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State Fiscal Year 2022 External Quality Review Technical Report *for* Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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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 42 Code of Federal Regulations (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)[1-1] 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).[2-1] The PIHPs contracted with MDHHS during state fiscal year (SFY) 2022 are displayed in Table 1-1.

Table 1-1—PIHPs in Michigan

PIHP Name	PIHP Short Name
NorthCare Network	NCN
Northern Michigan Regional Entity	NMRE
Lakeshore Regional Entity	LRE
Southwest Michigan Behavioral Health	SWMBH
Mid-State Health Network	MSHN
Community Mental Health Partnership of Southeast Michigan	CMHPSM
Detroit Wayne Integrated Health Network	DWIHN
Oakland Community Health Network	OCHN
Macomb County Community Mental Health	MCCMH
Region 10 PIHP	Region 10

[1-1] MDHHS announced the creation of BPHASA effective March 21, 2022. The BPHASA combined Michigan's Medicaid office, services for aging adults, and community-based services for adults with I/DD, SMI, and SUDs under one umbrella within MDHHS. For more information, refer to https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/behavioral-and-physical-health-and-aging-services.

[1-2] The PIHPs serve Medicaid members included under the following: 1115 Demonstration Waiver, 1915(i); 1115 Healthy Michigan Plan (HMP); Flint 1115 Waiver; the Community Block Grant; 1915(c) Habilitation Supports Waiver (HSW); 1915(c) Children Waivers (Serious Emotional Disturbance Waiver [SEDW] and Children's Waiver Program [CWP]); and the SUD Community Grant.

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 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 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).[1-3] The purpose of these 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 2022 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 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.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 11, 2023.

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
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
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 Children's Health Insurance Program (CHIP) Managed Care Regulations

Michigan Behavioral Health Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2022 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)[1-4] and support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid members.

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

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Ensure high quality and high levels of access to care	**Conclusions:** Through its contract with the PIHPs, MDHHS established network adequacy standards for the Michigan Behavioral Health Managed Care program that supports the needs of its members with mental illness and SUD diagnoses. These	☒ Quality ☒ Timeliness ☒ Access

[1-4] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Jan 9, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	standards include time and distance standards as well as Medicaid member-to-provider ratios for services provided to both adult and child members. The PIHPs were required to have a plan for how they effectuated each network adequacy standard, and plans had to address maximum time and distance; timely appointments; and language, cultural competence, and physical accessibility. The PIHPs were also required to report performance measure data to MDHHS on a scheduled basis using the specifications documented in the PIHP Reporting Codebooks included as part of Michigan's Mission-Based Performance Indicator System (MMBPIS). Performance measure data were published to MDHHS' website approximately 30 days after the reporting due date. Through the EQR PMV, HSAG determined that all but one PIHP had reportable rates, indicating that MDHHS could use most of the data reported by the PIHPs in its quality improvement (QI) efforts. Additionally, of the 13 performance measures included under MMBPIS, four measures have an MDHHS-established minimum performance standard (MPS), and three of the four measures are further stratified by populations for a total of seven indicators having an established MPS. Programwide, the MPS of 95 percent was met for performance 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*, for both the child and adult populations; the MPS of 95 percent was met for performance indicator #4b, *the percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*, for the eligible population; and the MPS of 15 percent was met for performance indicator #10, *the percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge*, for both the child and adult populations. These findings indicate that most members receiving services through the PIHPs received timely pre-admission screening dispositions for psychiatric inpatient care, and that members discharged from a substance abuse detox unit were seen by a SUD provider in a timely manner after discharge. Overall, there was also a low prevalence of members being readmitted to an inpatient psychiatric unit within 30 days of hospital discharge. However, programwide, performance indicator #4a, *the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*, did not meet the MPS of 95 percent for either the children or the adult population, and performance declined substantially from the 2021 rates for this indicator. These findings suggest that members were not being seen at all or were not being seen in a timely manner after being	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	discharged from psychiatric inpatient units. This could be the result of ineffective transitions of care processes or an insufficient network of mental health providers to provide services to the Medicaid members with diagnosed mental illnesses. Further, although no MPS was established by MDHHS for performance indicators #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.*; and #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*, these indicators specifically assess how quickly new members requesting non-emergency services can obtain biopsychosocial assessments and access SUD and/or mental health treatment. Statewide rates show a decline in performance from 2021 to 2022 for all three performance indicators and all applicable populations, indicating substantial opportunities for MDHHS and its PIHPs to ensure new child and adult Medicaid members can access timely SUD and mental health treatment. **Recommendations:** To further support its efforts to effectively monitor the quality and timeliness of, and access to healthcare services furnished to Medicaid members, MDHHS should establish MPSs for performance indicators #2, #2e, and #3 and require the PIHPs to submit corrective action plans (CAPs) for any deficiencies identified through MDHHS' monitoring processes for all performance indicators with an established MPS. Additionally, although HSAG conducted validation of the SFY 2022 Quarter 1 (Q1) performance indicator rates, MDHHS published performance indicator reports quarterly, which occurred prior to the completion of PMV. Through the data validation process, one PIHP received a designation of *Do Not Report (DNR)* for indicator #3, indicating the PIHP did not calculate this indicator in compliance with MDHHS' PIHP Codebook specifications. Therefore, the rate published on MDHHS' website was inaccurate and incomparable to the other PIHPs and should not be used by MDHHS in its QI activities. MDHHS may want to consider only publishing performance indicator data that have been validated by its EQRO or by MDHHS through other validation activities. Additionally, when the rates are published prior to PMV completion, a PIHP could potentially correct an identified deficiency and submit an accurate rate to MDHHS instead of receiving a *DNR* designation. Therefore, to	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	provide MDHHS with the opportunity to obtain the most accurate data possible in support of the evaluation of PIHP performance indicators, MDHHS could also consider allowing the PIHPs to resubmit the updated, accurate performance indicator data to MDHHS when issues are identified through PMV. Further, MDHHS could consider requiring the PIHPs to report final, updated, quarterly performance indicator data to MDHHS, upon conclusion of the annual PMV, so that these final rates can be used to assess overall progress with achieving the related CQS goals and objectives. Through MDHHS' process to review and update its CQS, HSAG also recommends that MDHHS consider adding a table within the CQS that outlines the specific performance measures and performance targets associated with each objective listed under each of the five Quality Strategy goals. Because the CQS includes all managed care programs in the State, MDHHS should specify each program's specific performance measure(s) that align to each of the objectives as they are applicable to the program or programs (i.e., what metric is used to assess the performance of each objective at the program level to determine overall progress with achieving each Quality Strategy goal). For the existing objectives that are not able to be supported through standardized performance measures, MDHHS could consider developing new objectives, or revise its existing objectives, to be specific, measurable, attainable, relevant, and time-bound (SMART).	
Goal 2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS, through its contract with the PIHPs, requires that all PIHP staff members are trained and possess current, working knowledge of the populations served, person-centered planning, self-determination, recovery and resiliency, cultural competency, etc. MDHHS also requires the PIHPS to work in collaboration with the Medicaid Health Plans (MHPs) on several pay-for-performance (P4P) measures, including that each MHP and PIHP must document joint care plans for members with appropriate severity/risk, who have been identified as receiving services from both entities. The PIHPs must also work in collaboration with the MHPs on *Follow-Up After Hospitalization for Mental Illness within 30 Days and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* performance measures. Further, for SFY 2022, the PIHPs were required to report performance measure data to MDHHS in support of Goal 2, that was validated through the PMV, including MMBPIS performance indicator #8, *the percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs [Community Mental Health Services Programs] *and PIHPs who are employed competitively*; performance indicator #9, t*he percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities*; performance indicator #13, *the percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s)*; and performance indicator #14, *the percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* Although MDHHS has not set benchmarks for these performance indicators, since the prior year, more MI Adults and I/DD Adults are employed competitively, and more MI Adults and I/DD Adults earn at least minimum wage from employment activities. There was also a slight increase in the percentage of adults with SMI who lived in a private residence alone, with a spouse, or with a non-relative than the prior year. The percentage of I/DD Adults and MI and I/DD Adults who lived in a private residence alone, with a spouse, or with a non-relative remained stable over the last two years. **Recommendations:** MDHHS could consider developing initiatives for the PIHPs related to performance indicators #8, #9, #13, and #14 that will support an increase in the prevalence rates related to employment, minimum wage pay, and housing particularly when these areas are identified as goals through members' person-centered care plans. As part of the initiatives, MDHHS could require the PIHPs to report successes and any noted barriers through the Quality Assessment and Performance Improvement (QAPI) program evaluation that PIHPs are required to submit to MDHHS annually.	
Goal 3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	**Conclusions:** Many Medicaid members receiving services from PIHPs are also enrolled in an MHP for their healthcare services. The MHP is responsible for non-specialty-level mental health services. Therefore, MDHHS requires the PIHPs to have a written agreement with each MHP serving any part of the PIHPs' service areas. The written agreement must describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination, and dispute resolution. At a minimum, these arrangements must address the integration of	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	physical and mental health services provided by the MHP and the PIHP for their shared members. In addition to MDHHS requiring collaborative activities with the MHPs to support coordinated care (e.g., shared performance measures), MDHHS requires the PIHPs to calculate and report MMBPIS performance indicators that demonstrate the effectiveness of the PIHPs' care coordination efforts. For example, as indicated through the SFY 2022 PMV activity, MDHHS evaluated these efforts under performance indicator #10, *the percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* Statewide, the PIHPs performed better than the MPS of 15 percent (i.e., rates are lower than 15 percent) for both the children and the adult populations, and performance improved from the 2021 rates for the associated indicators. Strong performance in this program area implies that the PIHPs implemented effective care coordination processes, such as ensuring members had effective transition plans prior to discharge, including appointments for follow-up services, crisis or relapse prevention plans, discharge medications, and referrals to other services as necessary to prevent readmission. Further, through the compliance review activity, the Behavioral Health Managed Care program demonstrated moderate performance in the Practice Guidelines standard, indicating that most providers providing mental health and SUD services were informed of the MDHHS-required policies that support these services. **Recommendations:** MDHHS has established common program-specific quality metrics across the PIHPs and MHPs to support the integration of services. However, HSAG recommends that the CQS be revised to specifically tie these metrics to the objectives under Goal 3.	
Goal 4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, the PIHPs were responsible for initiating a new PIP to address healthcare disparities. While MDHHS did not mandate a statewide topic, the PIHPs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicator(s). Through the PIHPs' analyses of their data, eight of the 10 PIHPs identified existing racial and ethnic disparities. Through the PIP activity, the PIHPs will implement interventions aimed at eliminating those racial and ethnic disparities. As demonstrated through the SFY 2022 PIP validation, nine of the 10 PIHPs designed a methodologically sound PIP that should support improvement in health outcomes and reduce disparities within the Behavioral Health Managed Care program.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: MDHHS has required PIPs to support the reduction in racial and ethnic disparities. As the PIPs progress and the PIHPs identify interventions, MDHHS should review the planned interventions to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. Additionally, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal 3.	
Goal 5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** Contract withhold arrangements and the Performance Bonus Incentive Program have been established by MDHHS to support program initiatives as specified in the MDHHS CQS. The Performance Bonus Incentive Pool includes PIHP/MHP joint metrics that require collaboration between the two entities for the ongoing coordination and integration of behavioral health and physical health services. The PIHPs and MHPs are also responsible for collectively reporting data pertaining to the follow-up after hospitalization for mental illness within 30 days and follow-up after an emergency department (ED) visit for alcohol and other drug dependence. However, the aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reform had on improving quality outcomes. **Recommendations:** MDHHS should consider revising the CQS to include the specific performance metrics MDHHS uses to evaluate progress toward achieving Goal 5. While MDHHS stipulates its expectations related to value-based initiatives and payment reforms within its contract with the PIHPs, HSAG did not evaluate the results of these activities as part of this EQR since they are not included as part of the annual EQR activities. Therefore, no additional recommendations can be provided in support of Goal 5.	☒ Quality ☐ Timeliness ☐ Access

2. Overview of the Prepaid Inpatient Health Plans

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Effective March 2021, BPHASA combined Michigan's Medicaid office, services for aging adults and community-based services for adults with I/DD, SMI, and SUDs under one umbrella within MDHHS. BPHASA is also the designated State Unit on Aging. Prior to March 2021, the Michigan Medicaid managed care programs were administered by separate divisions within MDHHS. The creation of BPHASA integrates MDHHS teams that focus on aging and long-term care issues and allows BPHASA to develop innovative policies that benefit Michigan and its residents. The restructure also builds on the administration's existing efforts to deliver services to adults with mild to moderate mental illness. Table 2-1 displays the Michigan managed care programs and the MCE(s) responsible for providing services to members.

Table 2-1—SFY 2022 Michigan Managed Care Programs

Medicaid Managed Care Program	MCEs
Comprehensive Health Care Program (CHCP), including: • Children's Health Insurance Program (CHIP)—MIChild • Children's Special Health Care Services Program • Healthy Michigan Plan (HMP) (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)
Managed Long-Term Services and Supports (LTSS), including: • MI Health Link Demonstration • MI Choice Waiver Program • Program of All-Inclusive Care for the Elderly (PACE)	Integrated Care Organizations (ICOs) Prepaid Ambulatory Health Plans (PAHPs, also referred to as waiver agencies) PACE organizations
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • HMP Dental	Dental PAHPs
Behavioral Health Managed Care	PIHPs

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 Community Mental Health Services Programs (CMHSPs). Michigan uses a managed care delivery structure including 10 PIHPs who contract for service delivery with 46 CMHSPs and other not-for-profit 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 QI 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[2-1]

PIHP	Operating Region	Affiliated CMHSP(s)
NCN	Region 1	Pathways Community Mental Health [CMH], Copper Country CMH, Hiawatha CMH, Northpointe CMH, Gogebic CMH
NMRE	Region 2	AuSable CMH, Centra Wellness Network, North Country CMH, Northern Lakes CMH, Northeast CMH
LRE	Region 3	Allegan CMH, Muskegon CMH, Network 180, Ottawa CMH, West MI [Michigan] CMH
SWMBH	Region 4	Barry CMH, Berrien CMH, Kalamazoo CMH, Pines CMH, St. Joseph CMH, Summit Pointe CMH, Van Buren CMH, Woodlands CMH

[2-1] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration. *10 Region PIHP Directors & Affiliates.* Available at: https://www.michigan.gov/documents/PIHPDIRECTOR_97962_7.pdf. Accessed on: Jan 9, 2023.

PIHP	Operating Region	Affiliated CMHSP(s)
MSHN	Region 5	Bay-Arenac CMH, CMH for Central MI, CEI [Clinton-Eaton-Ingham] CMH, Gratiot CMH, Huron CMH, Ionia CMH, Lifeways CMH, Montcalm CMH, Newaygo CMH, Saginaw CMH, Shiawassee CMH, Tuscola CMH
CMHPSM	Region 6	Washtenaw CMH, Lenawee CMH, Livingston CMH, Monroe CMH
DWIHN	Region 7	Detroit-Wayne CMH
OCHN	Region 8	Oakland CMH
MCCMH	Region 9	Macomb CMH
Region 10	Region 10	Genesee CMH, Lapeer CMH, Sanilac CMH, St. Clair CMH

Quality Strategy

The 2020–2023 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, 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 2020–2023 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 also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. Michigan's CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Ojectives[2-2]

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes consumers' health and safety.
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1**: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.

[2-2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Jan 9, 2023.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of 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		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

The CQS also includes a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule. The common domains include:

- Network Adequacy and Availability
- Access to Care
- Member Satisfaction
- Health Equity

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the CQS.

Quality Initiatives and Interventions

Through its CQS, MDHHS has also implemented many initiatives and interventions that focus on QI. 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 (IT)/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 social determinants of health, 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 QI 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).

3. Assessment of Prepaid Inpatient Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2022 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 weakness 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 2022 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 process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2022 PIP activity, the PIHPs initiated new PIP topics that focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator. HSAG conducted validation on the PIP Design stage (Steps 1 through 6) and Implementation stage (Steps 7 and 8, as applicable) of the selected PIP topic for each PIHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS Protocol 1). Table 3-1 outlines the selected PIP topics and performance indicator(s) as defined by each PIHP.

Table 3-1—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* [COD] *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* [Opioid Health Home] *Services, Enrolled in the Service, and are Retained in the Service*	Client enrollment.
LRE	*FUH* [Follow-up After Hospitalization for Mental Illness] *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* [ED] *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 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 Black/African American Population and the White Population*	1. The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. 2. The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

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

Performance Measure Validation

For the SFY 2022 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 CMS' EQR protocol for the validation of performance measures (CMS Protocol 2) and included a PIHP information systems capabilities assessment (ISCA) and a review of data reported for the first quarter of SFY 2022.

Based on all validation methods used to collect information during the Michigan SFY 2022 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 3-2.

Table 3-2—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 during the quarter that were 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 percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.
#9	The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

Compliance Review

SFY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the MDHHS-contracted PIHPs comprise 13 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable state-specific contract requirements and areas of focus identified by MDHHS. HSAG conducted a review of the first six standards in Year One (SFY 2021). For SFY 2022, the remaining seven standards were reviewed (Year Two of the cycle). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 3-3 outlines the standards reviewed over the three-year compliance review cycle. The compliance review activity was conducted in accordance with CMS' EQR protocol for the review of compliance with Medicaid and CHIP managed care regulations (CMS Protocol 3).

