific to the Black/African-American population or implement interventions that are tailored to their needs.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • During PSV with St. Clair County Community Mental Health, it was identified for one indicator #3 case that the medically necessary ongoing covered service date did not match what was reported in the member-level detail file submitted to HSAG. While St. Clair County Community Mental Health reviewed all remaining cases and confirmed there were no other cases with manual overrides that had incorrect dates entered and no impact on reporting, as the service date was still within the required time frame for indicator #3, HSAG recommends that **Region 10** and the CMHSP expand upon their performance indicator validation checks to ensure any manually entered dates as a result of system overrides are reviewed for accuracy.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Following receipt of the final 2023 Performance Measure Validation (PMV) Review Report, **Region 10** staff presented findings to the Quality Management Committee (QMC). The QMC includes representatives from the PIHP and CMHSPs. The committee meets monthly and performance indicators (PIs) are a standing agenda item. • CMHSPs were asked to validate manual entries during performance indicator review processes. • The PIHP continues to review a sample of events for indicator #3.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The PIHP is not aware of any cases with manual overrides that had incorrect dates entered.
c. Identify any barriers to implementing initiatives: • No barriers have been identified.
HSAG Assessment: **Region 10** fully addressed the prior year's recommendation for indicator #3 to expand upon its validation checks to ensure manually entered dates as a result of system overrides are reviewed for accuracy. HSAG identified a case in which the medically necessary ongoing covered service date did not match what was reported in the member-level detail file for a CMHSP. During the SFY 2024 review, HSAG learned that **Region 10** reviewed all exceptions, performed random spot checks for "in-compliance" and "out-of-compliance" dispositions, and used comparison reports for trending during monthly Quality Management Committee (QMC) meetings with the CMHSPs as part of its oversight. Further, **Region 10** reviewed

2. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation
overridden cases with the CMHSPs to check for possible errors in manual entries during monthly QMC meetings. In addition, during the SFY 2024 audit, HSAG did not identify this issue.

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Region 10** did not remediate the two elements for the Health Information Systems standard. **Region 10** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Region 10** has not implemented the Provider Directory API in accordance with all requirements of 42 CFR §431.70. Having this information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. HSAG continues to recommend that **Region 10** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Region 10** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Region 10** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Region 10** participated in discussions regarding Patient Access and Provider Directory APIs during statewide Chief Information Officer (CIO) Forum meetings. • **Region 10** thoroughly reviewed the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). • **Region 10** will follow up with the electronic health record vendor regarding the implementation of the API.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No performance improvement has been noted as the Patient Access and Provider Directory APIs have not been implemented.
c. Identify any barriers to implementing initiatives: • Considerations of potential costs associated. • **Region 10** is not a direct provider of service, and therefore not as familiar with individuals served as the providers. • Clarity of roles of MDHHS, PIHPs, and providers.
HSAG Assessment: **Region 10** has made minimal progress in implementing HSAG's recommendations, and the Patient Access and Provider Directory APIs have yet to be implemented. As **Region 10** has been noncompliant for several years, HSAG recommends that **Region 10** prioritize full implementation of the

3. Prior Year Recommendations from the EQR Technical Report for Compliance Review
Patient Access API and consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application. Further, as CMS has continued to enhance the interoperability requirements, HSAG recommends that **Region 10** review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and begin preparations to implement any new API requirements. Lastly, with CMS increasing the interoperability requirements, this should stress the importance to **Region 10** of not delaying implementation of the APIs any further.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **Region 10** did not submit institutional encounters timely, where 7.1 percent of institutional encounters were submitted within 120 days of payment, and 54.5 percent of encounters were submitted within 360 days. **Region 10** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. • The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97.9 percent and 92.9 percent, respectively. Additionally, 97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Region 10**'s enrollment data may not be complete. **Region 10** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.
MCE's Response: ***(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The PIHP has internally discussed the timeliness of institutional encounters. It was determined that a report should be developed to identify which institutional encounters have not been submitted timely and which CMHSPs have submitted institutional encounters untimely. The PIHP is following up with the electronic health record vendor to determine if a report is or can be available in the electronic health record. • Regarding the validity rates in both professional and institutional data, the PIHP does not currently have a validation review process in place. The PIHP has considered the reasons individuals served may not present in the enrollment file, such as County of Financial Responsibility (COFR) arrangements between counties (across regions), individuals reporting they are homeless in the region, and individuals outside of the region receiving Certified Community Behavioral Health Clinic (CCBHC) Demonstration services. As a next step, the PIHP will outreach MDHHS to inquire about the threshold for this measure and potential action steps.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Because a report is not yet available to monitor timeliness of institutional encounters, the PIHP is not yet able to determine noted performance improvement. • Because the PIHP does not yet have a clear understanding of the threshold and potential action steps to address the validity rates in both professional and institutional data, the PIHP is not yet able to determine noted performance improvement.

4. Prior Year Recommendations from the EQR Technical Report for Encounter Data Validation
c. Identify any barriers to implementing initiatives: • For the development of a report to monitor timeliness of institutional encounters, the PIHP must first follow up with the electronic health record vendor. This task has not yet been completed due to other time-sensitive tasks and electronic health record revisions and reports needed. • Regarding the validity rates in both professional and institutional data, the PIHP does not yet have a clear understanding of this requirement or a threshold. Because the PIHP serves individuals with COFR arrangements between counties, individuals reporting they are homeless in the region, and individuals outside of the region receiving CCBHC Demonstration services, it is expected this will continue to be a finding.
HSAG Assessment: HSAG has determined that **Region 10** has partially addressed the prior year's recommendations. Regarding timeliness of institutional encounter submissions, **Region 10** reported that it has internally discussed timeliness issues and identified the need for a report to pinpoint untimely institutional encounters and the responsible CMHSPs. **Region 10** is actively following up with its EHR vendor to explore the feasibility of developing such a report. However, while these steps have been outlined, no tangible progress has been made in implementing a monitoring process, as the report is not yet developed. For enrollment data completeness, **Region 10** acknowledged the need to understand validity rate thresholds and potential corrective actions, citing specific challenges such as County of Financial Responsibility (COFR) arrangements, homelessness, and Certified Community Behavioral Health Clinic (CCBHC) services provided outside the region. **Region 10** plans to reach out to MDHHS for guidance. While **Region 10** has identified potential causes for data discrepancies, no actions have been taken to reconcile enrollment data or formalize collaboration with MDHHS. In conclusion, **Region 10** has acknowledged the issues highlighted by HSAG and outlined preliminary steps to address them. However, significant progress has not been made in implementing effective solutions for monitoring encounter timeliness and reconciling enrollment data. To strengthen compliance with HSAG's recommendations, **Region 10** should: • Expedite the development of an automated report for monitoring institutional encounter timeliness and establish interim manual tracking processes. • Collaborate with MDHHS to clarify validity thresholds and reconcile discrepancies in enrollment data. • Implement routine internal reviews for both encounter timeliness and enrollment completeness to proactively address gaps. • Prioritize communication with the EHR vendor to ensure timely development of required reports and system enhancements. These steps will enhance data quality, address barriers, and align **Region 10** with HSAG's recommendations.