Table 3-3—Three-Year Cycle of Compliance Reviews

Compliance Review Standards	Associated Federal Citations[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.10 §438.100	✓		Review of PIHPs' implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		

Compliance Review Standards	Associated Federal Citations[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] The Health Information Systems standard includes an assessment of each PIHP's information system (IS) capabilities.

External Quality Review Activity Results

Region 1—NorthCare Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **NorthCare Network**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-4 displays the overall validation status and the baseline results for the performance indicator. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-4—Overall Validation Rating for NCN

PIP Topic	Validation Status	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring Treatment from a Network Provider	*Met*	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.	17.78%		

R1 = Remeasurement 1
R2 = Remeasurement 2

The goal for **NorthCare Network**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-5 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-5—Baseline Interventions for NCN

Intervention Descriptions
NorthCare Network had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: NorthCare Network designed a methodologically sound PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses. [**Quality**]

Recommendation: Although there were no identified weaknesses, HSAG recommends that **NorthCare Network** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner. As the PIP progresses, **NorthCare Network** should also ensure it has effective processes for reassessing the identified barriers and develop active, targeted interventions that can be tracked and trended to determine each intervention's impact on the indicator outcomes.

Performance Measure Validation

HSAG evaluated **NorthCare Network**'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.

NorthCare Network 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **NorthCare Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-6 presents **NorthCare Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **NorthCare Network** met or exceeded the MPS.

Table 3-6—Performance Measure Results for NCN

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	98.99%	95.00%
#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.		
MI–Children—Indicator #2a	71.88%	NA
MI–Adults—Indicator #2b	64.63%	NA
I/DD–Children—Indicator #2c	55.56%	NA
I/DD–Adults—Indicator #2d	63.64%	NA
Total—Indicator #2	66.79%	NA
#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]		
Consumers	74.56%	NA
#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–Children—Indicator #3a	72.73%	NA
MI–Adults—Indicator #3b	67.38%	NA
I/DD–Children—Indicator #3c	78.57%	NA
I/DD–Adults—Indicator #3d	55.00%	NA
Total—Indicator #3	69.21%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	95.65%	95.00%
Adults	97.30%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.84%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	92.97%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	17.39%	—
I/DD–Adults—Indicator #8b	7.90%	—
MI and I/DD–Adults—Indicator #8c	8.14%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	100.00%	—
I/DD–Adults—Indicator #9b	92.75%	—
MI and I/DD–Adults—Indicator #9c	95.24%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	20.83%	15.00%
MI and I/DD–Adults—Indicator #10b	10.23%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	16.93%	—
MI and I/DD–Adults	20.56%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	53.73%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: NorthCare Network has shown strides in increasing the completeness and accuracy of data by proactively working with Peter Chang Enterprises, Inc. (PCE), toward implementing inpatient hospital electronic submission. As a result of HSAG's SFY 2020 and 2021 audit recommendations, **NorthCare Network** worked toward allowing inpatient services to be directly entered into ELMER (the PIHP's information system), and PCE has completed programming for inpatient hospital electronic submission. It is currently in the testing phase, and once the testing phase is complete, it will be rolled out first to one of its larger, contracted hospital systems. [**Quality**, **Timeliness**, and **Access**]

Strength #2: NorthCare Network has continued to improve upon accuracy of data by ensuring alignment between its member-level data provided to HSAG and final rates reported to MDHHS. During the SFY 2022 audit, HSAG was able to easily confirm that the data counts and rates from the member-level data provided to HSAG and the final rates reported to MDHHS aligned. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upon HSAG's review of the indicator #2 member-level data provided, it was noted that there were cases listed as "In-Compliance" in the member-level detail file for indicator #2 that either had a completed biopsychosocial assessment date outside of 14 days or no biopsychosocial assessment date listed. [**Quality**]

Why the weakness exists: NorthCare Network confirmed that the incorrect biopsychosocial assessment dates were populated for these cases. The biopsychosocial assessment dates were updated in the member-level data for all cases, and HSAG confirmed that they were all within the 14-day criteria.

Recommendation: While no other cases were identified with incorrect biopsychosocial assessment dates, to further ensure the accuracy of its reported data, HSAG recommends for future reporting that **NorthCare Network** further enhance its validation process by conducting a quality check prior to submission of data for cases listed as compliant with blank biopsychosocial assessment dates or dates outside of the 14-day criteria.

Weakness #2: Upon HSAG's review of the indicator #4a member-level data provided, it was noted that there were cases listed as "In-Compliance" in the member-level detail file for indicator #4a that had a follow-up care date beyond seven days of discharge from a psychiatric inpatient unit or no follow-up care date listed. [**Quality**]

Why the weakness exists: **NorthCare Network** confirmed that the incorrect follow-up care dates were populated for these cases. The follow-up care dates were updated in the member-level data for both cases, and HSAG confirmed that they were all within the seven-day criteria.

Recommendation: While no other cases were identified with incorrect follow-up care dates, to further ensure the accuracy of its reported data, HSAG recommends for future reporting that **NorthCare Network** further enhance its validation process by conducting a quality check prior to submission of data for cases listed as compliant with follow-up care dates outside of the seven-day criteria or with no follow-up care date listed.

Weakness #3: Upon HSAG's review of indicator #1 member-level data provided, HSAG identified one member's pre-admission screening for psychiatric inpatient care completion time was documented as zero minutes. [**Quality**]

Why the weakness exists: The PIHP indicated that this inaccurate time resulted from an individual staff member making a data entry error.

Recommendation: Although there was only one member record identified that had an elapsed time of zero minutes, for future reporting, HSAG recommends the PIHP conduct an additional final review of the detailed data for indicator #1 and specifically look for members with zero minutes reported as the elapsed time. HSAG also recommends that the PIHP explore potential system changes that PCE could implement that may assist in preventing inaccurate data entry of time of decision for reporting indicator #1.

Weakness #4: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted five **NorthCare Network** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in five member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends **NorthCare Network** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered.

Weakness #5: While **NorthCare Network** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to reduce readmissions of MI and I/DD children to an inpatient psychiatric unit within 30 days of discharge, as the PIHP did not meet the MPS for this indicator (i.e., *#10a: The percentage of readmissions of MI an I/DD children during the quarter to an inpatient psychiatric unit within 30 days of discharge*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for indicator #10a was above the MPS by over 5 percentage points, suggesting that some MI and I/DD children may have been prematurely discharged from an inpatient psychiatric unit or that post-discharge follow-up was not timely or adequate. **NorthCare Network** identified staffing shortages as a significant barrier overall for ensuring timely access to care across their region.

Recommendation: HSAG recommends that **NorthCare Network** focus its efforts on reducing the number of inpatient psychiatric unit readmissions for MI and I/DD children by working with providers on adequate discharge planning, patient education, and coordination of services post-

discharge. In addition, HSAG recommends that **NorthCare Network** educate providers on the potential of telemedicine as an option for providing post-discharge follow-up care and encourage members to access follow-up services via telemedicine where possible.

Compliance Review

Performance Results

Table 3-7 presents **NorthCare Network**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **NorthCare Network** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **NorthCare Network**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-7—SFY 2021 and SFY 2022 Standard Compliance Scores for NCN

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**71%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**93%**
Standard VI—Coverage and Authorization of Services	§438.210	**82%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**100%**
Standard IX—Grievance and Appeal Systems	§438.228	**79%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**80%**
Standard XI—Practice Guidelines	§438.236	**86%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**90%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-8 presents **NorthCare Network**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **NorthCare Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **NorthCare Network** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-8—SFY 2022 Standard Compliance Review Scores for NCN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	11	0	0	**100%**
Standard IX—Grievance and Appeal Systems	38	38	30	8	0	**79%**
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	**80%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	27	3	0	**90%**
Total	**119**	**118**	**99**	**19**	**1**	**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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths for **NorthCare Network** through the compliance review activity.

Weaknesses and Recommendations

Weakness #1: NorthCare Network received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **NorthCare Network**'s processes were identified related to primary source verification (PSV); obtaining all required attestations, Medicare or Medicaid sanctions, and exclusions queries; timely credentialing decisions; provider-specific performance review at recredentialing; and written communication to providers of the credentialing decision.

Recommendation: While **NorthCare Network** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **NorthCare Network** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: NorthCare Network received a score of 79 percent in the Grievance and Appeal Systems program area, indicating that the PIHP had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. Of note, a total of eight deficiencies were identified. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **NorthCare Network**'s processes were identified related to grievance extension notices, resolution of grievances, acknowledgement of appeals, timely resolution of appeals, content of appeal resolution letters, oral notice of an expedited appeal resolution, timely reinstatement of services, and record retention time frames.

Recommendation: While **NorthCare Network** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of grievance and appeal processes completed by the PIHP and/or by its delegates. HSAG recommends that **NorthCare Network** conduct a comprehensive review of a random sample of grievance and appeal

files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

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

HSAG performed a comprehensive assessment of **NorthCare Network**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **NorthCare Network** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **NorthCare Network**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-9 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **NorthCare Network**'s Medicaid members.

Table 3-9—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **NorthCare Network** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **NorthCare Network** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although **NorthCare Network**'s child and adult members were also seen in a timely manner for follow-up care after psychiatric inpatient stays, which should have significantly reduced the risk of rehospitalization, a high prevalence of child members were being readmitted to the hospital or inpatient facility within 30 days of discharge. This finding could imply multiple factors, including that the lower level of care was not appropriate for the members' needs at the time of discharge; poor member outpatient visit compliance, when additional follow-up appointments were scheduled; difficulties accessing mental health professionals in a timely manner after the initial follow-up appointment; the parents/guardians of members were not satisfied with the provider or the plan of care being provided and stopped treatment; and/or the follow-up care was not successful at preventing the readmissions. As part of its QI efforts, **NorthCare Network** should analyze the reasons for all readmissions to determine the root cause and potential trends and implement interventions to mitigate barriers that may be contributing to the high rate of readmissions. Additionally, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **NorthCare Network**'s rates for the 11 related performance indicators were at or between 55.00 percent and 78.57 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, **NorthCare Network** demonstrated that

Performance Area	Overall Performance Impact
	it had an adequate QAPI program. As such, **NorthCare Network** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in areas where gaps are identified in member health outcomes. **NorthCare Network** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **NorthCare Network** demonstrated that its members discharged from psychiatric inpatient units and from substance abuse detox units were seen in a timely manner for follow-up care with a mental health or SUD professional, suggesting **NorthCare Network** had effective processes to transition members in a timely manner into outpatient care. Additionally, through the PIP activity, **NorthCare Network** is focusing efforts on increasing the percentage of its members ages 12 years and older who are diagnosed both with SUD and mental illness and receiving integrated treatment services. Specifically, through the PIP, **NorthCare Network** will identify barriers and implement interventions that will increase the delivery of evidenced-based SUD and mental health treatment concurrently to support more members toward full recovery, with the ultimate goal to improve members' overall health and functional status. In conjunction with these efforts, **NorthCare Network** should continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality**—As part of its efforts to identify disparities within its region, **NorthCare Network** documented within the PIP Submission Form that the largest diverse population in Region 1 is the American Indian/Alaska Native population, which comprises about 5.54 percent of the total population in Region 1. However, through its analyses, **NorthCare Network** determined American Indian/Alaska Native members were receiving a higher percentage of integrated services than the White population. **NorthCare Network** did identify a slight disparity in care in the prevalence of integrated services for members ages 12 to 25 years. Although Region 1 has not identified a statistically significant racial or ethnic disparity in healthcare, **NorthCare Network** should continue efforts to evaluate for and subsequently reduce any disparities (e.g., race, age, gender) to address health inequity in support of CQS Goal #4.

Region 2—Northern Michigan Regional Entity

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Northern Michigan Regional Entity**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met, Partially Met, Not Met).* Table 3-10 displays the overall validation status and the baseline results for the performance indicator. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-10—Overall Validation Rating for NMRE

PIP Topic	Validation Status	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
The Percentage of Individuals Who are Eligible for OHH Services, Enrolled in the Service, and are Retained in the Service	*Met*	Client Enrollment.	7.7%		

R1 = Remeasurement 1
R2 = Remeasurement 2

The goal for **Northern Michigan Regional Entity**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-11 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-11—Baseline Interventions for NMRE

Intervention Descriptions
Northern Michigan Regional Entity had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Northern Michigan Regional Entity designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Northern Michigan Regional Entity** use appropriate causal/barrier analysis methods to identify barriers to care and initiate active interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Northern Michigan Regional Entity**'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.

Northern Michigan Regional Entity 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Northern Michigan Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-12 presents **Northern Michigan Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Northern Michigan Regional Entity** met or exceeded the MPS.

Table 3-12—Performance Measure Results for NMRE

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	98.78%	95.00%
Adults—Indicator #1b	98.86%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#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–Children—Indicator #2a	53.15%	NA
MI–Adults—Indicator #2b	50.63%	NA
I/DD–Children—Indicator #2c	55.74%	NA
I/DD–Adults—Indicator #2d	46.88%	NA
Total—Indicator #2	51.61%	NA
#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]		
Consumers	64.41%	NA
#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–Children—Indicator #3a	63.22%	NA
MI–Adults—Indicator #3b	68.30%	NA
I/DD–Children—Indicator #3c	86.44%	NA
I/DD–Adults—Indicator #3d	81.82%	NA
Total—Indicator #3	68.13%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	100.00%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	95.65%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.66%	—
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	88.57%	—

Performance Indicator	Rate	Minimum Performance Standard
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	21.76%	—
I/DD–Adults—Indicator #8b	11.08%	—
MI and I/DD–Adults—Indicator #8c	15.55%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or 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%	—
I/DD–Adults—Indicator #9b	69.58%	—
MI and I/DD–Adults—Indicator #9c	94.59%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	5.00%	15.00%
MI and I/DD–Adults—Indicator #10b	11.95%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	20.85%	—
MI and I/DD–Adults	32.93%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	50.58%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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 to care.

Strengths

Strength #1: Northern Michigan Regional Entity continued to have thorough and effective processes in place regarding oversight of its affiliated CMHSPs and the tracing and validating of data throughout the performance measure calculation process. The PIHP replicates State validations in its internal processes wherever possible to minimize rejections and ensure the highest degree of data accuracy. It also uses a proactive approach with its provider network, looking for new ways to assist and collaborate, and anticipating future challenges with training and outreach. These are indicators of a dedicated approach to overseeing complex processes and delivering accurate results. [**Quality**]

Strength #2: Northern Michigan Regional Entity leverages technology and automation to streamline processes, reduce manual data entry, and ease administrative burden. The implementation of the new method for the CMHSPs to submit their indicators into **Northern Michigan Regional Entity**'s automated process is a strong example of its strategic leveraging of technology. This strategy can also be seen in the comprehensive dashboards and monitoring tools used with eligibility data and the encounter submission process. [**Quality**]

Strength #3: Northern Michigan Regional Entity demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: During the PSV portion of the review for indicators #4a and #4b, both indicators had a case that was manually changed from non-compliant to compliant in error. [**Quality**]

Why the weakness exists: Calculating performance indicators using standard processes and programming allows the accuracy of the results to be assessed based on review of that process. When manual changes to the data are applied outside of the calculations, it makes the results vulnerable to bias and error. While not all calculations can be automated, the introduction of manual changes can be balanced with increased scrutiny and documentation to ensure that the changes are clearly visible and reviewed in detail. The current review processes were unable to prevent these errors, indicating that additional structure may be needed.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** include an extra step in the calculation process to highlight manual changes to determination of compliance. The reviewer applying the manual change should document an extra note or comment in the system that

is dedicated to the rationale for the change. When **Northern Michigan Regional Entity**'s validation process occurs and the results are reviewed for accuracy, each note indicating the rationale for the change should be assessed for appropriateness and validated that there is sufficient evidence in the system to support the noted rationale. This is especially important when a non-compliant case is manually changed to compliant to ensure that the results do not appear inflated or biased.

Weakness #2: During the data integration and rate production portion of the review, it was noted that the providers were reluctant to provide any additional data beyond summary counts, which hinders the PIHP's ability to monitor the indicator and work with the providers on improving health outcomes and data quality. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Northern Michigan Regional Entity** noted that the providers do not feel the PIHP is entitled to the background information because the PIHP is not funding the services. The providers have interpreted the funding stream as an indicator that the PIHP does not need that level of data to perform its job function within the partnership.

Recommendation: HSAG recommends that the PIHP pursue this concern directly with MDHHS. The rationale for withholding the data from **Northern Michigan Regional Entity** is not consistent across the state, and other PIHPs are able to receive the data and report the measure with adequate oversight. The situation may require MDHHS intervention to define and standardize what level of data sharing is appropriate.

Weakness #3: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted two **Northern Michigan Regional Entity** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in two member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Compliance Review

Performance Results

Table 3-13 presents **Northern Michigan Regional Entity**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Northern Michigan Regional Entity** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Northern Michigan Regional Entity**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-13—SFY 2021 and SFY 2022 Standard Compliance Scores for NMRE

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**100%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**50%**
Standard V—Coordination and Continuity of Care	§438.208	**100%**
Standard VI—Coverage and Authorization of Services	§438.210	**64%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**
Standard IX—Grievance and Appeal Systems	§438.228	**84%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**80%**
Standard XI—Practice Guidelines	§438.236	**57%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**70%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-14 presents **Northern Michigan Regional Entity**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Northern Michigan Regional Entity**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Northern Michigan Regional Entity** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-14—SFY 2022 Standard Compliance Review Scores for NMRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	**80%**
Standard XI—Practice Guidelines	7	7	4	3	0	**57%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	21	9	0	**70%**
Total	**119**	**118**	**92**	**26**	**1**	**78%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths for **Northern Michigan Regional Entity** through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Northern Michigan Regional Entity received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Northern Michigan Regional Entity**'s processes were identified related to PSV, Medicare or Medicaid sanctions and exclusions queries, obtaining all required attestations, timely credentialing decisions, provider-specific performance review at recredentialing, and written communication to providers of the credentialing decision.

Recommendation: While **Northern Michigan Regional Entity** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Northern Michigan Regional Entity** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: Northern Michigan Regional Entity received a score of 57 percent in the Practice Guidelines program area, indicating that clinical practice guidelines (CPGs) were not being adopted in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of policies and procedures, committee meeting minutes, and communication materials, gaps in **Northern Michigan Regional Entity**'s processes were identified related to adopting CPGs in consultation with network providers, reviewing CPGs periodically, and disseminating CPGs to all affected providers.

Recommendation: While **Northern Michigan Regional Entity** was required to develop a CAP, HSAG recommends that the PIHP develop mechanisms to solicit provider network input when adopting a new CPG or during an annual review of existing adopted CPGs. **Northern Michigan Regional Entity** should adopt CPGs through a committee that includes provider network voting membership. **Northern Michigan Regional Entity** should consider a minimum voting quorum; for example, a minimum of five voting network providers of specified specialties. HSAG also

recommends that **Northern Michigan Regional Entity** include as an agenda item the annual scheduled review of existing adopted CPGs through this committee. Further, HSAG recommends that **Northern Michigan Regional Entity** notify its entire provider network (i.e., providers directly contracted with the PIHP and providers contracted with the PIHP's delegates) annually, and ad hoc for newly adopted CPGs, via a provider newsletter, of the availability of the adopted CPGs. The provider newsletter should also encourage network providers to contact **Northern Michigan Regional Entity** with comments or feedback about the existing adopted CPGs or with recommendations for potential future CPGs.

Weakness #3: Northern Michigan Regional Entity received a score of 70 percent in the Quality Assessment and Performance Improvement Program (QAPI) area, indicating that the PIHP had not developed or implemented a QAPI program in accordance with all contractual requirements. Of note, a total of nine deficiencies were identified. [**Quality**, **Timelines**, and **Access**]

Why the weakness exists: Through a review of the QAPI program and supporting documentation, gaps in **Northern Michigan Regional Entity**'s processes were identified related to the mechanisms for adopting and communicating process and outcome improvement, annual QAPI program timely submission to MDHHS, board of director (BOD) review of routine written reports, implementation of a second PIP, monitoring of time frames for reviewing sentinel events, reporting and analysis of the average length of time of intrusive or restrictive techniques, procedures for the assessment of member experience with services, comprehensive annual QAPI program evaluation, and dissemination of the QAPI program evaluation.

Recommendation: While **Northern Michigan Regional Entity** was required to develop a CAP, HSAG recommends that the PIHP conduct a comprehensive review of its QAPI program—specifically, the annual program description, workplan, and evaluation. This review should include a comparison of each individual QAPI program element required under **Northern Michigan Regional Entity**'s contract with MDHHS against the PIHP's current QAPI program. **Northern Michigan Regional Entity** should also leverage MDHHS' QAPI program checklist in this review. **Northern Michigan Regional Entity** could consider developing a crosswalk of each individual provision with a description of how/where the PIHP is or is not meeting the requirement. For gaps HSAG identified during the compliance review activity, and self-identified gaps through this crosswalk, **Northern Michigan Regional Entity** should identify an action plan of how it will come into compliance with the requirement(s). If **Northern Michigan Regional Entity** develops the recommended crosswalk, the PIHP could submit it with the annual QAPI submission to MDHHS to solicit additional collaboration between the PIHP and MDHHS.

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

HSAG performed a comprehensive assessment of **Northern Michigan Regional Entity**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Northern Michigan Regional Entity** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Northern Michigan Regional Entity**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-15 displays each applicable

performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Northern Michigan Regional Entity**'s Medicaid members.

Table 3-15—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Northern Michigan Regional Entity** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Northern Michigan Regional Entity** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Northern Michigan Regional Entity**'s rates for the 11 related performance indicators were at or between 46.88 percent and 86.44 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, gaps were identified in **Northern Michigan Regional Entity's** QAPI program. As such, as **Northern Michigan Regional Entity** implements plans of action identified through its CAP to support process improvement, it should consider how to develop new or leverage existing QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support improvement in areas where gaps are identified in member health outcomes. **Northern Michigan Regional Entity** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Northern Michigan Regional Entity** demonstrated that its members discharged from psychiatric inpatient units and from substance abuse detox units were seen in a timely manner for follow-up care with a mental health or SUD professional and had relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting that **Northern Michigan Regional Entity** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate. Additionally, through the PIP activity, **Northern Michigan Regional Entity** is focusing efforts to increase the percentage of its Medicaid members with a diagnosis of an opioid use disorder who receive services through the Opioid Health Home program. The Opioid Health Home program provides comprehensive care management and coordination services and functions as the central point of contact for directing patient-centered care across the broader healthcare system. Specifically, through the PIP, **Northern Michigan Regional Entity** will implement initiatives to increase members' access to medication assisted treatment and integrated behavioral, primary, and recovery-centered services, with a goal to decrease opioid-related hospitalizations and deaths, and improve members' chances for recovery, relief

Performance Area	Overall Performance Impact
	of symptoms, and improved functioning. In conjunction with these efforts, **Northern Michigan Regional Entity** and the Opioid Health Home program should continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality**—As part of its efforts to identify disparities within its region, **Northern Michigan Regional Entity** documented within the PIP Submission Form that it has the highest per capita number of Medicaid members with an opioid use disorder diagnosis in the State. However, through data analyses, **Northern Michigan Regional Entity** was unable to identify a statistically significant racial or ethnic disparity in healthcare. Although no racial or ethnic disparities were determined for Region 2 during the initiation of the PIP, **Northern Michigan Regional Entity** should continue efforts to evaluate for and subsequently reduce any disparities (e.g., race, age, gender) to address health inequity in support of CQS Goal #4.

Region 3—Lakeshore Regional Entity

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Lakeshore Regional Entity**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-16 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-16—Overall Validation Rating for LRE

PIP Topic	Validation Status	Performance Indicators	Performance Indicator Results			
			Baseline	R1	R2	Disparity
FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black	*Met*	FUH Metric for Adults and Children Combined Who Identify as African American/Black.	60.2%			Yes
		FUH Metric for Adults and Children Combined Who Identify as White.	70.9%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Lakeshore Regional Entity**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-17 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-17—Baseline Interventions for LRE

Intervention Descriptions
Lakeshore Regional Entity had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Lakeshore Regional Entity designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Lakeshore Regional Entity** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Lakeshore Regional Entity**'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.

Lakeshore Regional Entity 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Lakeshore Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-18 presents **Lakeshore Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Lakeshore Regional Entity** met or exceeded the MPS.

Table 3-18—Performance Measure Results for LRE

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	99.71%	95.00%
Adults—Indicator #1b	98.82%	95.00%
#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.		
MI–Children—Indicator #2a	71.73%	NA
MI–Adults—Indicator #2b	78.94%	NA
I/DD–Children—Indicator #2c	73.33%	NA
I/DD–Adults—Indicator #2d	47.22%	NA
Total—Indicator #2	73.41%	NA
#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]		
Consumers	68.48%	NA
#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–Children—Indicator #3a	75.59%	NA
MI–Adults—Indicator #3b	70.29%	NA
I/DD–Children—Indicator #3c	80.00%	NA
I/DD–Adults—Indicator #3d	79.73%	NA
Total—Indicator #3	74.35%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	96.51%	95.00%
Adults	97.28%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	97.66%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	5.33%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	77.22%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	17.70%	—
I/DD–Adults—Indicator #8b	8.79%	—
MI and I/DD–Adults—Indicator #8c	8.92%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	99.78%	—
I/DD–Adults—Indicator #9b	92.57%	—
MI and I/DD–Adults—Indicator #9c	91.06%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	6.03%	15.00%
MI and I/DD–Adults—Indicator #10b	9.81%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	15.31%	—
MI and I/DD–Adults	23.60%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	46.66%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: Lakeshore Regional Entity demonstrated appropriate oversight, implementation, and monitoring of CAPs that had been implemented with its CMHSPs throughout the measurement period. [**Quality**]

Strength #2: Lakeshore Regional Entity deployed significant data QI mechanisms throughout the prior year, investing in a data warehouse and more real-time monitoring of its data through Power BI technology. The PIHP demonstrated strength in its efforts to maintain closer oversight of its data, including CMHSP-reported data, using the new Power BI dashboards, ensuring ongoing monitoring of data completeness and accuracy. [**Quality**]

Strength #3: Lakeshore Regional Entity demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: While **Lakeshore Regional Entity** had strong CMHSP oversight processes in place, HSAG observed some individual user error in documentation of system data, which could potentially result in errors in reporting. [**Quality** and **Timeliness**]

Why the weakness exists: Individual CMHSP staff members had manual user errors in some documentation that was identified through the PSV portion of PMV. Although not a trend, such errors could have additional downstream impact on the quality and timeliness of follow-up care provided to members. Based on PIHP feedback during the virtual audit review, CMHSP staffing resource limitations may also contribute to the CMSHPs lacking staff members to conduct routine data entry reviews and audits.

Recommendation: Lakeshore Regional Entity should work closely with its CMHSPs to conduct an evaluation of their routine auditing of staff members' data entry. While HSAG acknowledges staffing constraints may present challenges to the CMHSPs maintaining a rigorous audit program, it is important to ensure data entry errors are readily identified and corrected to avoid potential impact to members and performance indicator data.

Weakness #2: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 13 **Lakeshore Regional Entity** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in 13 member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Lakeshore Regional Entity** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This recommendation was provided in the SFY 2021 PMV as well, so **Lakeshore Regional Entity** should take additional steps to ensure its validation process accounts for discrepancies in wage and income values.

Compliance Review

Performance Results

Table 3-19 presents **Lakeshore Regional Entity**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Lakeshore Regional Entity** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Lakeshore Regional Entity**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-19—SFY 2021 and SFY 2022 Standard Compliance Scores for LRE

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**89%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**71%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**50%**
Standard V—Coordination and Continuity of Care	§438.208	**79%**
Standard VI—Coverage and Authorization of Services	§438.210	**73%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**81%**
Standard VIII—Confidentiality[3]	§438.224	**82%**
Standard IX—Grievance and Appeal Systems	§438.228	**87%**

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Standard X—Subcontractual Relationships and Delegation	§438.230	**60%**
Standard XI—Practice Guidelines	§438.236	**86%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**87%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-20 presents **Lakeshore Regional Entity**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Lakeshore Regional Entity**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Lakeshore Regional Entity** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-20—SFY 2022 Standard Compliance Review Scores for LRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	13	3	0	**81%**
Standard VIII—Confidentiality[1]	11	11	9	2	0	**82%**
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard X—Subcontractual Relationships and Delegation	5	5	3	2	0	**60%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	26	4	0	**87%**
Total	**119**	**118**	**99**	**19**	**1**	**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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths for **Lakeshore Regional Entity** through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Lakeshore Regional Entity received a score of 60 percent in the Subcontractual Relationships and Delegation program area, indicating that delegates' entities were not being monitored in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Northern Michigan Regional Entity**'s processes were identified related to the oversight and monitoring of its delegates and the content of delegated written agreements—specifically, missing federally required provisions.

Recommendation: While **Lakeshore Regional Entity** was required to develop a CAP, HSAG recommends that the PIHP conduct a scheduled annual review of each delegate's written agreement to ensure the agreement includes all federally and contractually required content. This review should occur annually regardless of changes to the federal managed care rule or with the PIHP's contract with MDHHS to assist in identifying potential gaps that may have been missed in past reviews of the written agreements. HSAG also recommends that the PIHP ensure that documentation of all future

oversight and monitories activities is maintained and readily accessible, and corrective action required of its delegates when performance is determined to be unsatisfactory (e.g., corrective action is mandated for all deficiencies identified through the oversight activities).

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

HSAG performed a comprehensive assessment of **Lakeshore Regional Entity**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Lakeshore Regional Entity** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Lakeshore Regional Entity**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-21 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Lakeshore Regional Entity**'s Medicaid members.

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

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Lakeshore Regional Entity** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Lakeshore Regional Entity** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Lakeshore Regional Entity**'s rates for the 11 related performance indicators were at or between 47.22 percent and 80.00 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, **Lakeshore Regional Entity** demonstrated that it had an adequate QAPI program. As such, **Lakeshore Regional Entity** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in areas where gaps are identified in member health outcomes. **Lakeshore Regional Entity** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Lakeshore Regional Entity** demonstrated that its members discharged from psychiatric inpatient units and from substance abuse detox units were seen in a timely manner for follow-up care with a mental health or SUD professional and had relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting that **Lakeshore Regional Entity** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was

Performance Area	Overall Performance Impact
	appropriate. In addition to its existing care coordination efforts, **Lakeshore Regional Entity** should continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—**Lakeshore Regional Entity** identified within its PIP Submission Form that, as determined through data analyses, 10.7 percent fewer African Americans/Blacks engaged in follow-up after hospitalization for mental illness within 30 days with a mental health provider than Whites. As such, **Lakeshore Regional Entity** initiated a PIP with a goal to increase follow-up visits with a mental health practitioner within 30 days after an inpatient discharge for selected mental illness diagnoses for the African-American/Black population and eliminate the identified disparity without a decline in performance for the White population. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner after psychiatric hospitalization can improve member outcomes, decrease the likelihood of rehospitalization, and improve the overall cost of care. Through its ongoing QI initiatives, **Lakeshore Regional Entity** should continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 4—Southwest Michigan Behavioral Health

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Southwest Michigan Behavioral Health**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-22 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-22—Overall Validation Rating for SWMBH

PIP Topic	Validation Status	Performance Indicators	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	*Met*	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.	14.53%			Yes
		The percentage of White beneficiaries with a 30-day follow up after an ED visit for alcohol or other drug abuse or dependence.	23.39%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Southwest Michigan Behavioral Health**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-23 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-23—Baseline Interventions for SWMBH

Intervention Descriptions
Southwest Michigan Behavioral Health had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Southwest Michigan Behavioral Health designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Southwest Michigan Behavioral Health** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Southwest Michigan Behavioral Health**'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.

Southwest Michigan Behavioral Health 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Southwest Michigan Behavioral Health** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-24 presents **Southwest Michigan Behavioral Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Southwest Michigan Behavioral Health** met or exceeded the MPS.

Table 3-24—Performance Measure Results for SWMBH

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	99.36%	95.00%
Adults—Indicator #1b	99.32%	95.00%
#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.		
MI–Children—Indicator #2a	71.97%	NA
MI–Adults—Indicator #2b	70.75%	NA
I/DD–Children—Indicator #2c	83.50%	NA
I/DD–Adults—Indicator #2d	82.35%	NA
Total—Indicator #2	72.12%	NA
#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]		
Consumers	64.26%	NA
#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–Children—Indicator #3a	64.99%	NA
MI–Adults—Indicator #3b	67.04%	NA
I/DD–Children—Indicator #3c	52.94%	NA
I/DD–Adults—Indicator #3d	80.00%	NA
Total—Indicator #3	65.64%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.11%	95.00%
Adults	96.21%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	97.93%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	5.90%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	88.13%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	19.14%	—
I/DD–Adults—Indicator #8b	8.46%	—
MI and I/DD–Adults—Indicator #8c	8.45%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	99.74%	—
I/DD–Adults—Indicator #9b	92.70%	—
MI and I/DD–Adults—Indicator #9c	88.75%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	7.69%	15.00%
MI and I/DD–Adults—Indicator #10b	12.27%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	20.06%	—
MI and I/DD–Adults	21.99%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	51.68%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: Southwest Michigan Behavioral Health created a reporting template for CMHSP data submissions of performance indicator data that includes all raw data required for the annual PMV review as well as additional formulas that are used to calculate the performance indicator rates for MDHHS reporting. The template is locked down after File Transfer Protocol submission each quarter to ensure that the counts reported can be validated during audit activities. This reporting template has significantly reduced issues noted previously during validation activities and improved the accuracy of calculated rates. [**Quality**]

Strength #2: Southwest Michigan Behavioral Health evaluated validation processes and programming code during annual CMHSP site reviews to ensure that non-Medicaid members were excluded from reporting to the PIHP on the performance indicators. This resulted in zero cases of non-Medicaid members being reported by the CMHSPs. [**Quality**]

Strength #3: Southwest Michigan Behavioral Health demonstrated general strength in ensuring its members received timely access to care and avoided readmissions as the PIHP met the MPS for all applicable indicators within the measurement period. [**Quality**, **Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: During initial review of the member-level file detail provided to HSAG and during PSV, it was noted for indicator #2 that two of a specific CMHSP's members were reported to have assessment dates prior to the date of the service request (i.e., 30 days and 231 days prior to the request). [**Quality**]

Why the weakness exists: The CMHSP reported that, for these two events, full assessments were not completed, and the programming logic used for pulling source data for the indicator pulled in historical assessment dates.