5. Prepaid Inpatient Health Plan Comparative Information

In addition to performing a comprehensive assessment of each PIHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each PIHP to assess the Michigan Behavioral Health Managed Care program. Specifically, HSAG identifies any patterns and commonalities that exist across the 10 PIHPs and the Michigan Behavioral Health Managed Care program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

Prepaid Inpatient Health Plan External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the PIHPs.

Validation of Performance Improvement Projects

For the SFY 2024 validation, the PIHPs submitted quality improvement strategies for their PIHP-specific PIP topic. HSAG's validation evaluated the technical methods the PIHPs' PIPs (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of each PIHP's PIP and assigned an overall confidence level of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence* for the two required validation ratings identified below. Table 5-1 provides a comparison of the overall PIP validation ratings and the scores for the PIP Design stage (Steps 1 through 6), Implementation stage (Steps 7 and 8), and Outcomes stage (Step 9), by PIHP. Table 5-1 also identifies whether a statistically significant racial or ethnic disparity was noted within the PIHP's data, and the disparate population that was targeted through the PIP, as applicable.

Table 5-1—Comparison of Validation Ratings and Scores, by PIHP

PIHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No) and Target Population
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
NCN	*Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring Treatment from a Network Provider*	*High Confidence*	*No Confidence*	100%	0%	0%	33%	0%	67%	No

PIHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No) and Target Population
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
NMRE	*The Percentage of Individuals Who are Eligible for OHH Services, Enrolled in the Service, and are Retained in the Service*	*High Confidence*	*High Confidence*	100%	0%	0%	100%	0%	0%	No
LRE	*FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black*	*Low Confidence*	*No Confidence*	75%	25%	0%	33%	0%	67%	Yes, African American/ Black
SWMBH	*Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	*High Confidence*	*Low Confidence*	100%	0%	0%	67%	0%	33%	Yes, African American/ Black
MSHN	*Improving the Rate of New Persons Who Have Received a Medically*	*High Confidence*	*No Confidence*	100%	0%	0%	33%	0%	67%	Yes, African American/ Black

PIHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No) and Target Population
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
	Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population									
CMHPSM	*Reduction of Disparity Rate Between Persons Served who are African American/Black and White and miss their appointment for an initial Biopsychosocial (BPS) Assessment and Assist Individuals in scheduling and*	*Low Confidence*	*No Confidence*	81%	19%	0%	33%	0%	67%	Yes, African American/ Black

PIHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No) and Target Population
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
	keeping their initial assessment for services									
DWIHN	*Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit*	*High Confidence*	*No Confidence*	100%	0%	0%	33%	0%	67%	Yes, African American/ Black
OCHN	*Improving Antidepressant Medication Management—Acute Phase*	*High Confidence*	*No Confidence*	100%	0%	0%	33%	0%	67%	Yes, African American/ Black
MCCMH	*Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient*	*High Confidence*	*No Confidence*	100%	0%	0%	33%	0%	67%	Yes, African American/ Black

PIHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No) and Target Population
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
	Psychiatric Hospitalizations									
Region 10	*Reducing Racial/Ethnic Disparities in Access to SUD Services*	*High Confidence*	*Low Confidence*	100%	0%	0%	67%	0%	33%	Yes, African American/ Black

Performance Measure Validation

Table 5-2 presents the PIHP-specific results for the SFY 2024 validated performance indicators. For each indicator, **green** font is used to denote the highest-performing PIHP(s), while **red** font is used to denote the lowest-performing PIHP(s).

Table 5-2—SFY 2024 PIHP-Specific Performance Measure Rate Percentages

Performance Indicator		Region 1 NCN	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#1	Children—Indicator #1a	**100%**	**98.43%**	98.70%	99.57%	98.58%	99.30%	99.44%	**100%**	99.33%	99.29%
	Adults—Indicator #1b	**100%**	98.86%	98.42%	99.52%	99.67%	99.84%	**96.55%**	97.99%	98.36%	98.57%
#2	MI–Children—Indicator #2a	**62.05%**	60.25%	58.03%	61.77%	60.43%	44.48%	**30.21%**	37.18%	39.52%	48.24%
	MI–Adults—Indicator #2b	56.68%	50.99%	48.00%	**68.58%**	64.31%	48.42%	57.36%	53.75%	**46.90%**	49.46%
	I/DD–Children—Indicator #2c	48.00%	73.44%	39.29%	**75.44%**	43.51%	51.75%	21.78%	**11.11%**	23.47%	45.95%
	I/DD–Adults—Indicator #2d	66.37%	60.00%	54.17%	**84.85%**	67.83%	45.83%	58.41%	**20.45%**	30.00%	50.00%
	Total—Indicator #2	58.20%	55.30%	51.73%	**67.17%**	61.79%	47.63%	47.64%	46.94%	**41.98%**	48.76%
#2e	Consumers	**54.41%**	60.15%	67.86%	59.09%	72.40%	59.22%	64.73%	**79.96%**	75.47%	74.15%
#3	MI–Children—Indicator #3a	64.83%	63.67%	59.84%	**54.91%**	58.28%	66.18%	79.70%	**88.26%**	61.24%	78.64%
	MI–Adults—Indicator #3b	59.70%	63.51%	60.81%	56.98%	58.09%	**53.12%**	90.49%	**99.11%**	86.23%	75.58%
	I/DD–Children—Indicator #3c	52.17%	65.71%	47.75%	**46.28%**	76.05%	65.98%	66.35%	**100%**	77.36%	87.71%
	I/DD–Adults—Indicator #3d	71.43%	82.14%	**51.90%**	91.18%	65.74%	92.86%	81.82%	**97.56%**	65.63%	80.00%
	Total—Indicator #3	61.49%	64.38%	58.72%	**56.28%**	59.72%	60.62%	85.22%	**95.54%**	77.27%	78.01%
#4a	Children	**100%**	92.00%	96.81%	96.20%	94.67%	88.10%	97.78%	84.62%	**64.84%**	91.43%
	Adults	**100%**	87.20%	94.80%	96.62%	95.20%	93.51%	98.67%	93.29%	**56.53%**	93.61%
#4b	Consumers[1]	**94.12%**	95.49%	**100%**	**100%**	95.02%	97.27%	97.25%	99.28%	**100%**	96.10%
#5	Medicaid Recipients[2]	6.86%	7.71%	5.37%	7.15%	7.35%	6.29%	5.83%	7.48%	4.77%	7.19%