Recommendation: While **Southwest Michigan Behavioral Health** provided updated files, HSAG recommends that the PIHP work with the CMHSP to complete updates to programming code to ensure that historical dates prior to the service request are not used for reporting compliance on the performance indicator.

Weakness #2: During initial review of the member-level detail file (the reporting template used by the PIHP for aggregating data and calculating indicator rates) provided to HSAG and during PSV, it was noted that non-Medicaid members were being included in reporting for indicator #4b. [**Quality**]

Why the weakness exists: Non-Medicaid members who had only SUD Block Grant coverage were included in the member-level detail file submission provided to HSAG for indicator #4b.

Recommendation: HSAG recommends that the PIHP implement visual validation checks on the raw data in the aggregated reporting template prior to MDHHS submission to ensure requirements within the MDHHS Codebook are being met. This will help ensure that appropriate populations are being included in performance indicator reporting but will also help to identify additional types of errors, such as reporting historical service dates that occur prior to a service request.

Weakness #3: During initial review of the member-level detail file (the reporting template used by the PIHP for aggregating data and calculating indicator rates) provided to HSAG and during PSV, it was noted that the count of compliant cases within the file for indicator #10 did not match the count reported to MDHHS for the performance indicator. [**Quality**]

Why the weakness exists: Four exceptions were not excluded from the compliant case count within the reporting template that was used to calculate and report data counts for indicator #10 to MDHHS because a CMHSP entered a value that was not part of the formula included in the exception column (i.e., "Yes" was entered for exceptions rather than "Y"), which caused the exceptions to not be captured as part of the exception formula rules.

Recommendation: HSAG recommends that the PIHP update the formulas in the reporting template to be inclusive of both "Yes/Y" to ensure accurate reporting going forward. Additionally, the PIHP is encouraged to remind CMHSPs of the template instructions and requirements for each column.

Weakness #4: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted nine **Southwest Michigan Behavioral Health** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in nine member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Compliance Review

Performance Results

Table 3-25 presents **Southwest Michigan Behavioral Health**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Southwest Michigan Behavioral Health** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Southwest Michigan Behavioral Health**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-25—SFY 2021 and SFY 2022 Standard Compliance Scores for SWMBH

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**86%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**86%**
Standard VI—Coverage and Authorization of Services	§438.210	**100%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**
Standard IX—Grievance and Appeal Systems	§438.228	**87%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XI—Practice Guidelines	§438.236	**71%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**67%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-26 presents **Southwest Michigan Behavioral Health**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Southwest Michigan Behavioral Health**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Southwest Michigan Behavioral Health** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-26—SFY 2022 Standard Compliance Review Scores for SWMBH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	5	2	0	**71%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	20	10	0	**67%**
Total	**119**	**118**	**94**	**24**	**1**	**80%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Southwest Michigan Behavioral Health received a score of 100 percent in the Subcontractual Relationships and Delegation program area, demonstrating the PIHP had appropriate written arrangements with its subcontractors and adequate oversight and monitoring mechanisms of delegated activities. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Southwest Michigan Behavioral Health received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Southwest Michigan Behavioral Health**'s processes were identified related to PSV, timely credentialing decisions, provider-specific performance review at recredentialing, and timely on-site quality assessments.

Recommendation: While **Southwest Michigan Behavioral Health** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Southwest Michigan Behavioral Health** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: Southwest Michigan Behavioral Health received a score of 67 percent in the QAPI program area, indicating that the PIHP had not developed or implemented a QAPI program in accordance with all contractual requirements. Of note, a total of 10 deficiencies were identified. [**Quality**, **Timelines**, and **Access**]

Why the weakness exists: Through a review of the QAPI program and supporting documentation, gaps in **Southwest Michigan Behavioral Health**'s processes were identified related to the review of the annual QAPI program effectiveness by the BOD; implementation of a second PIP; review of aggregated mortality; analysis of critical incidents, sentinel events, and risk events; analysis of data from the Behavior Treatment Review Committee; assessment of member experience with services; comprehensive annual QAPI program evaluation; dissemination of the QAPI program evaluation; and qualifications of non-licensed providers.

Recommendation: While **Southwest Michigan Behavioral Health** was required to develop a CAP, HSAG recommends that the PIHP conduct a comprehensive review of its QAPI program—

specifically, the annual program description, workplan, and evaluation. This review should include a comparison of each individual QAPI program element required under **Southwest Michigan Behavioral Health**'s contract with MDHHS against the PIHP's current QAPI program. **Southwest Michigan Behavioral Health** should also leverage MDHHS' QAPI program checklist in this review. **Southwest Michigan Behavioral Health** could consider developing a crosswalk of each individual provision with a description of how/where the PIHP is or is not meeting the requirement. For gaps HSAG identified during the compliance review activity, and self-identified gaps through this crosswalk, **Southwest Michigan Behavioral Health** should identify an action plan for how it will come into compliance with the requirement(s). If **Southwest Michigan Behavioral Health** develops the recommended crosswalk, the PIHP could submit it with the annual QAPI submission to MDHHS to solicit additional collaboration between the PIHP and MDHHS.

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

HSAG performed a comprehensive assessment of **Southwest Michigan Behavioral Health**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Southwest Michigan Behavioral Health** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Southwest Michigan Behavioral Health**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-27 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Southwest Michigan Behavioral Health**'s Medicaid members.

Table 3-27—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Southwest Michigan Behavioral Health** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Southwest Michigan Behavioral Health** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Southwest Michigan Behavioral Health**'s rates for the 11 related performance indicators were at or between 52.94 percent and 83.50 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, gaps were identified in **Southwest Michigan Behavioral Health**'s QAPI program. As such, as **Southwest Michigan Behavioral Health** implements plans of action identified through its CAP to support process improvement, it should consider how to develop new or leverage existing QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support

Performance Area	Overall Performance Impact
	improvement in areas where gaps are identified in member health outcomes. **Southwest Michigan Behavioral Health** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Southwest Michigan Behavioral Health** demonstrated that its members discharged from psychiatric inpatient units and from substance abuse detox units were seen in a timely manner for follow-up care with a mental health or SUD professional and had relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting that **Southwest Michigan Behavioral Health** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate. In addition to its existing care coordination efforts to improve members' timely access to services, **Southwest Michigan Behavioral Health** should continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—**Southwest Michigan Behavioral Health** identified within its PIP Submission Form that, as determined through data analyses, a statistically significant disparity between its African-American/Black and White populations in its Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] performance measure rate for *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.* As such, **Southwest Michigan Behavioral Health** initiated a PIP with a goal to increase follow-up visits within 30 days after an ED visit for alcohol or other drug abuse or dependence for the African-American/Black population and eliminate the identified disparity without a decline in performance for the White population. By initiating effective interventions as part of the PIP, **Southwest Michigan Behavioral Health** should see an increase in the rates of ED follow-up care for alcohol and other drug use in the African-American/Black Medicaid-enrolled population in Region 4, while improving members' health status and decreasing the risk of overdose deaths. Through its ongoing QI initiatives, **Southwest Michigan Behavioral Health** should also continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

[3-1] HEDIS® is a registered trademark of the NCQA.

Region 5—Mid-State Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Mid-State Health Network**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-28 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-28—Overall Validation Rating for MSHN

PIP Topic	Validation Status	Performance Indicators	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	*Met*	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.	65.04%			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.	69.49%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Mid-State Health Network**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-29 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-29—Baseline Interventions for MSHN

Intervention Descriptions
Mid-State Health Network had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Mid-State Health Network designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although no weaknesses were identified, HSAG recommends that **Mid-State Health Network** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Mid-State Health Network**'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.

Mid-State Health Network 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Mid-State Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-30 presents **Mid-State Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Mid-State Health Network** met or exceeded the MPS.

Table 3-30—Performance Measure Results for MSHN

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	96.73%	95.00%
Adults—Indicator #1b	99.19%	95.00%
#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.		
MI–Children—Indicator #2a	65.77%	NA
MI–Adults—Indicator #2b	62.59%	NA
I/DD–Children—Indicator #2c	62.21%	NA
I/DD–Adults—Indicator #2d	64.56%	NA
Total—Indicator #2	63.73%	NA
#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]		
Consumers	74.92%	NA
#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–Children—Indicator #3a	57.60%	NA
MI–Adults—Indicator #3b	63.07%	NA
I/DD–Children—Indicator #3c	68.00%	NA
I/DD–Adults—Indicator #3d	56.58%	NA
Total—Indicator #3	61.27%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	96.81%	95.00%
Adults	94.93%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	95.48%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.47%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	86.95%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	19.46%	—
I/DD–Adults—Indicator #8b	7.52%	—
MI and I/DD–Adults—Indicator #8c	9.38%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or 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%	—
I/DD–Adults—Indicator #9b	89.20%	—
MI and I/DD–Adults—Indicator #9c	92.76%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	3.85%	15.00%
MI and I/DD–Adults—Indicator #10b	11.44%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	18.55%	—
MI and I/DD–Adults	26.64%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	49.78%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: Mid-State Health Network worked closely with the regional CMHSPs to implement multiple interventions to improve access to services (e.g., same-day access, appointment reminders, psychiatric urgent care centers, utilizing paraprofessionals such as family support assistants, and developing a support program for inpatient high utilizers). [**Quality**, **Timeliness**, and **Access**]

Strength #2: Mid-State Health Network has increasingly leveraged CAPs with delegated CMHSPs, and reported that through the process of working closely with the CMHSPs and monitoring performance improvement efforts, **Mid-State Health Network** and its CMHSPs collectively found many systemic issues that they worked together to address through process improvements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: For indicator #2, four cases reported to HSAG in the member-level detail file indicated numerator compliance, but the assessment date in the file was prior to the service request date (e.g., 1, 351, 356, or 2,325 days prior to the request). [**Quality**]

Why the weakness exists: Programming code used by the CMHSP for the indicator was allowing dates prior to the service request to be identified as a completed assessment date.

Recommendation: The MDHHS Codebook specifications state that the date of assessment must fall within 14 days following the service request. HSAG recommends that **Mid-State Health Network** ensure that programming code used for data extraction from source systems is not using service dates prior to the qualifying event to identify numerator compliance.

Weakness #2: Two discrepancies were identified in the PSV samples for indicator #3, as clinical documentation could not be located to validate the service dates reported in the member-level detail file provided to HSAG. [**Quality**]

Why the weakness exists: One CMHSP's programming code was including no-show appointments as compliant follow-up service dates.

Recommendation: HSAG recommends that **Mid-State Health Network** ensure that programming code for all delegated CMHSPs is not identifying no-show appointments as a compliant record for the performance indicator. Additionally, HSAG recommends that the PIHP continue using the Encounters-to-BH-TEDS report as an additional check of any records that show as compliant in the BH-TEDS record but do not have a corresponding encounter for the same date.

Weakness #3: Two cases reported from one CMHSP for indicators #4a and #10 were reported as exceptions; but upon further review during PSV, it was determined that the records did not quality as exceptions. [**Quality**]

Why the weakness exists: The CMHSP reported during the virtual review that staff members appeared to mark the cases as exceptions in the BH-TEDS record screen even though they did not qualify as exceptions in the MDHHS Codebook.

Recommendation: HSAG recommends that **Mid-State Health Network** ensure that all delegated CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator. HSAG also recommends that the PIHP include unusual case scenarios during QI committee meetings with the CMHSPs in the region to ensure that all delegates are interpreting the scenarios consistently and in accordance with the specifications.

Weakness #4: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 12 **Mid-State Health Network** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in 12 member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Mid-State Health Network** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Weakness #5: While **Mid-State Health Network** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to adults after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for adults for indicator #4a fell slightly below the MPS, suggesting that some adults discharged from an inpatient psychiatric unit may not have been able to get timely access to post-discharge follow-up.

Recommendation: HSAG recommends that **Mid-State Health Network** closely monitor adults' discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*.

Compliance Review

Performance Results

Table 3-31 presents **Mid-State Health Network**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Mid-State Health Network** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Mid-State Health Network** implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-31—SFY 2021 and SFY 2022 Standard Compliance Scores for MSHN

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**71%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**93%**
Standard VI—Coverage and Authorization of Services	§438.210	**91%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**
Standard IX—Grievance and Appeal Systems	§438.228	**84%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XI—Practice Guidelines	§438.236	**100%**
Standard XII—Health Information Systems[4]	§438.242	**92%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**93%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-32 presents **Mid-State Health Network**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Mid-State Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Mid-State Health Network** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-32—SFY 2022 Standard Compliance Review Scores for MSHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems[2]	12	12	11	1	0	**92%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**119**	**119**	**105**	**14**	**0**	**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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Mid-State Health Network received a score of 100 percent in the Subcontractual Relationships and Delegation program area, demonstrating the PIHP had appropriate written arrangements with its subcontractors and adequate oversight and monitoring mechanisms of delegated activities in accordance with all federal and/or contractual requirements. [**Quality**]

Strength #2: Mid-State Health Network received a score of 100 percent in the Practice Guidelines program area, demonstrating the PIHP had adopted CPGs to serve as a resource for network providers in clinical decision making in accordance with all federal and/or contractual requirements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Mid-State Health Network received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Mid-State Health Network**'s processes were identified related to PSV, obtaining all required attestations, timely credentialing decisions, written notice of credentialing decision to providers, provider-specific performance review at recredentialing, and Medicare and Medicaid sanction and exclusion queries.

Recommendation: While **Mid-State Health Network** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Mid-State Health Network** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

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

HSAG performed a comprehensive assessment of **Mid-State Health Network**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Mid-State Health Network** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Mid-State Health Network**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-33 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Mid-State Health Network**'s Medicaid members.

Table 3-33—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Mid-State Health Network** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Mid-State Health Network** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Mid-State Health Network**'s rates for the 11 related performance indicators were at or between 56.58 percent and 74.92 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, **Mid-State Health Network** demonstrated that it had an adequate QAPI program. As such, **Mid-State Health Network** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in areas where gaps are identified in member health outcomes. **Mid-State Health Network** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Mid-State Health Network** demonstrated that its members discharged from substance abuse detox units were seen in a timely manner for follow-up care with a SUD professional, and child members discharged from a psychiatric inpatient unit were also seen in a timely manner by a mental health provider after discharge. Additionally, **Mid-State Health Network** had relatively low prevalence rates of adult and child members readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting **Mid-State Health Network** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate in most instances. However, **Mid-State Health Network** did not meet the MPS for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within seven days for its adult population, suggesting opportunities exist to

Performance Area	Overall Performance Impact
	mitigate the barriers adult members face regarding timely access to post-discharge follow-up, which may include network gaps or member noncompliance with outpatient treatment plans. In addition to its existing care coordination efforts to improve members' timely access to services, **Mid-State Health Network** should also continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—Through data analysis, **Mid-State Health Network** identified a racial disparity between its Black/African-American and White populations receiving a medically necessary, ongoing covered service within 14 days of completing a biopsychosocial assessment. As such, **Mid-State Health Network** initiated a PIP to improve the rate of Black/African-American members new to services who were receiving a medically necessary service within 14 days of completing a biopsychosocial assessment and eliminate the identified disparity without a decline in performance for the White population. This PIP also aligns to performance indicator #3, which is validated through PMV. Receiving timely necessary services and addressing biological, psychological, and social influences improves overall mental and physical health and well-being. In addition to the disparity identified through the PIP activity, **Mid-State Health Network** should continue efforts to evaluate for and subsequently reduce any disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 6—Community Mental Health Partnership of Southeast Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Community Mental Health Partnership of Southeast Michigan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-34 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-34—Overall Validation Rating for CMHPSM

PIP Topic	Validation Status	Performance Indicators	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	*Met*	Initial assessment no-show rate for African-American consumers.	22.9%			Yes
		Initial assessment no-show rate for White consumers.	12.2%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals of **Community Mental Health Partnership of Southeast Michigan**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-35 displays the interventions, as available, initiated to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-35—Baseline Interventions for CMHPSM

Intervention Descriptions
Community Mental Health Partnership of Southeast Michigan had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Community Mental Health Partnership of Southeast Michigan designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Community Mental Health Partnership of Southeast Michigan**'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.

Community Mental Health Partnership of Southeast Michigan 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Community Mental Health Partnership of Southeast Michigan** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-36 presents **Community Mental Health Partnership of Southeast Michigan**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Community Mental Health Partnership of Southeast Michigan** met or exceeded the MPS.

Table 3-36—Performance Measure Results for CMHPSM

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	98.80%	95.00%
Adults—Indicator #1b	99.30%	95.00%
#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.		
MI–Children—Indicator #2a	68.15%	NA
MI–Adults—Indicator #2b	63.95%	NA
I/DD–Children—Indicator #2c	72.06%	NA
I/DD–Adults—Indicator #2d	59.38%	NA
Total—Indicator #2	66.17%	NA
#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]		
Consumers	61.98%	NA
#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–Children—Indicator #3a	73.08%	NA
MI–Adults—Indicator #3b	81.28%	NA
I/DD–Children—Indicator #3c	85.29%	NA
I/DD–Adults—Indicator #3d	57.14%	NA
Total—Indicator #3	77.25%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	89.74%	95.00%
Adults	95.95%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	98.77%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.11%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	85.33%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	16.40%	—
I/DD–Adults—Indicator #8b	9.63%	—
MI and I/DD–Adults—Indicator #8c	8.97%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	99.52%	—
I/DD–Adults—Indicator #9b	88.95%	—
MI and I/DD–Adults—Indicator #9c	91.43%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	5.13%	15.00%
MI and I/DD–Adults—Indicator #10b	12.39%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	25.61%	—
MI and I/DD–Adults	34.35%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	36.31%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: The tracking of indicator #2e directly within CRCT (the PIHP's IS) reduces the risk of human error, which could exist with a manual tracking process. Additionally, documenting the expired requests directly within the CRCT system allows **Community Mental Health Partnership of Southeast Michigan** to have nearly real-time oversight of expired requests; therefore, the use of the CRCT system to automate indicator #2e tracking and reporting is considered a strength. [**Quality**, **Timeliness**, and **Access**]

Strength #2: As identified previously, **Community Mental Health Partnership of Southeast Michigan** demonstrated overall strength in its partnerships and consistent processes and systems used across all of its CMHSPs. This ensured standardization in how all of the CMHSPs document within information systems supporting 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 CMHSP. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV of one CMHSP's SUD cases for indicator #4b, one case was noted as compliant when in fact it should have been documented as an exception. [**Quality**]

Why the weakness exists: An isolated employee error led to a staff member incorrectly documenting the case as compliant using a manual system override.

Recommendation: HSAG recommends the PIHP require the CMHSP to deploy additional quality assurance steps to more readily detect and correct employees' manual documentation errors. Such mechanisms may include additional audit review of compliant cases and cases documented as exceptions. **Community Mental Health Partnership of Southeast Michigan** could further consider requesting PCE to create a report that identifies all manual system overrides, thereby supporting the PIHP in conducting its own additional quality checks of these cases.

Weakness #2: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted four **Community Mental Health Partnership of Southeast Michigan** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in two member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Weakness #3: While **Community Mental Health Partnership of Southeast Michigan** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to children after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for children for indicator #4a fell below the MPS by over 5 percentage points, suggesting that some children discharged from an inpatient psychiatric unit may not have been able to get timely access to post-discharge follow-up.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** closely monitor discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*.

Compliance Review

Performance Results

Table 3-37 presents **Community Mental Health Partnership of Southeast Michigan**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Community Mental Health Partnership of Southeast Michigan** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Community Mental Health Partnership of Southeast Michigan**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-37—SFY 2021 and SFY 2022 Standard Compliance Scores for CMHPSM

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Standard III—Availability of Services	§438.206	**71%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**79%**
Standard VI—Coverage and Authorization of Services	§438.210	**82%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**
Standard IX—Grievance and Appeal Systems	§438.228	**76%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**80%**
Standard XI—Practice Guidelines	§438.236	**86%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**73%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-38 presents **Community Mental Health Partnership of Southeast Michigan**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Community Mental Health Partnership of Southeast Michigan**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Community Mental Health Partnership of Southeast Michigan** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-38—SFY 2022 Standard Compliance Review Scores for CMHPSM

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	29	9	0	**76%**
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	**80%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	22	8	0	**73%**
Total	**119**	**118**	**92**	**26**	**1**	**78%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths for **Community Mental Health Partnership of Southeast Michigan** through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Community Mental Health Partnership of Southeast Michigan received a score of 75 percent in the Provider Selection program area, indicating that providers may not be

appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Community Mental Health Partnership of Southeast Michigan** processes were identified related to PSV, timely credentialing decisions, disclosure questions, work history, and provider-specific performance review at recredentialing. Additionally, **Community Mental Health Partnership of Southeast Michigan** was unable to provide documentation assuring that all provider types were being credentialed in accordance with its contract with MDHHS.

Recommendation: While **Community Mental Health Partnership of Southeast Michigan** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: Community Mental Health Partnership of Southeast Michigan received a score of 76 percent in the Grievance and Appeal Systems program area, indicating that the PIHP had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. Of note, a total of nine deficiencies were identified. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **Community Mental Health Partnership of Southeast Michigan**'s processes were identified related to resolution of grievances, written consent of the member, acknowledgement of appeals, extension notice requirements, appeal resolution notices, timely reinstatement of services, and record retention time frames.

Recommendation: While **Community Mental Health Partnership of Southeast Michigan** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of grievance and appeal processes completed by the PIHP and/or by its delegates. HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** conduct a comprehensive review of a random sample of grievance and appeal files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #3: Community Mental Health Partnership of Southeast Michigan received a score of 73 percent in the QAPI program area, indicating that the PIHP had not developed or implemented a QAPI program in accordance with all contractual requirements. Of note, a total of eight deficiencies were identified. [**Quality**, **Timelines**, and **Access**]

Why the weakness exists: Through a review of the QAPI program and supporting documentation, gaps in **Community Mental Health Partnership of Southeast Michigan**'s processes were identified related to critical incidents and sentinel events time frame requirements; review of

aggregated mortality data; analysis of critical incidents, sentinel events, and risk events; analysis of data from the Behavior Treatment Review Committee; assessment of member experience with services; comprehensive annual QAPI program evaluation; dissemination of the QAPI program evaluation; and qualifications of non-licensed providers.

Recommendation: While **Community Mental Health Partnership of Southeast Michigan Health** was required to develop a CAP, HSAG recommends that the PIHP conduct a comprehensive review of its QAPI program—specifically, the annual program description, workplan, and evaluation. This review should include a comparison of each individual QAPI program element required under **Community Mental Health Partnership of Southeast Michigan**'s contract with MDHHS against the PIHP's current QAPI program. **Community Mental Health Partnership of Southeast Michigan** should also leverage MDHHS' QAPI program checklist in this review. **Community Mental Health Partnership of Southeast Michigan** could consider developing a crosswalk of each individual provision with a description of how/where the PIHP is or is not meeting the requirement. For gaps HSAG identified during the compliance review activity, and self-identified gaps through this crosswalk, **Community Mental Health Partnership of Southeast Michigan** should identify an action plan for how it will come into compliance with the requirement(s). If **Community Mental Health Partnership of Southeast Michigan** develops the recommended crosswalk, the PIHP could submit the crosswalk with the annual QAPI submission to MDHHS to solicit additional collaboration between the PIHP and MDHHS.

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

HSAG performed a comprehensive assessment of **Community Mental Health Partnership of Southeast Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Community Mental Health Partnership of Southeast Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Community Mental Health Partnership of Southeast Michigan**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-39 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Community Mental Health Partnership of Southeast Michigan**'s Medicaid members.

Table 3-39—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Community Mental Health Partnership of Southeast Michigan** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Community Mental Health Partnership of Southeast Michigan** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Community Mental Health Partnership of Southeast**

Performance Area	Overall Performance Impact
	Michigan's rates for the 11 related performance indicators were at or between 57.14 percent and 85.29 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, gaps were identified in **Community Mental Health Partnership of Southeast Michigan**'s QAPI program. As such, as **Community Mental Health Partnership of Southeast Michigan** implements plans of action identified through its CAP to support process improvement, it should consider how to develop new or leverage existing QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support improvement in areas where gaps are identified in member health outcomes. **Community Mental Health Partnership of Southeast Michigan** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Community Mental Health Partnership of Southeast Michigan** demonstrated that its members discharged from substance abuse detox units were seen in a timely manner for follow-up care with a SUD professional, and adult members discharged from a psychiatric inpatient unit were also seen in a timely manner by a mental health provider after discharge. Additionally, **Community Mental Health Partnership of Southeast Michigan** had relatively low prevalence rates of adult and child members readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting **Community Mental Health Partnership of Southeast Michigan** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate in most instances. However, **Community Mental Health Partnership of Southeast Michigan** did not meet the MPS for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within seven days for its child population, suggesting opportunities exist to mitigate the barriers child members face regarding timely access to post-discharge follow-up, which may include network gaps or member noncompliance with outpatient treatment plans. In addition to its existing care coordination efforts to improve members' timely access to services, **Community Mental Health Partnership of Southeast Michigan** should also continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality** and **Timeliness**—**Community Mental Health Partnership of Southeast Michigan** identified within its PIP Submission Form that, as determined through data analyses, 22.9 percent of eligible African-American/Black members had a no-show rate for the initial biopsychosocial assessment, while 12.2 percent of eligible White members did not show for their

Performance Area	Overall Performance Impact
	initial biopsychosocial assessment during the measurement period, indicating a disparity existed between the two populations. As such, **Community Mental Health Partnership of Southeast Michigan** initiated a PIP with a goal to decrease, and eventually eliminate, the initial assessment no-show rate disparity between African-American/Black and White members, without a decline in performance for the White members. Reducing the rate of racial disparity between African-American/Black and White members missing or not being able to attend their initial biopsychosocial assessment appointment, and assisting them to ensure they receive an initial assessment within 14 days of their request, has the potential for all members seeking community mental health services to have an equal opportunity to seek the services they need and/or requested, improve overall initial workflows with services provided, and potentially increase satisfaction with initial services by resolving existing barriers that prevent members from attending this initial appointment. This PIP also aligns to performance indicator #2a, which is validated through PMV. In addition to the disparity identified through the PIP activity, **Community Mental Health Partnership of Southeast Michigan** should continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 7—Detroit Wayne Integrated Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Detroit Wayne Integrated Health Network**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-40 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-40—Overall Validation Rating for DWIHN

PIP Topic	Validation Status	Performance Indicators	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	*Met*	Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population.	35.7%			Yes
		Follow-Up within 7 Days After Hospitalization for Mental Illness for the White Population.	40.2%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Detroit Wayne Integrated Health Network**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-41 displays the interventions, as available, initiated to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-41—Baseline Interventions for DWIHN

Intervention Descriptions
Detroit Wayne Integrated Health Network had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Detroit Wayne Integrated Health Network designed a methodologically sound PIP. **[Quality]**

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Detroit Wayne Integrated Health Network** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Detroit Wayne Integrated Health Network**'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. **Detroit Wayne Integrated Health Network** works directly with service providers and the Medicaid population. As a result, oversight of affiliated CMHSPs was not applicable to the PIHP's PMV.

Detroit Wayne Integrated Health Network 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Detroit Wayne Integrated Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-42 presents **Detroit Wayne Integrated Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Detroit Wayne Integrated Health Network** met or exceeded the MPS.

Table 3-42—Performance Measure Results for DWIHN

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	97.78%	95.00%
Adults—Indicator #1b	97.14%	95.00%
#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.		
MI–Children—Indicator #2a	44.40%	NA
MI–Adults—Indicator #2b	57.14%	NA
I/DD–Children—Indicator #2c	47.90%	NA
I/DD–Adults—Indicator #2d	53.45%	NA
Total—Indicator #2	52.85%	NA
#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]		
Consumers	62.96%	NA
#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–Children—Indicator #3a	80.61%	NA
MI–Adults—Indicator #3b	81.15%	NA
I/DD–Children—Indicator #3c	90.54%	NA
I/DD–Adults—Indicator #3d	88.00%	NA
Total—Indicator #3	82.36%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.15%	95.00%
Adults	94.80%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	5.90%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	91.02%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	14.00%	—
I/DD–Adults—Indicator #8b	8.23%	—
MI and I/DD–Adults—Indicator #8c	6.02%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	99.77%	—
I/DD–Adults—Indicator #9b	93.69%	—
MI and I/DD–Adults—Indicator #9c	96.69%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	5.06%	15.00%
MI and I/DD–Adults—Indicator #10b	14.93%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	21.69%	—
MI and I/DD–Adults	27.84%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	38.15%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: Detroit Wayne Integrated Health Network continued to show strides in improving indicator performance. Most notably was its development of a Recidivism Workgroup of both internal and external stakeholders to improve rates related to indicator #10b. The workgroups engaged in collaborative quarterly meetings to ensure the continuity of quality of care. **Detroit Wayne Integrated Health Network** actively worked with the clinically responsible service providers (CRSPs) to help define the responsibilities of the CRSP providers, create chart alerts for frequent patients, and define protocols to direct members to the appropriate service levels of care based on observation. The efforts from this group produced an 8.08 percent rate drop for indicator #10b as of Q1 SFY 2022. **Detroit Wayne Integrated Health Network** noted during the review that this was the first time in three years the region has been able to meet the MDHHS standard threshold for the indicator. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Detroit Wayne Integrated Health Network continued to improve upon BH-TEDS reporting. **Detroit Wayne Integrated Health Network** worked with PCE to update MH-WIN (the PIHP's IS) software to add additional edits to ensure that all required fields had to be populated before saving. In addition, disability designation data values within MH-WIN were now required to be updated as part of the instituted edits. In addition, **Detroit Wayne Integrated Health Network** established a defined validation of BH-TEDS data, dispersing detailed documents to providers of what needed to be completed as part of the BH-TEDS process and created a workflow of reviews between the providers and region in order to ensure completeness of the data prior to submission to MDHHS. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During the PSV session of the virtual review for indicator #1, it was identified that **Detroit Wayne Integrated Health Network**'s member-level detail file was capturing a different pre-admission screening and disposition date and time for one case. Another case was identified as having a different disposition screening date and time. [**Quality**]

Why the weakness exists: Detroit Wayne Integrated Health Network noted that the provider(s), in error, updated the existing screening for both cases instead of creating a new screening for the member. These errors led to two cases being identified as out of compliance when documentation supported these cases as being compliant.

Recommendation: While no other cases reviewed during PSV contained this anomaly, in order to improve rates related to indicator #1 and ensure providers are correctly capturing screening data and

meeting MDHHS Codebook requirements, HSAG recommends that **Detroit Wayne Integrated Health Network** provide training to its providers to ensure they understand the process and procedures of correctly capturing data related to the pre-admission screening. In addition, HSAG recommends that **Detroit Wayne Integrated Health Network** monitor and review cases that might appear to be anomalies as a quality check. For the two cases that were mentioned above, both cases were out of compliance by nearly a week and should have initiated an inquiry internally by the PIHP due to being so far out of compliance.

Weakness #2: During the PSV session of the virtual review for indicator #2, **Detroit Wayne Integrated Health Network** was unable to locate additional documentation within its MH-WIN system for cases #4 and #5 after the members no showed for their appointments within 14 days of request of service. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Detroit Wayne Integrated Health Network** was not capturing additional documentation from the providers to show follow-up within 14 days of the request even after the members no showed.

Recommendation: HSAG recommends that **Detroit Wayne Integrated Health Network** capture additional follow-up by the providers to ensure providers are still trying to follow-up with a member within the 14-day window in order show due diligence of trying to meet MDHHS specifications for the indicator.

Weakness #3: While **Detroit Wayne Integrated Health Network** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to adults after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for adults for indicator #4a fell slightly below the MPS, suggesting that some adults discharged from an inpatient psychiatric unit may not have been able to get timely access to post-discharge follow-up. **Detroit Wayne Integrated Health Network** identified staffing shortages as a barrier for ensuring timely access to care.

Recommendation: HSAG recommends that **Detroit Wayne Integrated Health Network** closely monitor adults' discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*. In addition, HSAG recommends that **Detroit Wayne Integrated Health Network** educate providers on the potential of telemedicine as an option for providing post-discharge follow-up care and encourage members to access follow-up services via telemedicine where possible.

Compliance Review

Performance Results

Table 3-43 presents **Detroit Wayne Integrated Health Network**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Detroit Wayne Integrated Health Network** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Detroit Wayne Integrated Health Network**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-43—SFY 2021 and SFY 2022 Standard Compliance Scores for DWIHN

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**86%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**0%**
Standard V—Coordination and Continuity of Care	§438.208	**79%**
Standard VI—Coverage and Authorization of Services	§438.210	**64%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**
Standard IX—Grievance and Appeal Systems	§438.228	**84%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**80%**
Standard XI—Practice Guidelines	§438.236	**86%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**83%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-44 presents **Detroit Wayne Integrated Health Network**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Detroit Wayne Integrated Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Detroit Wayne Integrated Health Network** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-44—SFY 2022 Standard Compliance Review Scores for DWIHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	**80%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	25	5	0	**83%**
Total	**119**	**118**	**98**	**20**	**1**	**83%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths for **Detroit Wayne Integrated Health Network** through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Detroit Wayne Integrated Health Network received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Detroit Wayne Integrated Health Network**'s processes were identified related to PSV, timely credentialing decisions, and the initial credentialing versus the recredentialing process.

Recommendation: While **Detroit Wayne Integrated Health Network** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Detroit Wayne Integrated Health Network** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

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

HSAG performed a comprehensive assessment of **Detroit Wayne Integrated Health Network**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Detroit Wayne Integrated Health Network** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Detroit Wayne Integrated Health Network**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-45 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Detroit Wayne Integrated Health Network**'s Medicaid members.