Performance Indicator		Region 1 NCN	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#6	HSW Enrollees[2]	98.91%	97.06%	95.00%	96.50%	96.86%	92.19%	95.77%	95.98%	92.38%	97.18%
#8	MI–Adults—Indicator #8a	21.83%	25.98%	23.54%	26.16%	23.35%	20.51%	**18.69%**	**26.80%**	24.17%	20.58%
	DD–Adults—Indicator #8b	8.81%	10.17%	13.12%	10.12%	9.12%	11.15%	8.56%	**15.11%**	**6.23%**	6.72%
	MI and DD–Adults—Indicator #8c	10.29%	**15.95%**	11.68%	11.14%	10.03%	9.58%	8.06%	11.07%	**7.70%**	9.73%
#9	MI–Adults—Indicator #9a	**98.75%**	99.83%	99.78%	**99.88%**	99.67%	99.34%	99.81%	99.85%	99.85%	99.32%
	DD–Adults—Indicator #9b	59.13%	**48.38%**	84.76%	**94.08%**	69.18%	71.71%	66.46%	73.19%	73.19%	63.08%
	MI and DD–Adults—Indicator #9c	**64.94%**	81.16%	87.31%	**93.79%**	77.06%	79.17%	80.00%	65.43%	65.43%	78.77%
#10	Children—Indicator #10a*	**20.83%**	10.77%	18.49%	7.89%	9.36%	18.00%	8.62%	5.88%	10.68%	**5.45%**
	Adults—Indicator #10b*	10.23%	13.06%	12.79%	12.59%	10.73%	9.40%	**17.58%**	**8.62%**	13.96%	13.77%
#13	DD–Adults	16.93%	20.99%	**13.61%**	17.59%	19.57%	**24.67%**	20.12%	19.51%	14.34%	15.54%
	MI and DD–Adults	20.56%	**32.64%**	**19.89%**	24.34%	26.12%	29.27%	23.01%	26.92%	21.23%	24.35%
#14	MI–Adults	**53.73%**	48.61%	40.93%	47.44%	48.00%	36.71%	39.62%	**33.80%**	47.30%	43.75%

* A lower rate indicates better performance.

Best-performing PIHPs' rates are denoted in **green** font.

Worst-performing PIHPs' rates are denoted in **red** font.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] No **red** or **green** font is shown for PIHPs' rates for this performance indicator since the rates do not indicate best or worse performance among PIHPs.

Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., for all 10 PIHPs, the total number of adults who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., for all 10 PIHPs, the total number of adults discharged from psychiatric inpatient facilities). These calculations excluded raw data from any PIHP that received a *Do Not Report (DNR)* audit designation.

Table 5-3 presents the SFY 2022, SFY 2023, and SFY 2024 statewide results for the validated performance indicators with year-over-year comparative rates. MDHHS defined a performance standard for four performance indicators (indicators #1, 4a, 4b, and 10) and standard percentile benchmarks for three indicators (indicators #2, 2e, and 3). For indicators with corresponding percentile benchmarks (i.e., indicators #2, 2e, and 3), SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. Please note that percentile benchmarks were not established for indicators #2, 2e, and 3 until SFY 2024. Therefore, the SFY 2023 rates were not compared to the percentile benchmarks. Additionally, the percentile benchmarks for indicators #2, 2e, and 3 are based on the cumulative percentage for the total eligible within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population for these indicators.

Table 5-3—SFY 2022–SFY 2024 Statewide Performance Measure Rates

Performance Indicator	2022 Rate	2023 Rate	2024 Rate
#1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard = 95% within 3 hours.*			
Children—Indicator #1a	**98.40%**	**98.60%**	**99.11%**
Adults—Indicator #1b	**97.90%**	**98.11%**	**98.41%**
#2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.*			
MI–Children—Indicator #2a	60.48%	50.54%	52.17%
MI–Adults—Indicator #2b	59.27%	55.21%	57.14%
I/DD–Children—Indicator #2c	62.06%	43.69%	40.27%
I/DD–Adults—Indicator #2d	56.33%	52.92%	54.79%
Total—Indicator #2	59.78%	52.83%	54.28%
#2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.[1] *50th Percentile = 68.2%. 75th Percentile = 75.3%.*			
Consumers	70.34%	68.56%	67.76%
#3: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*			
MI–Children—Indicator #3a	72.27%	66.44%	65.66%
MI–Adults—Indicator #3b	73.90%	71.53%	70.98%