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

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Detroit Wayne Integrated Health Network** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Detroit Wayne Integrated Health Network** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Detroit Wayne Integrated Health Network**'s rates for the 11 related performance indicators were at or between 44.40 percent and 90.54 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, **Detroit Wayne Integrated Health Network** demonstrated that it had an adequate QAPI program. As such, **Detroit Wayne Integrated Health Network** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in areas where gaps are identified in member health outcomes. **Detroit Wayne Integrated Health Network** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Detroit Wayne Integrated Health Network** demonstrated that its members discharged from substance abuse detox units were seen in a timely manner for follow-up care with a SUD professional, and child members discharged from a psychiatric inpatient unit were also seen in a timely manner by a mental health provider after discharge. Additionally, **Detroit Wayne Integrated Health Network** had relatively low prevalence rates of adult and child members readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting **Detroit Wayne Integrated Health Network** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate in most instances. However, **Detroit Wayne Integrated Health Network** did not meet the MPS for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within seven days for its adult population, suggesting opportunities exist to mitigate the barriers some adult members face regarding timely access to post-discharge follow-up, which may include network gaps or member noncompliance with outpatient treatment plans. In addition to its existing care coordination efforts to improve members' timely access to services, **Detroit Wayne Integrated Health Network** should also continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the

Performance Area	Overall Performance Impact
	social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—**Detroit Wayne Integrated Health Network** identified within its PIP Submission Form that, as determined through data analyses, 35.7 percent of African-American/Black members followed up in a timely manner with a mental health provider after discharge from an inpatient psychiatric stay compared to 40.2 percent of White members, indicating a disparity existed between the two populations. As such, **Detroit Wayne Integrated Health Network** initiated a PIP with a goal to reduce the racial disparity of African-American members seen for follow-up care within seven days of discharge from a psychiatric inpatient unit. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce the risk of repeat hospitalization. This PIP also aligns to performance indicator #4a, which is validated through PMV, and for the SFY 2022 activity, timely follow-up after inpatient discharge for the adult population did not meet the MDHHS-established MPS. In addition to the disparity identified through the PIP activity, **Detroit Wayne Integrated Health Network** should continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 8—Oakland Community Health Network

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Oakland Community Health Network**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-46 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-46—Overall Validation Rating for OCHN

PIP Topic	Validation Status	Performance Indicators	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Improving Antidepressant Medication Management—Acute Phase	*Met*	The rate for White adult members who maintained antidepressant medication management for 84 days.	53.2%			Yes
		The rate for African-American adult members who maintained antidepressant medication management for 84 days.	46.2%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Oakland Community Health Network**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-47 displays the interventions initiated to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-47—Baseline Interventions for OCHN

Intervention Descriptions	
Educated providers on the World Health Organization's technical report on medication safety in polypharmacy which highlights guidelines and best practices.	Educated provider staff annually on updated acute care discharge protocols developed by the PIHP to include best practices for medication psychoeducation and medication reminders to members leaving acute care settings.
Educated and encouraged providers to use shared decision making skills to support adherence.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Oakland Community Health Network designed a methodologically sound PIP. **[Quality]**

Strength #2: Oakland Community Health Network used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Oakland Community Health Network** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of new interventions. The PIHP will need to develop methods to evaluate the effectiveness of each intervention and use the outcomes to determine each intervention's next steps.

Performance Measure Validation

HSAG evaluated **Oakland Community Health Network**'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. **Oakland Community Health Network** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

Oakland Community Health Network 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Oakland Community Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-48 presents **Oakland Community Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Oakland Community Health Network** met or exceeded the MPS.

Table 3-48—Performance Measure Results for OCHN

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	97.92%	95.00%
Adults—Indicator #1b	93.04%	95.00%
#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.		
MI–Children—Indicator #2a	45.54%	NA
MI–Adults—Indicator #2b	50.43%	NA
I/DD–Children—Indicator #2c	53.33%	NA
I/DD–Adults—Indicator #2d	42.86%	NA
Total—Indicator #2	48.61%	NA
#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]		
Consumers	92.21%	NA
#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–Children—Indicator #3a	99.63%	NA
MI–Adults—Indicator #3b	99.77%	NA
I/DD–Children—Indicator #3c	100.00%	NA
I/DD–Adults—Indicator #3d	100.00%	NA
Total—Indicator #3	99.74%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	95.56%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	7.00%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	91.40%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	19.14%	—
I/DD–Adults—Indicator #8b	12.57%	—
MI and I/DD–Adults—Indicator #8c	8.62%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	99.60%	—
I/DD–Adults—Indicator #9b	77.84%	—
MI and I/DD–Adults—Indicator #9c	62.42%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	0.00%	15.00%
MI and I/DD–Adults—Indicator #10b	5.96%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	18.99%	—
MI and I/DD–Adults	27.18%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	33.13%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: Oakland Community Health Network made noteworthy efforts to expand and improve services in innovative ways to meet the needs of its members. The new children's crisis stabilization unit opening in 2022 will be able to deliver services more quickly to children in need of higher levels of care. New school mental health navigators (SMHN) will increase access to diverse mental health services for students. Co-responders accompanying law enforcement on calls for persons in need of mental health services will improve outcomes for those individuals in need. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Oakland Community Health Network continued to use an internal Quality Team to help with quality control and reporting. This enhanced structure aided in additional reviews and better quality control procedures. [**Quality**]

Strength #3: Oakland Community Health Network created Smart Sheets for review of indicators that were marked as out of compliance. These Smart Sheets have helped providers understand how to properly identify exceptions, if necessary. This is the third year that **Oakland Community Health Network** has used Smart Sheets. [**Quality**]

Strength #4: Oakland Community Health Network implemented a health information exchange (HIE) calendar that can be shared across provider groups. This went live in October 2021 and eliminated the need for duplicate entry of the information into two systems and increased the ability of the PIHP to assist and collaborate with those providers that do not use ODIN (the PIHP's IS). [**Quality**]

Weaknesses and Recommendations

Weakness #1: During the review of eligibility data processing, **Oakland Community Health Network** noted that if members were eligible on either the 820, 834, or 271 files, they were considered eligible for services and that any discrepancies between the files did not need to be reported back to MDHHS unless there was a noted trend of issues in the enrollment data. However, the enrollment files were used by multiple stakeholders within the overall care delivery system for the State of Michigan. Reporting discrepancies for correction is valuable for maintaining the accuracy of the central enrollment record. [**Quality**]

Why the weakness exists: Oakland Community Health Network noted that its processes allowed it to serve its members effectively and maintain accurate data in its systems. **Oakland Community Health Network** corrected data in its own system as needed when discrepancies arose.

Recommendation: HSAG recommends that **Oakland Community Health Network** notify MDHHS of all data discrepancies regardless of its ability to work around the discrepancy.

Weakness #2: During the PSV portion of the audit, it was found that **Oakland Community Health Network** used an additional methodology for indicator #10 for which readmissions were not counted in the numerator if members were not able to see their providers before the readmission. This interpretation of the measure was not in alignment with the specifications and did not support a consistent comparison with the Michigan PIHPs. [**Quality**]

Why the weakness exists: Oakland Community Health Network noted that it was its understanding that members who readmitted within 30 days of discharge prior to interacting with their providers were not impactable and that it would be acceptable to list them as exceptions.

Recommendation: HSAG recommends that **Oakland Community Health Network** adjust its calculations to align with the specifications by removing the condition that members must see their providers prior to readmission to be counted in the numerator.

Weakness #3: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted nine **Oakland Community Health Network** member records with discrepant employment and minimum wage BH-TEDS data. [**Quality**]

Why the weakness exists: While errors in nine member records were not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Oakland Community Health Network** employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Weakness #4: Oakland Community Health Network's percentage of reported expired requests was an outlier in comparison amongst all PIHPs. [**Quality**]

Why the weakness exists: Oakland Community Health Network's percentage of reported expired requests was an outlier as the reported expired request percentage was significantly lower when compared amongst all PIHPs. It is possible the low percentage may exist due to underreporting of expired requests.

Recommendation: HSAG recommends that **Oakland Community Health Network** further explore the outlier percentage and determine if there is any potential for underreporting. If a root-cause is identified, **Oakland Community Health Network** should proactively alter its approach for tracking and reporting expired requests.

Weakness #5: While **Oakland Community Health Network** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to improve the timeliness of completing psychiatric inpatient care pre-admission screening dispositions for adult members, as the PIHP did not meet the MPS for this indicator (i.e., *#1b: 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—Adults) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for indicator #1b fell below the MPS by nearly 2 percentage points, suggesting that psychiatric inpatient care pre-admission screening dispositions were not always being completed within the required three hour timeframe for adult members.

Recommendation: HSAG recommends that **Oakland Community Health Network** closely monitor psychiatric inpatient care pre-admissions for adults to ensure the pre-admission screening disposition is completed within the critical three hour time frame in alignment with the requirements of indicator *#1b: 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—Adults*.

Compliance Review

Performance Results

Table 3-49 presents **Oakland Community Health Network**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Oakland Community Health Network** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Oakland Community Health Network**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-49—SFY 2021 and SFY 2022 Standard Compliance Scores for OCHN

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**89%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**71%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**50%**
Standard V—Coordination and Continuity of Care	§438.208	**93%**
Standard VI—Coverage and Authorization of Services	§438.210	**82%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Standard IX—Grievance and Appeal Systems	§438.228	**84%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**40%**
Standard XI—Practice Guidelines	§438.236	**100%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**93%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-50 presents **Oakland Community Health Network**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Oakland Community Health Network**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Oakland Community Health Network** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-50—Summary of Standard Compliance Review Scores for OCHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	2	3	0	**40%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**119**	**118**	**100**	**18**	**1**	**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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Oakland Community Health Network received a score of 100 percent in the Practice Guidelines program area, demonstrating that the PIHP had adopted CPGs to serve as a resource for network providers in clinical decision making in accordance with all federal and/or contractual requirements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Oakland Community Health Network received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Oakland Community Health Network**'s processes were identified related to PSV, written communication to providers of credentialing decisions, provider-specific performance review at recredentialing, timely credentialing decisions, and the initial credentialing versus the recredentialing process.

Recommendation: While **Oakland Community Health Network** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that

Oakland Community Health Network conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: Oakland Community Health Network received a score of 40 percent in the Subcontractual Relationships and Delegation program area, indicating that the PIHP did not execute delegated written arrangements in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Oakland Community Health Network**'s processes were identified related to the content of delegated written agreements—specifically, missing federally required provisions.

Recommendation: While **Oakland Community Health Network** was required to develop a CAP, HSAG recommends that the PIHP conduct a scheduled annual review of each delegate's written agreement to ensure it includes all federally and contractually required content. This review should occur annually, regardless of changes to the federal managed care rule or with the PIHP's contract with MDHHS, to assist in identifying potential gaps that may have been missed in past reviews of the written agreements. HSAG also recommends that the PIHP ensure that documentation of all future oversight and monitoring activities is maintained and readily accessible, and that corrective action is required of its delegates when performance is determined to be unsatisfactory (e.g., corrective action is mandated for all deficiencies identified through the oversight activities).

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

HSAG performed a comprehensive assessment of **Oakland Community Health Network**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Oakland Community Health Network** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Oakland Community Health Network**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-51 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Oakland Community Health Network**'s Medicaid members.

Table 3-51—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Oakland Community Health Network** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Oakland Community Health Network** demonstrated that child members were receiving timely pre-admission screening dispositions for psychiatric inpatient care; however, the pre-admission screening dispositions for psychiatric inpatient care were not always completed within three hours for its adult members. This finding suggests that **Oakland Community Health Network** may not have

Performance Area	Overall Performance Impact
	sufficient staff to conduct timely screenings. As part of its QI efforts, **Oakland Community Health Network** should determine the root cause for the untimely pre-admission screenings for its adult members and implement interventions to mitigate barriers that may be contributing to untimely pre-admission screening dispositions. Additionally, although MDHHS has not yet established a performance standard for performance indicator #2, which measures timely completion of biopsychosocial assessments for new members within 14 days of a non-emergency request for service, **Oakland Community Health Network**'s rates for the associated five related performance indicators were at or between 42.86 percent and 53.33 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments. However, for performance indicators #2e and #3, which measure timely access to services for new members with SUD upon request for services and timely access to covered services after completing a biopsychosocial assessment, **Oakland Community Health Network** performed better than all PIHPs for all associated indicators, indicating **Oakland Community Health Network** had a sufficient network of SUD and mental health providers for new members to start treatment in a timely manner after the request for services and completion of the biopsychosocial assessment. Through the compliance review activity, **Oakland Community Health Network** demonstrated that it had an adequate QAPI program. As such, **Oakland Community Health Network** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in any areas where gaps are identified in member health outcomes. **Oakland Community Health Network** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers and employed staff to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Oakland Community Health Network** demonstrated that its members discharged from psychiatric inpatient units and from substance abuse detox units were seen in a timely manner for follow-up care with a mental health or SUD professional and had relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge, suggesting that **Oakland Community Health Network** had effective processes to transition members in a timely manner into outpatient care and that the lower level of care provided was appropriate. In addition to its existing care coordination efforts to improve members' timely access to services, **Oakland Community Health Network** should also continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.

Performance Area	Overall Performance Impact
Disparities in Care	**Quality**—**Oakland Community Health Network** identified within its PIP Submission Form that, as determined through data analyses, a disparity between its White and African-American populations in the continuation adherence rate for adult members (18 years of age and older) with a diagnosis of major depression who maintained their antidepressant medication for at least 84 days (12 weeks). **Oakland Community Health Network** reported that 53.2 percent of eligible White adults maintained their antidepressant medication for at least 84 days, while only 46.2 percent of eligible African-American adults maintained their antidepressant medication for at least 84 days during the measurement period. As such, **Oakland Community Health Network** initiated a PIP with a goal that there will no longer be a statistically significant rate difference between the two subgroups, and that the disparate subgroup (African-American adults) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White adults). By initiating effective interventions as part of the PIP, **Oakland Community Health Network** should see an increase in the continued use of antidepressant medication management for the African-American population. Improving antidepressant medication adherence supports wellness and health outcomes for members diagnosed with depression, while also reducing healthcare costs. Through its ongoing QI initiatives, **Oakland Community Health Network** should also continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 9—Macomb County Community Mental Health

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Macomb County Community Mental Health**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-52 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-52—Overall Validation Rating for MCCMH

PIP Topic	Validation Status	Performance Indicators	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	*Not Met*	The percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.	84.2%			Yes
		The percentage of African-American adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.	74.9%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Macomb County Community Mental Health**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African Americans) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian Americans) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-53 displays the interventions, as available, initiated by the PIHP to address the barriers identified through QI and causal/barrier analysis processes.

Table 3-53—Baseline Interventions for MCCMH

Intervention Descriptions	
The PIHP will pull data, broken down by provider, on providers' compliance rates for seeing members seven days after being discharged from a psychiatric unit. Follow-up will occur with certain providers to assess whether additional support is needed.	The PIHP will meet with providers to reiterate the importance of follow-up after an inpatient stay and provide space to discuss any specific challenges providers may be facing.

Intervention Descriptions	
The PIHP will review project compliance rates on the performance indicators, with consideration to race and ethnicity, against other PIHPs for comparison.	The PIHP will issue a memorandum (memo) to the provider network to remind providers of the importance of the performance indicator standard and detail expectations moving forward.
The PIHP will explore issuing incentive payments for providers who consistently meet the follow-up after inpatient stay standard.	The PIHP will hold a follow-up meeting with providers 30 days after the initial meeting to discuss reported improvements and review persisting challenges.
The PIHP staff will contact the plan hospital liaison team for coordination of discharging members who do not have a scheduled follow-up appointment.	The PIHP hospital liaison team will meet with members discharging from an inpatient stay and unable to secure a follow-up appointment to provide necessary services and coordination.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Macomb County Community Mental Health's Aim statement set the focus of the project, and the performance indicators were well defined. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Macomb County Community Mental Health received a *Met* score for 50 percent of the requirements within the Design stage of the project, indicating gaps in the PIHP's documentation and data collection methods within the design of the PIP. [**Quality**]

Why the weakness exists: Macomb County Community Mental Health received *Not Met* or *Partially Met* scores across five evaluation elements, including:

- The PIP topic was not selected following collection and analysis of plan-specific data to determine an existing racial/ethnic disparity.
- The PIP eligible population was not completely described to include all inclusion and exclusion criteria.
- The data sources and data elements were not clearly defined or described, and the PIHP's percentage of administrative data completeness was not provided.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** review the PIP Completion Instructions to ensure that all requirements for each completed evaluation element have been addressed. **Macomb County Community Mental Health** should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

Weakness #2: Macomb County Community Mental Health received a *Met* score for 29 percent of the requirements within the Implementation stage of the project, indicating gaps in the PIHP's documentation within the data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Macomb County Community Mental Health received *Not Met* or *Partially Met* scores across five evaluation elements, including:

- The narrative interpretation of performance indicator results did not clearly describe the baseline performance or report statistical testing to determine an existing disparity within the baseline measurement period.
- The documentation did not clearly or completely describe the causal/barrier analysis process, methods, or tools used to identify and prioritize barriers.
- Not all interventions clearly addressed the corresponding barrier to care.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** completely describe the performance in each measurement period, including the statistical testing results between population subgroups, to determine if a disparity exists. HSAG recommends that **Macomb County Community Mental Health** use appropriate causal/barrier analysis methods to identify barriers to care and implement interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Macomb County Community Mental Health**'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. **Macomb County Community Mental Health** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

Macomb County Community Mental Health received an indicator designation of *Reportable* for 11 indicators, signifying that **Macomb County Community Mental Health** had calculated the indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Macomb County Community Mental Health** received an indicator designation of *Do Not Report* for indicator #3, indicating that **Macomb County Community Mental Health** did not calculate this indicator in compliance with MDHHS Codebook specifications. Additionally, indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for indicator #2e, and SFY 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Results

Table 3-54 presents **Macomb County Community Mental Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Macomb County Community Mental Health** met or exceeded the MPS.