Performance Indicator	2022 Rate	2023 Rate	2024 Rate
I/DD–Children—Indicator #3c	80.39%	78.59%	66.54%
I/DD–Adults—Indicator #3d	76.05%	72.06%	75.37%
Total—Indicator #3	73.95%	70.51%	69.32%
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard = 95%.*			
Children	92.07%	91.10%	90.18%
Adults	89.91%	86.47%	90.69%
#4b: The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. *Standard = 95%.*			
Consumers	**98.43%**	**97.15%**	**97.79%**
#5: The percent of Medicaid recipients having received PIHP managed services.			
Medicaid Recipients	6.07%	6.22%	6.43%
#6: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.			
HSW Enrollees	88.22%	94.39%	95.88%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]			
MI–Adults—Indicator #8a	17.05%	20.62%	22.50%
DD–Adults—Indicator #8b	8.61%	9.57%	10.07%
MI and DD–Adults—Indicator #8c	8.41%	9.63%	10.13%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]			
MI–Adults—Indicator #9a	99.66%	99.89%	99.72%
DD–Adults—Indicator #9b	79.93%	89.67%	66.81%
MI and DD–Adults—Indicator #9c	82.77%	92.74%	76.61%
#10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *Standard = 15% or less within 30 days.*			
Children—Indicator #10a	**6.53%**	**7.38%**	**10.06%**
Adults—Indicator #10b	**12.34%**	**12.62%**	**13.52%**
#13: The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.			
DD–Adults	19.39%	19.26%	18.57%
MI and DD–Adults	26.24%	25.65%	24.68%

Performance Indicator	2022 Rate	2023 Rate	2024 Rate
#14: The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.			
MI–Adults	44.11%	43.69%	42.96%

The statewide rates that met or exceeded the performance standard are denoted in **green** font for performance indicators that have a performance standard.

SFY 2024 rates with bold **orange** font indicate that the overall total rate met the established 50th percentile for the indicator. PIHPs that are in the 50th–75th percentile benchmark are expected to reach or exceed the 75th percentile.

SFY 2024 rates with bold **green** font indicate that the overall total rate met the established 75th percentile for the indicator. PIHPs that are above the 75th percentile benchmark are expected to maintain the level of performance.

* A lower rate indicates better performance.

[1] Please note that the PIHP data for indicator #2e are displayed for information only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow identification of opportunities to improve rate accuracy for future reporting.

[2] Competitive employment includes full time and part time. This indicator includes all adults by population no matter their employment status.

[3] Employed consumers include full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults who meet the "employed" status.

Compliance Review

HSAG calculated the Michigan Behavioral Health Managed Care program overall performance in each of the five performance standards reviewed during the current three-year compliance review cycle. Table 5-4 compares the statewide average compliance score with the compliance score achieved by each PIHP for the standards reviewed in SFY 2024. **Green** shading is used to denote the highest-performing PIHP(s), while **red** shading is used to denote the lowest-performing PIHP(s) in each standard.

Table 5-4—PIHP and Statewide Compliance Review Scores for SFY 2024

Standard	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	62%	76%	76%	86%	76%	86%	82%	81%	81%	95%	**80%**
III	94%	100%	100%	100%	100%	83%	94%	100%	94%	94%	**96%**
IV	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
V	100%	93%	100%	100%	93%	93%	100%	87%	93%	93%	**95%**
VI	68%	73%	68%	73%	68%	73%	77%	77%	64%	73%	**71%**
Statewide Average	**81%**	**86%**	**86%**	**89%**	**85%**	**85%**	**88%**	**87%**	**84%**	**89%**	**86%**

Standard I—Member Rights and Member Information
Standard III—Availability of Services
Standard IV—Assurances of Adequate Capacity and Services
Standard V—Coordination and Continuity of Care
Standard VI—Coverage and Authorization of Services

Network Adequacy Validation

Each PIHP was assessed based upon following its own defined network adequacy indicator methodology as programwide standardized methodology and guidance were not available to the PIHPs at the time of the NAV audits. Considering the PIHPs did not apply consistent methodology to network adequacy indicator reporting, programwide and comparative results are not available as the results cannot be aggregated or compared across the PIHPs.

Encounter Data Validation

Representatives from each PIHP procured medical records for sampled members from their contracted providers based on the final sample lists provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 5-5 presents the EDV MRR results for all PIHPs stratified by analytic review categories. The analysis categorized findings using three levels of concern: "✓" indicated no or minor concerns noted, "–" indicated moderate concerns noted, and "✗" indicated major concerns noted. For PIHP-specific results, refer to Section 3.

Medical Record Procurement Status

The *Medical Record Procurement Status Rate* was assessed based on the following criteria: rates of 95 percent and above were assigned a "✓", rates from 90 percent to less than 95 percent were assigned a "–", and rates below 90 percent were assigned an "✗".

Encounter Data Completeness

The completeness of encounter data was assessed based on the four key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). A "✓" was assigned if all data elements had an omission rate of 10 percent or less. A "–" was assigned if any single data element had an omission rate exceeding 10 percent. An "✗" was applied under any of the following conditions: if one data element had an omission rate exceeding 25 percent, if two data elements had omission rates exceeding 20 percent, or if three data elements had omission rates above 15 percent. These thresholds help identify potential gaps in data submission and ensure a consistent standard for completeness evaluation.

Encounter Data Accuracy

For the accuracy rate assessment, the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *All-Element Accuracy Rates* were used as primary metrics. At the individual level, if all data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) had accuracy rates of at least 95 percent, a "✓" was assigned. If at least one individual element rate was from 90 percent to less than 95 percent, a "–" was assigned, and if at least one individual element rate was below 90 percent, an "✗" was assigned. For the *All-Element Accuracy Rate*, the following classifications were applied: rates of 80 percent or above were assigned a "✓", rates from 60 percent to below 80 percent were assigned a "–", and rates below 60 percent were assigned an "✗".

This classification helps determine the reliability of encounter data across PIHPs and highlights areas where accuracy improvements may be necessary. It is important to note that the denominator for the element accuracy rate for each data element was defined differently than the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the individual data element accuracy rates. Using the *Diagnosis Code* data element as an example, each diagnosis code was assigned to one of the four mutually exclusive categories: medical record omission, encounter data omission, accurate, or inaccurate. When evaluating the element accuracy for each key data element, the denominator is the number of values in the categories of accurate and inaccurate. However, for the all-element accuracy rate, the denominator is the total number of dates of service that matched between the medical records and encounter data, and the numerator is the total number of dates of service with the same values for **all** key data elements. Therefore, for each date of service, if any of the data elements were in the medical record omission, encounter data omission, or inaccurate categories, the date of service was not counted in the numerator for the all-element accuracy rate.

By applying these evaluation criteria, the MRR provides a comprehensive assessment of data integrity, allowing for targeted improvements in PIHP data submission practices.

Table 5-5—EDV PIHP Comparison

Analysis	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Medical Record Procurement Status										
Medical Record Procurement Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Second Date of Service Submission Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Completeness										
Medical Record Omission Rate	✗	–	–	–	–	–	✗	✗	✗	–
Encounter Data Omission Rate	✓	–	✓	✓	✓	✓	✓	✓	–	✓
Encounter Data Accuracy										
Diagnosis Code Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Analysis	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Procedure Code Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Procedure Code Modifier Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
All-Element Accuracy Rate	×	–	–	–	×	–	×	×	×	–

✓	No or minor concerns noted.
–	Moderate concerns noted.
×	Major concerns noted.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the PIHPs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Michigan Behavioral Health Managed Care program to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members. Table 6-1 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the Michigan Behavioral Health Managed Care program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. A dash (–) is noted in Table 6-1 if no trends were identified through an EQR activity that substantially impacted a goal; the EQR activity results could not be used to evaluate a goal; or a CQS goal did not include a quality measure for the SBHS or BCCHPS populations.

Table 6-1—Programwide Conclusions and Recommendations

Performance Impact on Goals and Objectives[6]		Performance Domain
Goal #1: Ensure high quality and high levels of access to care		
✓	The statewide child and adult rates for indicator #1: *The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours* exceeded the CQS goal of 95 percent.	☒ Quality ☒ Timeliness ☒ Access
✗	The aggregated statewide rate for indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* fell below the 50th percentile.	
✗	The aggregated statewide rate for indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* fell below the 50th percentile.	
✗	The programwide compliance rate for the Coverage and Authorization of Services program area was only 71 percent. All PIHPs had challenges implementing service authorization requirements and creating ABD notices that included all required content, were specific to the member's circumstance, and were easily understood (e.g., the notices were not written at the state-required reading grade level).[7]	

[6] All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all performance measures validated through the PMV, and performance measures without a corresponding CQS quality measure were excluded.

[7] While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and objective(s) within the CQS.

	Performance Impact on Goals and Objectives[6]	Performance Domain
✗	Five PIHPs had an "All-Element Accuracy Rate" below 60 percent, indicating major concerns with encounter data not being supported by the members' medical records and highlighting areas where accuracy improvements may be necessary. Accurate and complete encounter data are critical to the success of a managed care program. MDHHS relies on the quality of encounter data submissions from the PIHPs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.[7]	
m	While the programwide compliance rate for the Assurances of Adequate Capacity and Services program area was 100 percent, the two elements related to member-to-provider ratios were scored *NA*, not applicable, as MDHHS did not require these network adequacy indicators to be reported on the annual network adequacy template and had not provided specifications to the PIHPs to ensure consistent calculation of member-to-provider ratios.[7]	
–	Considering the PIHPs did not have standardized guidance at the time of network adequacy report submissions to MDHHS, many of the PIHPs applied inconsistent methodology for network adequacy time and distance indicator calculations; therefore, the PIHP network adequacy results could not be compared across PIHPs or aggregated to provide programwide results.	
–	The EQR activities do not produce data to assess the impact of the seven quality measures of the BCCHPS program under CQS Objective 1.3.	
Goal #2: Strengthen person and family-centered approaches		
✓	The programwide compliance review rate for the Coordination and Continuity of Care standard was 95 percent. All PIHPs demonstrated having adequate processes for most elements for comprehensively assessing and producing person-centered service plans for its members.[7]	☒ Quality ☐ Timeliness ☐ Access
–	The CQS not does include quality measures for the SBHS program under Goal #2.	
–	The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under Objective 2.1.	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	Through the Coordination and Continuity of Care standard of the compliance review activity, all PIHPs demonstrated having adequate processes to coordinate care between managed care programs, community supports, and transitions between care settings.[7]	☒ Quality ☒ Timeliness ☒ Access
–	The EQR activities do not produce data to assess the impact of the two quality measures for the SBHS program under Objective 3.1. Of note, these two quality measures, *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Child* and *Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days–Adult*, are included as new quality measures in year one of MDHHS' behavioral health quality measure overhaul. Performance	

	Performance Impact on Goals and Objectives[6]	Performance Domain
	of these measures will be assessed in future technical reports when included as part of the PMV activity.	
–	The EQR activities do not produce data to assess the impact of the two quality measures for the BCCHPS program under Objective 3.2.	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
m	While MDHHS required the PIHPs to continue with PIP topics focused on disparities within their populations, seven PIHPs did not demonstrate a statistically significant change in their performance indicator rates. Additionally, while three PIHPs demonstrated a statistically significant increase in their performance indicator rates, two of those PIHPs did not eliminate the disparity and the third PIHP had not identified a disparity within its region's membership.	☒ Quality ☒ Timeliness ☒ Access
–	The EQR activities do not produce data to assess the impact of the one quality measure for the SBHS program under Objective 4.1. Of note, the CQS quality measure, *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*, is included as a new measure in year one of MDHHS' behavioral health quality measure overhaul. Performance of this measure will be assessed in future technical reports when included as part of the PMV activity.	
–	The EQR activities do not produce sufficient data to assess the impact of the two quality measures of the BCCHPS program under Objective 4.1. Of note, while indicator #2: *The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* and indicator #3: *The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment* are included in the PMV activity, the data reported are not stratified by persons of color.	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
–	The CQS not does include quality measures for the SBHS and BCCHPS programs under Goal #5.	☒ Quality ☐ Timeliness ☐ Access
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that MDHHS' value-based initiatives and payment reform had on improving quality outcomes.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS' CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Michigan Behavioral Health Managed Care program members:

- MDHHS is overhauling its QAPIP beginning SFY 2025 through SFY 2028, with the identification of new performance measures that align with CMS Core Set reporting, the Home and Community-Based Services CAHPS survey, and CMS' Long-Term Services and Supports quality measures. As such, HSAG recommends that MDHHS conduct a comprehensive review of the CQS to determine any revisions that MDHHS should make to the