Table 3-54—Performance Measure Results for MCCMH

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	99.41%	95.00%
#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.		
MI–Children—Indicator #2a	32.73%	NA
MI–Adults—Indicator #2b	45.09%	NA
I/DD–Children—Indicator #2c	57.78%	NA
I/DD–Adults—Indicator #2d	45.16%	NA
Total—Indicator #2	42.22%	NA
#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]		
Consumers	87.56%	NA
#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–Children—Indicator #3a	DNR	NA
MI–Adults—Indicator #3b	DNR	NA
I/DD–Children—Indicator #3c	DNR	NA
I/DD–Adults—Indicator #3d	DNR	NA
Total—Indicator #3	DNR	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	52.63%	95.00%
Adults	55.44%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	4.48%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	92.81%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	17.21%	—
I/DD–Adults—Indicator #8b	5.03%	—
MI and I/DD–Adults—Indicator #8c	6.42%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]		
MI–Adults—Indicator #9a	100.00%	—
I/DD–Adults—Indicator #9b	94.17%	—
MI and I/DD–Adults—Indicator #9c	93.94%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	10.00%	15.00%
MI and I/DD–Adults—Indicator #10b	14.83%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	16.74%	—
MI and I/DD–Adults	22.14%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	46.20%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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.

DNR indicates the indicator was not calculated in compliance with specifications and received a *Do Not Report* designation.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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: To improve upon performance indicator rates, **Macomb County Community Mental Health** worked with network providers to review performance indicator data on a quarterly basis. **Macomb County Community Mental Health** also routinely and systematically audited data submitted by its providers, further ensuring data completeness and accuracy. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upon review of **Macomb County Community Mental Health**'s member-level detail file submission, HSAG identified 17 cases reported for indicator #1 that had a request date outside of the reporting period. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** indicated that the 17 cases were correctly included in reporting based on the medically cleared/detoxed date on the Certificate of Need (CON). However, the performance indicator report in FOCUS (the PIHP's IS) incorrectly displayed another date field from the CON as the request date. **Macomb County Community Mental Health** worked with its vendor, PCE, to implement an immediate fix and submitted a revised member-level detail file with the correct request dates listed. HSAG confirmed that all request dates were within the reporting period for all cases in indicator #1.

Recommendation: While an immediate fix was put in place by PCE for the incorrect request date issue, HSAG recommends that **Macomb County Community Mental Health** employ additional validation checks to ensure that the appropriate request dates are included in future reporting. The validation checks should include checking member-level data for request dates outside of the reporting period to further ensure data accuracy.

Weakness #2: For indicator #2, there was one case reported as an exception in error and five cases reported as compliant with a biopsychosocial assessment date outside of 14 calendar days of a non-emergency request for service. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** removed the exception case from reporting and noted that it should not have been included as outpatient services were never requested. For the five cases reported as compliant with a biopsychosocial assessment date outside of 14 calendar days of a non-emergency request for service, **Macomb County Community Mental Health** indicated that four cases were a result of provider billing errors, as the wrong service code was billed and, therefore, the FOCUS performance indicator report identified the following or

incorrect biopsychosocial assessment for reporting. Additionally, one case was the result of a manual override from out of compliance to compliance in error.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** enhance its current validation process to include a check for reported exceptions for performance indicators that the MDHHS Codebook does not allow exceptions/exclusions. The validation process should also include checking member-level data for cases with biopsychosocial assessment dates outside of the 14 calendar day criteria prior to submitting member-level data to HSAG for review.

Weakness #3: During PSV of member records, HSAG identified one member reported for indicator #2 that was reported as compliant in error. [**Quality**]

Why the weakness exists: One member was reported as compliant in error for indicator #2, as there was no biopsychosocial assessment completed.

Recommendation: HSAG recommends that the PIHP implement additional validation checks to further ensure data accuracy for future reporting periods. This additional level of validation could involve thoroughly reviewing in-compliance records listed in the member-level data to look for discrepancies for indicator #2, such as cases reported as compliant with no biopsychosocial assessment completed.

Weakness #4: HSAG noted a numerator and denominator mismatch between what was reported to MDHHS and what was reported in the PIHP member-level detail file provided to HSAG for indicators #2 and #2e. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** indicated that due to staff turnover, it was unable to confirm the reason for the mismatch. However, **Macomb County Community Mental Health** believes the mismatch was due to Quality Department staff downloading an Excel version of the report and making changes in the downloaded Excel file without making the corresponding changes to the performance indicator report stored in FOCUS. When preparing the member-level detail file for HSAG, staff members included information from the performance indicator report in FOCUS rather than the downloaded Excel file used for reporting to MDHHS. For indicator #2e, **Macomb County Community Mental Health** indicated that a portion of the data reported for indicator #2e is captured outside of **Macomb County Community Mental Health**'s FOCUS electronic health record (EHR) system. Specifically, members that scheduled intakes directly with SUD service providers and, in that case, were not screened by **Macomb County Community Mental Health** (the PIHP does not schedule intakes). SUD service providers sent this additional data to **Macomb County Community Mental Health** separately. Given that the data were captured outside of FOCUS, this information was not included in the member-level detail report downloaded from FOCUS for reporting to MDHHS.

Recommendation: HSAG recommends that for future reporting of indicator #2e, **Macomb County Community Mental Health** ensure that all information, including information captured outside of FOCUS by SUD providers relevant to expired requests, is included in reporting. **Macomb County Community Mental Health** could implement a validation step that includes checking for SUD provider reports, including expired request information, prior to submitting final rates to MDHHS to further ensure accuracy of reported data. Additionally, prior to submitting member-level detail file data to HSAG, HSAG recommends that **Macomb County Community Mental Health** conduct a

data count check across all reported performance indicators to ensure that it aligns with the final reported counts to MDHHS.

Weakness #5: For indicator #3, the incorrect ongoing covered service was identified for four cases due to an issue identified with PCE's performance indicator logic. Upon reviewing the revised member-level detail file submission counts following PCE's regeneration of the performance indicator data based on updating programming logic, HSAG noted a significant difference of more than 5 percentage points between the total rate for indicator #3 and the final submitted rate to MDHHS. Therefore, the reported rates for this indicator were determined to be materially biased and should not be reported. [**Quality**]

Why the weakness exists: The incorrect ongoing covered service was identified for four cases due to an issue identified with PCE's performance indicator logic. In some instances, FOCUS was recognizing the intake as the ongoing covered service when there was no ongoing service; and in other instances, there was an ongoing covered service, but the incorrect date was pulled. PCE corrected the issue and regenerated the performance indicator data based on updating programming logic so that it reflected the appropriate ongoing covered service date for these cases as well as all reported cases in indicator #3. Upon reviewing the revised member-level detail file submission counts, HSAG noted a significant difference of more than 5 percentage points between the total rate for indicator #3 and the final submitted rate to MDHHS. Therefore, the reported rates for this indicator were determined to be materially biased and should not be reported.

Recommendation: Although PCE corrected the issue with the ongoing covered service date through revised programming logic, HSAG recommends that **Macomb County Community Mental Health** enhance its validation processes to ensure that accurate dates are being captured within the system for the purpose of performance indicator reporting. This should include review of a statistically valid sample of cases to ensure appropriate dates are captured as well as visual validation checks on the raw data prior to MDHHS submission.

Weakness #6: While **Macomb County Community Mental Health** met the MPS for all but one indicator with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to members after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*) and also demonstrated a significant decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for adults and children for indicator #4a fell below the MPS by over 40 percentage points, suggesting that some adults and children discharged from an inpatient psychiatric unit may not have been able to get timely access to post-discharge follow-up.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** closely monitor discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*.

Compliance Review

Performance Results

Table 3-55 presents **Macomb County Community Mental Health**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Oakland Community Health Network** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Macomb County Community Mental Health**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-55—SFY 2021 and SFY 2022 Standard Compliance Scores for MCCMH

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**84%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**100%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**79%**
Standard VI—Coverage and Authorization of Services	§438.210	**73%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**82%**
Standard IX—Grievance and Appeal Systems	§438.228	**89%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**20%**
Standard XI—Practice Guidelines	§438.236	**57%**
Standard XII—Health Information Systems[4]	§438.242	**73%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**67%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-56 presents **Macomb County Community Mental Health**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Macomb County Community Mental Health**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Macomb County Community Mental Health** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-56—SFY 2022 Standard Compliance Review Scores for MCCMH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	9	2	0	**82%**
Standard IX—Grievance and Appeal Systems	38	38	34	4	0	**89%**
Standard X—Subcontractual Relationships and Delegation	5	5	1	4	0	**20%**
Standard XI—Practice Guidelines	7	7	4	3	0	**57%**
Standard XII—Health Information Systems[2]	12	11	8	3	1	**73%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	20	10	0	**67%**
Total	**119**	**118**	**88**	**30**	**1**	**75%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: HSAG did not identify any substantial strengths of **Macomb County Community Mental Health** through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Macomb County Community Mental Health received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Macomb County Community Mental Health**'s processes were identified related to PSV, Medicaid and Medicare exclusion/sanction queries, written communication to providers of credentialing decisions, and timely credentialing decisions.

Recommendation: While **Macomb County Community Mental Health** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Macomb County Community Mental Health** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

Weakness #2: Macomb County Community Mental Health received a score of 20 percent in the Subcontractual Relationships and Delegation program area, indicating that its delegated entities were not being monitored in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Macomb County Community Mental Health**'s processes were identified related to the oversight and monitoring of its delegates and the content of delegated written agreements. Specifically, the agreements were missing federally required provisions.

Recommendation: While **Macomb County Community Mental Health** was required to develop a CAP, HSAG recommends that the PIHP conduct a scheduled annual review of each delegate's written agreement to ensure it includes all federally and contractually required content. This review should occur annually, regardless of changes to the federal managed care rule or with the PIHP's contract with MDHHS, to assist in identifying potential gaps that may have been missed in past

reviews of the written agreements. HSAG also recommends that the PIHP ensure that documentation of all future oversight and monitoring activities is maintained and readily accessible, and that corrective action is required of its delegates when performance is determined to be unsatisfactory (e.g., corrective action is mandated for all deficiencies identified through the oversight activities).

Weakness #3: **Macomb County Community Mental Health** received a score of 57 percent in the Practice Guidelines program area, indicating that CPGs were not being adopted in accordance with all federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of policies and procedures, committee meeting minutes, and communication materials, gaps in **Macomb County Community Mental Health**'s processes were identified related to adopting CPGs in consultation with network providers, reviewing CPGs periodically, and disseminating CPGs to all affected providers.

Recommendation: While **Macomb County Community Mental Health** was required to develop a CAP, HSAG recommends that the PIHP develop mechanisms to solicit provider network input when adopting a new CPG or during an annual review of existing adopted CPGs. **Macomb County Community Mental Health** should adopt CPGs through a committee that includes provider network voting membership. **Macomb County Community Mental Health** should consider a minimum voting quorum; for example, a minimum of five voting network providers of specified specialties. HSAG also recommends that **Macomb County Community Mental Health** include as an agenda item the annual scheduled review of existing adopted CPGs through this committee. Further, HSAG recommends that **Macomb County Community Mental Health** notify its entire provider network (i.e., providers directly contracted with the PIHP, and providers contracted with the PIHP's delegates) annually, and ad hoc for newly adopted CPGs, via a provider newsletter, of the availability of the adopted CPGs. The provider newsletter should also encourage network providers to contact **Macomb County Community Mental Health** with comments or feedback to the existing adopted CPGs or with recommendations for potential future CPGs.

Weakness #4: **Macomb County Community Mental Health** received a score of 73 percent in the Health Information Systems program area, indicating that the PIHP had not implemented components of its IS in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of the PIHP's IS capabilities, gaps in **Macomb County Community Mental Health**'s processes were identified related to implementation of Patient Access and Provider Directory Application Programming Interface (API) requirements, and comprehensive utilization reports.

Recommendation: While **Macomb County Community Mental Health** was required to develop a CAP, HSAG recommends that the PIHP conduct thorough research of CMS' API technical specifications when implementing its remediation plan. Additionally, HSAG recommends that the PIHP develop comparative utilization reports by service, with comparisons between provider agencies and regionwide. These reports should be reviewed regularly (e.g., quarterly, annually) by the utilization management committee and/or QAPI committee to identify service utilization pattern trends, and outliers requiring intervention.

Weakness #5: Macomb County Community Mental Health received a score of 67 percent in the QAPI program area, indicating that the PIHP had not developed or implemented a QAPI program in accordance with all contractual requirements. Of note, a total of 10 deficiencies were identified. [**Quality**, **Timelines**, and **Access**]

Why the weakness exists: Through a review of the QAPI program and supporting documentation, gaps in **Macomb County Community Mental Health**'s processes were identified related to adopting and communicating process outcome improvement; the BOD's routine review of QAPI program reports; member participation in the QAPI program; implementation of a second PIP; time frame requirements for critical incidents and sentinel events; analysis of critical incidents, sentinel events, and risk events; analysis of data from the Behavior Treatment Review Committee; assessment of member experience with services; comprehensive annual QAPI program evaluation; and dissemination of the QAPI program evaluation.

Recommendation: While **Macomb County Community Mental Health** was required to develop a CAP, HSAG recommends that the PIHP conduct a comprehensive review of its QAPI program—specifically, the annual program description, workplan, and evaluation. This review should include a comparison of each individual QAPI program element required under **Macomb County Community Mental Health**'s contract with MDHHS against the PIHP's current QAPI program. **Macomb County Community Mental Health** should also leverage MDHHS' QAPI program checklist in this review. **Macomb County Community Mental Health** could consider developing a crosswalk of each individual provision with a description of how/where the PIHP is or is not meeting the requirement. For gaps HSAG identified during the compliance review activity, and self-identified gaps through this crosswalk, **Macomb County Community Mental Health** should identify an action plan for how it will come into compliance with the requirement(s). If **Macomb County Community Mental Health** develops the recommended crosswalk, the PIHP could submit the crosswalk with the annual QAPI submission to MDHHS to solicit additional collaboration between the PIHP and MDHHS.

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

HSAG performed a comprehensive assessment of **Macomb County Community Mental Health**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Macomb County Community Mental Health** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Macomb County Community Mental Health**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-57 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Macomb County Community Mental Health**'s Medicaid members.

Table 3-57—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Macomb County Community Mental Health** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Macomb County Community Mental Health** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Macomb County Community Mental Health**'s rates for the 11 related performance indicators were either not able to be reported due to incorrect performance indicator reporting logic (performance indicator #3) or the rates were at or between 32.73 percent and 87.56 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD or mental health professionals. Through the compliance review activity, gaps were identified in **Macomb County Community Mental Health**'s QAPI program. As such, as **Macomb County Community Mental Health** implements plans of action identified through its CAP to support process improvement, it should consider how to develop new or leverage existing QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support improvement in areas where gaps are identified in member health outcomes. **Macomb County Community Mental Health** should also continuously monitor network adequacy and capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Macomb County Community Mental Health** demonstrated relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge. Even though **Macomb County Community Mental Health**'s members were not being readmitted back to the hospital often and members who were discharged from a substance abuse detox unit received timely follow-up care with SUD professionals, child and adult members discharged from psychiatric inpatient units were not seen in a timely manner for follow-up care with mental health professionals, suggesting that **Macomb County Community Mental Health** had opportunities to improve its processes to transition members in a timely manner into outpatient care and/or there was a lack of mental health providers available to see all members within seven days of discharge. As part of its QI efforts, **Macomb County Community Mental Health** should analyze the reasons members are not seeing providers in a timely manner after being discharged from a psychiatric inpatient unit to determine the root cause and implement interventions to mitigate barriers that may be contributing to the lack of timely follow-up care. In addition to any care coordination efforts already in place to improve members' timely access to services, **Macomb County Community Mental Health** should also continue to

Performance Area	Overall Performance Impact
	encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—**Macomb County Community Mental Health** identified within its PIP Submission Form that, as determined through data analyses, a disparity existed between its White population and African-American population obtaining services after inpatient psychiatric hospitalization. As such, **Macomb County Community Mental Health** initiated a PIP with a goal to increase the percentage of eligible African-American adults who receive follow-up care within seven days of an inpatient psychiatric discharge and eliminate the identified disparity without a decline in performance for eligible White adults. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce the risk of repeat hospitalization. This PIP also aligns to performance indicator #4a, which is validated through PMV, and remains an area of opportunity for **Macomb County Community Mental Health** as the MPSs for child and adult members were not attained. In addition to the disparity identified through the PIP activity, **Macomb County Community Mental Health** should continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

Region 10 PIHP

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Region 10 PIHP**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-58 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2024.

Table 3-58—Overall Validation Rating for Region 10

PIP Topic	Validation Status	Performance Indicators	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Racial/Ethnic Disparities in Access to SUD Services	*Met*	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%			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%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Region 10 PIHP**'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) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-59 displays the interventions, as available, initiated by the PIHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-59—Baseline Interventions for Region 10

Intervention Descriptions
Region 10 PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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 PIHP designed a methodologically sound PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although no weaknesses were identified, HSAG recommends that **Region 10 PIHP** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

HSAG evaluated **Region 10 PIHP**'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 PIHP 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 2022 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Region 10 PIHP** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-60 presents **Region 10 PIHP**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS. Rates shaded in yellow indicate that **Region 10 PIHP** met or exceeded the MPS.