Performance Impact on Goals and Objectives[6]	Performance Domain
existing objectives (i.e., quality measures) to ensure alignment with the new performance measures that the PIHPs will be required to report. While two of the new performance measures are already included as quality measures within the CQS, MDHHS will need to consider what other quality measures should be added to the CQS for the Behavioral Health Managed Care program to align with its QAPIP's new performance measures in support of the CQS goals and objectives. MDHHS could also consider whether it should develop and add quality measures to Goal #5 within the CQS since there are currently no identified quality measures for the Michigan Behavioral Health Managed Care program to monitor performance with *improving quality outcomes through value-based initiatives and payment reform*. • HSAG recommends that MDHHS issue formal guidance to all PIHPs, detailing its expectations for how the PIHPs should calculate time and distance to applicable providers. Additionally, HSAG recommends that MDHHS provide formal guidance to all PIHPs, clearly outlining the expectations for categorizing servicing counties during reporting to ensure better alignment with MDHHS standards. Further, HSAG recommends that MDHHS provide specifications to the PIHPs for the calculation of its member-to-provider network adequacy standards. As an assessment of network adequacy must be submitted by the PIHPs to MDHHS at least annually, HSAG also recommends that MDHHS update its network adequacy template to include member-to-provider ratio indicators. Updates to MDHHS' contract with the PIHPs and reporting template should improve MDHHS' and the PIHPs' ability to monitor for any gaps in network adequacy that may be a contributing barrier to members accessing timely care and services. • HSAG recommends that MDHHS review the PIHPs' UM programs to identify opportunities to streamlines processes and ensure consistent tracking and reporting across all PIHPs. Specifically, MDHHS should clarify whether a service authorization request begins the 14-calendar-day time frame (or seven days effective in 2026) when a member initially contacts the PIHP/CMHSP and requests services, or if the time frame begins when the service authorization request is submitted to the UM department for approval or denial. If MDHHS determines that the service authorization request begins when a member initially requests services with the PIHP, the PIHPs would need to complete any applicable assessments and approve/deny authorizations within 14 calendar days (or within seven days effective in 2026). • As CMS has implemented appointment timeliness standards effective in 2027, MDHHS could determine that the PIHPs have 10 business days to schedule an appointment to determine the member's service needs, and then the PIHP has seven calendar days from the appointment to render an approval/denial decision by the UM department. • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its PIHPs as follows within the required effective dates for each specific requirement: – Require the PIHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. – Require the PIHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each PIHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each PIHP, and it enables the PIHPs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining the necessary quality checks for quality and appropriateness of care.	

Performance Impact on Goals and Objectives[6]	Performance Domain
• To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), MDHHS should implement the following within the required effective dates for each specific requirement: – Review the maximum appointment wait time standards (e.g., 10 business days for outpatient mental health and SUD appointments) and update its contracts with its PIHPs, as applicable. – If determined by CMS to be applicable to the Michigan Behavioral Health Managed Care program, MDHHS should contract with an independent vendor to perform secret shopper surveys of PIHP compliance with appointment wait times and the accuracy of provider directories, and require directory inaccuracies to be sent to MDHHS within three days of discovery. Results from the secret shopper survey will provide assurances to MDHHS that the PIHPs' networks have the capacity to serve the expected enrollment in their service areas, and they offer appropriate access to preventive and primary care services for their members.	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), PIHPs are required to have a comprehensive QAPIP, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must involve:

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

The primary objective of PIP validation is to determine the PIHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the PIHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PIHP improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the PIHP during the PIP.

MDHHS requires that each PIHP conduct at least one PIP subject to validation by HSAG. In SFY 2024, the PIHPs submitted quality improvement strategies for their PIHP-specific PIP topics. HSAG conducted validation on the PIP Design stage (Steps 1 through 6), Implementation stage (Steps 7 through 8), and Outcomes stage (Step 9) of the selected PIP topic for each PIHP. The PIP topics chosen by PIHPs

addressed CMS' requirements related to quality outcomes—specifically, the quality of and access to care and services. MDHHS requested that the PIHPs also implement PIPs that focus on eliminating disparities within their populations, when applicable.

Technical Methods of Data Collection and Analysis

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[8]

Aligning with the CMS EQR Protocol 1, HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each PIHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS protocols identify 9 steps that should be validated for each PIP. For the SFY 2024 submissions, the PIHPs reported quality improvement strategies and were validated for Steps 1 through Step 8 in the PIP Validation Tool as appropriate.

The nine steps included in the PIP Validation Tool are listed below:

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

HSAG used the following methodology to evaluate PIPs conducted by the PIHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs (CMS EQR Protocol 1).

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

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

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the PIHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

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

     Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate group demonstrated statistically significant improvement

over the baseline performance; however, there remains a statistically significant difference between the disparate group and the comparison group.

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

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

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

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

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

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

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

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

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

The PIHPs had the opportunity to receive initial PIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to MDHHS and the PIHPs.

Description of Data Obtained and Related Time Period

For SFY 2024, the PIHPs submitted quality improvement strategies. The performance indicator measurement period dates for the PIP are listed in Table A-1.

Table A-1—Measurement Period Dates

Data Obtained	Measurement Period	Reporting Year (Measurement Period)
Administrative	Baseline	SFY 2022 (CY 2021)
Administrative	Remeasurement 1	SFY 2024 (CY 2023)
Administrative	Remeasurement 2	SFY 2025 (CY 2024)

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the PIHP provided to members, HSAG validated the PIPs to ensure the PIHP used a sound methodology in its design and PIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and the PIP goal) and qualitative results (e.g., technical design of the PIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Performance Measure Validation

Activity Objectives

As set forth in 42 CFR §438.350(a), the validation of performance measures calculated by the PIHPs and/or the State during the preceding 12 months was one of the mandatory EQR activities. The primary objectives of the performance measure validation activities were to:

- Evaluate the accuracy of the performance measure data calculated and/or reported by the PIHP.
- Determine the extent to which the specific performance measures calculated and/or reported by the PIHP (or on behalf of the PIHP) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure reporting and calculation process.

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table A-3 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of SFY 2024, which began October 1, 2023, and ended December 31, 2023. Table A-4 lists the performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 3 identifies key types of data that should be reviewed as part of the validation process. The type of data collected and how HSAG conducted an analysis of the data included:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' IS; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs and CMHSPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs/CMHSPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.

- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2023 performance indicator reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

PMV Activities

HSAG conducted PMV virtually with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the IS, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for

verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

Description of Data Obtained and Related Time Period

As identified in CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **ISCAT—**HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDHHS' and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each PIHP (if applicable) and from MDHHS (for the indicators calculated by MDHHS). If the PIHP did not produce source code to generate the performance indicators, the PIHP submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by MDHHS.
- **Previous Performance Measure Results Reports—**HSAG obtained these reports from MDHHS and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results—**HSAG obtained the calculated results from MDHHS and each PIHP.

- **Virtual On-Site Interviews and Demonstrations**—HSAG also obtained information through interaction, discussion, and formal interviews with key PIHP and MDHHS staff members as well as through virtual on-site systems demonstrations.

Table A-2 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-2—Data Sources and Time Frames

Data Sources	Period to Which Data Applied
ISCAT (from PIHPs)	SFY 2023 and Q1 SFY 2024
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2023 and Q1 SFY 2024
Previous performance measure results reports (from MDHHS)	SFY 2023
Performance measure results (from PIHPs and MDHHS)	SFY 2023 and Q1 SFY 2024
Supporting documentation (from PIHPs and MDHHS)	SFY 2023 and Q1 SFY 2024
Virtual interviews and systems demonstrations (from PIHPs)	July 19–August 6, 2024

Table A-3 displays the performance indicators calculated by the PIHPs, and Table A-4 displays the performance indicators calculated by MDHHS that were included in the validation of performance measures, the subpopulations, the validation review period to which the data applied, and the agency responsible for calculating the indicator.

Table A-3—Performance Indicators Calculated by the PIHPs

Indicator		Sub-Populations	Measurement Period
#1	*The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*	• Children • Adults	Q1 SFY 2024
#2	*The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Q1 SFY 2024

Indicator		Sub-Populations	Measurement Period
#3	*The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.*	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Q1 SFY 2024
#4a	*The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.*	• Children • Adults	Q1 SFY 2024
#4b	*The percent of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days.*	• Consumers	Q1 SFY 2024
#10	*The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*	• Children • Adults	Q1 SFY 2024

Table A-4—Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#2e	*The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.*	• Consumers	Q1 SFY 2024
#5	*The percent of Medicaid recipients having received PIHP managed services.*	• Medicaid Recipients	Q1 SFY 2024
#6	*The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*	• HSW Enrollees	Q1 SFY 2024
#8	*The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.*	• MI–Adults • DD–Adults • MI and DD–Adults	SFY 2023

Indicator		Sub-Populations	Measurement Period
#9	*The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*	• MI–Adults • DD–Adults • MI and DD–Adults	SFY 2023
#13	*The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.*	• DD–Adults • MI and DD–Adults	SFY 2023
#14	*The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.*	• MI–Adults	SFY 2023

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the PIHP provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to the MPSs) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the PIHPs contracted with MDHHS to deliver services to Michigan's Behavioral Health Managed Care program members.

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2024 through SFY 2026. MDHHS requested that HSAG conduct a review of the first half of the standards (with the exception of Standard II) in Year One (SFY 2024) and a review of the remaining half of the standards in Year Two (SFY 2025). The SFY 2026 (Year Three) compliance review will consist of a review of the standards and elements that required a CAP during the SFY 2024 (Year One) and SFY 2025 (Year Two) compliance review activities.

Table A-5 outlines the standards reviewed over the three-year review cycle.

Table A-5—Division of Standards Over Review Periods

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of the PIHP's Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[4]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan MHPs. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 due to upcoming changes in PIHP financial liability of emergency services and pending guidance from MDHHS.

[4] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

MDHHS and the individual PIHPs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the tools was selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between MDHHS and the PIHP as they related to the scope of the review. The review processes used by HSAG to evaluate the PIHP's compliance were consistent with the CMS EQR Protocol 3.

HSAG's review consisted of the following activities for each of the PIHPs:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.

- Prepared and forwarded to the PIHP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review documentation tracker.
- Scheduled the site review with the PIHP.
- Hosted a pre-site review preparation session with all PIHPs.
- Generated a list of 10 sample records for service and payment denial case file reviews.
- Conducted a desk review of supporting documentation that the PIHP submitted to HSAG.
- Followed up with the PIHP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the one-day site review interview session and provided the agenda to the PIHP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed PIHP key program staff members.
- Conducted a review of service and payment denial records.
- Conducted an IS review of the data systems that the PIHP used in its operations, applicable to the standards/elements under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the PIHP.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared a report and CAP template for the PIHP to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the PIHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the PIHP during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the PIHP were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the PIHP's service and payment denials to verify that the PIHP had implemented what the PIHP had documented in its policy. HSAG selected 10 records for service and payment denials from the full universe of records provided by the PIHP. The file reviews were not intended to be a statistically significant representation of all the PIHP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by the PIHP staff members. Based on the results of the file reviews, the PIHP must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the PIHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the PIHP's progress in achieving compliance with State and federal requirements.

- Scores assigned to the PIHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to MDHHS staff members for their review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess the PIHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the PIHP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for service and payment denials.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the PIHP's key staff members. Table A-6 lists the major data sources HSAG used to determine the PIHP's performance in complying with requirements and the time period to which the data applied.

Table A-6—Description of PIHP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	Prior to April 30, 2024
Information obtained from a review of a sample of service and payment denial files	Denials that occurred between October 1, 2023, and March 31, 2024
Information obtained through interviews	August 19, 2024–September 16, 2024

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses for each PIHP individually, HSAG used the results of the program areas reviewed, including comprehensive case file reviews for two program areas. As any element not achieving compliance required a formal action plan, HSAG determined each PIHP's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area with more than three elements with a *Not Met* score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the PIHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Network Adequacy Validation

Activity Objectives

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, or PAHPs are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the MDHHS-defined network adequacy indicators reported by the PIHPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by MDHHS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the PIHPs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[9]

HSAG conducted a virtual review with the PIHPs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each PIHP included the following:

- Opening meeting
- Review of the ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

HSAG conducted interviews with key PIHP staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained and Related Time Period

HSAG prepared a document request packet that was submitted to each PIHP outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each PIHP information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the PIHP to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the PIHP to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions
- Network Adequacy Reporting Template submission to MDHHS using dates of service from October 1, 2022, through September 30, 2023. "NA," as used throughout a PIHP's performance results, means "Not Applicable." This designation is applied in cases where a PIHP has no members to serve, has no available service providers in the area, or when the concept of urbanicity does not apply to the PIHP's region. Additionally, "NA" is used when a particular designation does not apply to the PIHP.

Process for Drawing Conclusions

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-7.

Table A-7—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-8 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-8—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

By assessing each PIHPs performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the PIHPs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table A-9.

Table A-9—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance		✓	✓

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2024, MDHHS contracted with HSAG to conduct an EDV activity. HSAG conducted the following core evaluation activity for all 10 PIHPs:

- MRR—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing the MDHHS' electronic encounter data to the information documented in the corresponding members' medical records for services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records* in the CMS EQR Protocol 5.

The review aimed to verify whether key data elements in the encounter data (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*), were supported by the information found in the medical records. The goal was to answer the following question:

- Are the data elements in the professional encounters complete and accurate when compared to information contained within the medical records?

Technical Methods of Data Collection and Analysis

The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Eligible Population Identification and Sampling**: HSAG identified eligible members continuously enrolled in the PIHP during the review period and generated a sample of members based on this eligibility. Random sampling was used to select 411 members from the eligible population for each PIHP. If a PIHP had less than 411 cases that were eligible for the review, all eligible cases were included in the review. The SURVEYSELECT procedure in SAS®,[10] was used to randomly select one professional visit for each sampled member. During the procurement period, MDHHS recommended reducing the burden on the PIHPs for the EDV activity. Consequently, the PIHPs were instructed to reduce the originally selected cases by 25 percent. This adjustment resulted in a total of 308 sampled cases, down from the initial 411.
- **Medical Record Procurement**: Each PIHP procured medical records from contracted providers and submitted to HSAG through a secure data exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide PIHPs in the procurement process.

[10] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

- **Review Process**: HSAG's trained reviewers verified whether the selected service date from MDHHS' encounter data could be matched with the medical record. For any discrepancies, reviewers documented omissions or inaccuracies.
- **Data Collection and Tool**: An HSAG-designed electronic data collection tool was used to ensure consistency in documenting findings. This tool included built-in checks to ensure data accuracy.
- **Data Validation and Quality Control**: HSAG reviewers underwent thorough training and interrater reliability testing, and the collected data were cross-checked to ensure consistency and accuracy throughout the review process.
- **Review Indicators and Analysis**: After the data collection, HSAG analysts conducted data analysis using specific review indicators. Table A-10 displays the review indicators that were used to report the MRR results.

Table A-10—MRR Indicators

Review Indicator	Denominator	Numerator
Medical Record Procurement Rate: Percentage of medical records submitted. Additionally, the reasons for missing medical records were presented.	Total number of requested sample cases.	Number of requested sample cases with medical records submitted for either the sampled date of service or the second date of service.
Second Date of Service Submission Rate: Percentage of sample cases with a second date of service submitted in the medical records.	Number of sample cases with medical records submitted.	Number of sample cases with a second date of service submitted in the medical records.
Medical Record Omission Rate: Percentage of data elements (e.g., *Date of Service*) identified in MDHHS' data warehouse that are not found in the members' medical records. HSAG calculated the review indicator for each data element.	Total number of data elements (e.g., *Date of Service*) identified in MDHHS' data warehouse (i.e., based on the sample dates of service and the second dates of service that are found in MDHHS' data warehouse).	Number of data elements (e.g., *Date of Service*) in the denominator but not found in the medical records.
Encounter Data Omission Rate: Percentage of data elements (e.g., *Date of Service*) identified in members' medical records, but not found in MDHHS' data warehouse. HSAG calculated the review indicator for each data element.	Total number of data elements (e.g., *Date of Service*) identified in members' medical records (i.e., based on the medical records procured for the sample dates of service and second dates of service).	Number of data elements (e.g., *Date of Service*) in the denominator but not found in MDHHS' data warehouse.
Diagnosis Code Accuracy: Percentage of diagnosis codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of diagnosis codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the	Number of diagnosis codes supported by the medical records.

Review Indicator	Denominator	Numerator
	second dates of service) that exist in both MDHHS' encounter data and the medical records. • Diagnosis codes present for both MDHHS' encounter data and the medical records.	
Procedure Code Accuracy: Percentage of procedure codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of procedure codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the medical records. • Procedure codes present for both MDHHS' encounter data and the medical records.	Number of procedure codes supported by the medical records.
Procedure Code Modifier Accuracy: Percentage of procedure code modifiers supported by the medical records.	Total number of procedure code modifiers that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the medical records. • Procedure code modifiers present for both MDHHS' encounter data and the medical records.	Number of procedure code modifiers supported by the medical records.
All-Element Accuracy Rate: Percentage of dates of service present in both MDHHS' encounter data and the medical records, with the same values for all data elements.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that are in both MDHHS' encounter data and the medical records.	The number of dates of service in the denominator with the same diagnosis codes, procedure codes, and procedure code modifiers for a given date of service.

Description of Data Obtained and Related Time Period

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2022, through September 30, 2023.
- Member demographic and enrollment data.
- Provider data.

Data obtained from the PIHPs included:

- Medical records for services rendered from October 1, 2022, through September 30, 2023.

Process for Drawing Conclusions

To draw conclusions about the encounter data completeness and accuracy between each PIHP's medical records, and the key data elements from MDHHS' encounter data, HSAG analyzed the results using key metrics previously described. To identify areas of strengths and weaknesses, HSAG leveraged its extensive experience working with other states in assessing the completeness and accuracy of encounter data, and medical records. This approach provided a comparative framework that enabled a thorough assessment of each PIHP's performance. HSAG determined each PIHP's substantial strengths and weaknesses as follows:

- Strength—Identified areas where data completeness and accuracy were consistently high, highlighting best practices and successful methodologies implemented by the PIHPs.
- Weakness—Highlighted areas with recurring data errors or omissions, assessing the impact on overall data reliability and compliance with MDHHS' requirements.

Additionally, for each identified weakness, HSAG provided recommendations to support improvements in the quality of encounter data submissions to MDHHS, aiming to enhance data integrity and ensure alignment with state requirements.