Table 3-60—Performance Measure Results for Region 10

Performance Indicator	Rate	Minimum Performance Standard
#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—Indicator #1a	100.00%	95.00%
Adults—Indicator #1b	100.00%	95.00%
#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.		
MI–Children—Indicator #2a	66.80%	NA
MI–Adults—Indicator #2b	51.83%	NA
I/DD–Children—Indicator #2c	67.68%	NA
I/DD–Adults—Indicator #2d	57.41%	NA
Total—Indicator #2	58.64%	NA
#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]		
Consumers	66.52%	NA
#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–Children—Indicator #3a	95.19%	NA
MI–Adults—Indicator #3b	88.60%	NA
I/DD–Children—Indicator #3c	92.73%	NA
I/DD–Adults—Indicator #3d	84.31%	NA
Total—Indicator #3	91.25%	NA
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	95.77%	95.00%
Adults	92.65%	95.00%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
Consumers	91.49%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.66%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of HSW enrollees during the reporting period 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 reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	90.56%	—
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.[2]		
MI–Adults—Indicator #8a	13.78%	—
I/DD–Adults—Indicator #8b	6.33%	—
MI and I/DD–Adults—Indicator #8c	7.58%	—
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or 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%	—
I/DD–Adults—Indicator #9b	93.57%	—
MI and I/DD–Adults—Indicator #9c	92.59%	—
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
MI and I/DD–Children—Indicator #10a	10.53%	15.00%
MI and I/DD–Adults—Indicator #10b	9.86%	15.00%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	16.89%	—
MI and I/DD–Adults	24.40%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	47.38%	—

Indicates that the reported rate met or exceeded the MPS.

— Indicates that an MPS was not established for this measure indicator.

NA indicates that an MPS was not currently established, as it was the second year of implementation for this measure indicator.

* 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 findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV 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 PIHP required root cause analyses and CAPs from the CMHSPs for performance indicators not meeting the MDHHS MPSs. During the monthly Quality Management Committee meetings and through the contract monitoring process, **Region 10 PIHP** evaluated any barriers that the CMHSPs identified as being non-compliant with performance indicator standards and helped build strategies for CMHSPs to meet performance indicator thresholds. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Region 10 PIHP required additional documentation and categorization of reasons for performance indicator non-compliance to determine why individuals were not accessing care and services and/or why individuals were not accessing care and services within established time frames. These additional documentation steps helped identify nuances and trends among providers, with the goal of improving the overall care of **Region 10 PIHP** members. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During the review, **Region 10 PIHP** discussed one CMHSP not being able to bill for assessment codes following changes to the assessment service codes by MDHHS since October 1, 2021. The CMHSP shared that there were approximately 104 intake assessment encounters that had not been reported for first quarter SFY 2022. [**Quality** and **Timeliness**]

Why the weakness exists: The CMHSP was unable to update assessment codes to match MDHHS changes in a timely matter in order to report all encounters for first quarter SFY 2022.

Recommendation: Region 10 PIHP was not readily able to identify potential performance indicator-specific rate impact. HSAG, therefore, recommends that **Region 10 PIHP** identify and implement a mechanism through which it can monitor encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future.

Weakness #2: During the review, **Region 10 PIHP** discussed one CMHSP had to update 6,000 lines of claims that were rejected and needed to be reprocessed in order to update encounter data since October 1, 2021. These encounters were for the Certified Community Behavioral Health Clinic (CCBHC) and processes for CCBHC encounter reporting were in the process of being finalized. These encounters were not reported to **Region 10 PIHP** since fixes were needed to be instituted. [**Quality** and **Timeliness**]

Why the weakness exists: The CMHSP was unable to receive clarification on the CCBHC program in order to finalize the process and reporting based on the new program prior to indicator rates being submitted for the quarter.

Recommendation: While the number of cases identified by **Region 10 PIHP** and the CMHSP were not impactful to the reported rates, HSAG recommends that **Region 10 PIHP** identify and implement a mechanism through which it can monitor encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future. In addition, HSAG encourages **Region 10 PIHP** to consider reaching out to MDHHS on behalf of the CMHSPs to obtain guidance on program changes prior to reporting quarterly indicator rates in order to mitigate any issues that might be a barrier in reporting indicator rates.

Weakness #3: During PSV, it was determined that one case for indicator #3 from one CMHSP had a different biopsychosocial date than what was provided to HSAG prior to the review. [**Quality**]

Why the weakness exists: After the review, **Region 10 PIHP** and the CMHSP were able to confirm that the member had an access screening completed on November 30, 2021, not a biopsychosocial assessment that was identified in PSV documentation as October 28, 2021. This case had an urgent need upon entry to the Mobile Intensive Crisis Stabilization (MICS) Program. The individual was discharged from MICS on November 30, 2021, and was seen for follow-up services (treatment planning) on December 1, 2021. Upon further review by **Region 10 PIHP** and the CMHSP, it was determined this case/performance indicator event should not be considered "in compliance" because of the crisis stabilization received before receiving ongoing service.

Recommendation: While the error was not impactful to the reported rate, HSAG recommends that **Region 10 PIHP** and the CMHSP employ additional oversight to their performance indicator validation processing to ensure service level detail used for calculating performance measures capture and match MDHHS specifications.

Weakness #4: While **Region 10 PIHP** met the MPS for all but two indicators with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to adults after discharge from a psychiatric inpatient unit, as the PIHP did not meet the MPS for this indicator (i.e., *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for adults for indicator #4a fell below the MPS by over 2 percentage points, suggesting that some adults discharged from an inpatient psychiatric unit may not have been able to get timely access to post-discharge follow-up.

Recommendation: HSAG recommends that **Region 10 PIHP** closely monitor adults' discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*.

Weakness #5: While **Region 10 PIHP** met the MPS for all but two indicators with an established MPS, opportunity exists for the PIHP to improve the timeliness of follow-up care provided to members after discharge from a substance abuse detox unit, as the PIHP did not meet the MPS for

this indicator (i.e., *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*) and also demonstrated a decline in performance since the prior year. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for indicator #4b fell below the MPS by over 3 percentage points, suggesting that some members discharged from a substance abuse detox unit may not have been able to get timely access to post-discharge follow-up.

Recommendation: HSAG recommends that **Region 10 PIHP** closely monitor members' discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*.

Compliance Review

Performance Results

Table 3-61 presents **Region 10 PIHP**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Region 10 PIHP** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Region 10 PIHP**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle and a re-assessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-61—SFY 2021 and SFY 2022 Standard Compliance Scores for Region 10

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Member Rights and Member Information	§438.10 §438.100	**79%**
Standard II—Emergency and Poststabilization Services[3]	§438.114	**100%**
Standard III—Availability of Services	§438.206	**86%**
Standard IV—Assurances of Adequate Capacity and Services	§438.207	**25%**
Standard V—Coordination and Continuity of Care	§438.208	**86%**
Standard VI—Coverage and Authorization of Services	§438.210	**73%**
Year Two (SFY 2022)		
Standard VII—Provider Selection	§438.214	**75%**
Standard VIII—Confidentiality[3]	§438.224	**91%**

Compliance Review Standards	Associated Federal Citations[1, 2]	Compliance Score
Standard IX—Grievance and Appeal Systems	§438.228	**87%**
Standard X—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XI—Practice Guidelines	§438.236	**100%**
Standard XII—Health Information Systems[4]	§438.242	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	**90%**
Year Three (SFY 2023)		
Review of PIHP implementation of Year One and Year Two CAPs		

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Table 3-62 presents **Region 10 PIHP**'s scores for each standard evaluated in the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Region 10 PIHP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with PIHP staff members. The SFY 2022 compliance review activity demonstrated how successful **Region 10 PIHP** was at interpreting standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-62—SFY 2022 Standard Compliance Review Scores for Region 10

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	27	3	0	**90%**
Total	**119**	**118**	**103**	**15**	**1**	**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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[2] The Health Information Systems standard includes an assessment of the PIHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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 PIHP received a score of 100 percent in the Subcontractual Relationships and Delegation program area, demonstrating that the PIHP had appropriate written arrangements with its subcontractors and adequate oversight and monitoring mechanisms of delegated activities. [**Quality**]

Strength #2: Region 10 PIHP received a score of 100 percent in the Practice Guidelines program area, demonstrating that the PIHP had adopted CPGs to serve as a resource for network providers in clinical decision making in accordance with all federal and/or contractual requirements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 10 PIHP received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with federal and/or contractual requirements. [**Quality**]

Why the weakness exists: Through a review of case files, gaps in **Region 10 PIHP** processes were identified related to PSV, written communication to providers of credentialing decisions, provider-specific performance review at recredentialing, timely credentialing decisions, and Medicare and Medicare exclusions/sanctions queries.

Recommendation: While **Region 10 PIHP** was required to develop a CAP, HSAG recommends that the PIHP enhance oversight and monitoring of the implementation of credentialing processes completed by the PIHP and/or by its delegates. HSAG recommends that **Region 10 PIHP** conduct a comprehensive review of a random sample of credentialing files and require a remediation plan for all identified deficiencies. Ongoing monitoring of internal and/or external processes should then be catered toward the performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved).

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

HSAG performed a comprehensive assessment of **Region 10 PIHP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Region 10 PIHP** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region 10 PIHP**'s overall performance contributed to the Michigan Behavioral Health Managed Care program's progress in achieving the CQS goals and objectives. Table 3-63 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Region 10 PIHP**'s Medicaid members.

Table 3-63—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Quality Care	**Quality, Timeliness,** and **Access**—Through MDHHS-required performance measure reporting, **Region 10 PIHP** has implemented procedures to track the quality, timeliness, and availability of care and services provided to its Medicaid members. Additionally, through the PMV activity, **Region 10 PIHP** demonstrated that child and adult members were receiving timely pre-admission screenings for psychiatric inpatient care. However, although MDHHS has not yet established a performance standard for performance indicators #2, #2e, and #3, which measure timely access to non-emergency services, **Region 10 PIHP**'s six rates associated with performance indicators #2 and #2e were at or between 51.83 percent and 67.68 percent, indicating continued opportunities to ensure that all members requesting services can obtain timely biopsychosocial assessments and appointments with SUD professionals. Of note, although some opportunities still exist for improvement for most populations, **Region 10 PIHP**'s rates under performance indicator #3 for *the percentage of new persons during the quarter starting any medically necessary ongoing covered services within 14 days of completing a non-emergent biopsychosocial assessment* indicated that many members could access mental health professionals for a timely appointment after the completion of the biopsychosocial assessment as indicated by rates at or between 84.31 percent and 95.19 percent. Through the compliance review activity, **Region 10 PIHP** demonstrated that it had a sufficient QAPI program. As such, **Region 10 PIHP** should continuously leverage its QAPI mechanisms to assess the quality and appropriateness of care being furnished to its members and implement strategies to support program improvement in areas where gaps are identified in member health outcomes. **Region 10 PIHP** should also continuously monitor network adequacy and

Performance Area	Overall Performance Impact
	capacity to ensure it has a sufficient network of providers to meet members' needs.
Care Coordination and Person-Centered Care	**Quality, Timeliness,** and **Access**—Through the PMV activity, **Region 10 PIHP** demonstrated relatively low prevalence rates of adult and child members being readmitted to the hospital or inpatient facility within 30 days of discharge. Additionally, child members discharged from psychiatric inpatient units were seen in a timely manner for follow-up care with a mental health professional. Even though **Region 10 PIHP**'s members were not being readmitted back to the hospital often and child members who were discharged from a psychiatric inpatient unit received timely follow-up care with mental health professionals, adults discharged from psychiatric inpatient units were not seen in a timely manner for follow-up care with mental health professionals, and many members discharged from substance abuse detox units were also not seen for follow-up care with a SUD provider within seven days of discharge, suggesting **Region 10 PIHP** had opportunities to improve its processes to transition all members in a timely manner into outpatient care and/or there was a lack of mental health and SUD providers available to see all members within seven days of discharge. As part of its QI efforts, **Region 10 PIHP** should analyze the reasons members are not seeing providers in a timely manner after being discharged from psychiatric inpatient units and substance abuse detox units to determine the root cause and implement interventions to mitigate barriers that may be contributing to the lack of timely follow-up care. In addition to any care coordination efforts already in place to improve members' timely access to services, **Region 10 PIHP** should also continue to encourage community engagement and systematic referrals among healthcare providers and to other needed services (e.g., to support physical health) and ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care plans in alignment with CQS Goal #2.
Disparities in Care	**Quality, Timeliness,** and **Access**—**Region 10 PIHP** identified within its PIP Submission Form that, as determined through data analyses, a disparity existed between its Black/African-American and White populations related to accessing timely SUD services. **Region 10 PIHP** reported that 68.1 percent of Black/African-American members received timely SUD services compared to 73.2 percent of White members during the measurement period. As such, **Region 10 PIHP** initiated a PIP with a goal to increase treatment or support provided within 14 days of a request for service among Black/African-American members with SUD, without a decline in performance for the White members. Addiction can result in negative health and social outcomes as well as increased risk for various mental and physical illnesses. Timely treatment of SUD may result in a reduction or elimination of substance use. This PIP also aligns to performance indicator #2e, which is validated through PMV. In addition to the disparity identified through the PIP activity, **Region 10 PIHP** should continue efforts to evaluate for and subsequently reduce all disparities (e.g., race, ethnicity, age, gender) to address health inequity in support of CQS Goal #4.

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 2021 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 2021 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 NorthCare

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **NorthCare Network** should reassess barriers linked to members 6 to 20 years of age and develop active targeted interventions that can be tracked and trended to determine the impact on the study indicator outcomes. The results should be used to guide decisions for QI efforts.
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 onset of this project NorthCare contracted for Relias' Care Management Technologies ProAct tool on the quality measure *Follow-up After Hospitalization for Mental Illness (FUH) within 7 days of Discharge* report for this project. This report applied HEDIS 2018 specifications for calculating baseline and remeasurement date for this PIP (Performance Improvement Project). • NorthCare's PIP did not demonstrate a significant improvement in the study indicator results due to barriers identified that included non-qualifying (HEDIS) follow-up services were provided such as T1016/T1017 (case management/supports coordination), not all CMHs [Community Mental Health Services Programs] were actively engaged in discharge planning, and ADTs (Admission, Discharge, Transfers) were not consistently being submitted by inpatient units. • Barriers were addressed with the exception of additional service codes as they were not part of the HEDIS code sets. The term of this project for HSAG validation ended, however, due to the importance of ensuring timely follow-up from inpatient hospital discharge NorthCare chose to continue a variation of the project and establish a new baseline in CY [calendar year] 21. However, the contract with Relias ended which required a complete rebuild of the report in-house which has been completed and is currently being validated. Once validation is completed a new baseline will be established. We do continue to monitor follow-up percentages as reported by our MMBPIS (Michigan Mission Based

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
Performance Indicator System – PI) measures which is different from our PIP calculations however does give us one picture of performance in terms of follow-up.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Will determine once data is validated.
c. Identify any barriers to implementing initiatives: • Timeliness of data.
HSAG Assessment: HSAG has determined that **NorthCare Network** did not address the prior year's recommendations. The PIHP described potential reasons for member noncompliance and explained that the project would be relaunched with a fresh baseline measurement period. However, the PIHP did not describe its process for reassessing the identified barriers or the method for developing active and targeted interventions. As such, HSAG recommends that **NorthCare Network** develop active targeted interventions that can be tracked and trended to determine each effort's impact on the indicator outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **NorthCare Network** and PCE should continue to work together on implementing the required updates to allow institutional providers to enter claims directly into ELMER to increase the quality and completeness of inpatient services claims data. • While **NorthCare Network** worked with PCE to update the logic to exclude mild-to-moderate MI Health Link members to mitigate future reporting issues, **NorthCare Network** should carefully review all applicable performance indicator data each time logic is updated to assess the impact on previously reported data. • Although **NorthCare Network** was able to later provide copies of the detailed data for the PIHP Medicaid members that aligned with the data reported to MDHHS, **NorthCare Network** should implement an additional level of validation to ensure future member-level data provided to HSAG align with the final reported rates to MDHHS. Additionally, since **NorthCare Network** uses the CMHSP PI event output sorted by PIHP only (Medicaid) to total all CMHSP data for reporting to MDHHS, for future reporting, **NorthCare Network** should confirm its reporting logic is accurately capturing new members for indicators #2 (i.e., #2a through #2e) and #3, as defined in the MDHHS Codebook (i.e., never seen by the PIHP for mental health services or for services for I/DD, or it has been 90 days or more since the individual has received mental health or I/DD services from the PIHP). This is important since the individual CMHSP data may identify a member as new (because the member is new to the CMHSP), whereas the member may have previously received services from the PIHP through a different CMHSP, thereby the member would not truly be a new PIHP member. • While **NorthCare Network** indicated that a contracted SUD provider had a CAP put in place to improve scheduling rates, demonstrating its efforts for improving the performance indicator, **NorthCare Network** should evaluate its other contracted SUD providers as well and explore further options to increase timely access to follow-up care for members discharged from a substance use detox unit.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
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):** • NorthCare's EHR (Electronic Health Record - ELMER) vendor (PCE) deployed necessary updates into ELMER training in July 2022. This allows for adequate testing prior to going live. The updates will provide the ability for institutional providers to enter claims directly into ELMER to increase the quality and completeness of inpatient services claims data. Once testing is completed, training for staff at UP Health System – Marquette will be scheduled and completed, and a go live date will be scheduled. • Recommendations related to performance indicators have been addressed. NorthCare has changed the reporting process in that data is now reported from a PIHP report versus a consolidated report from the five CMHSP data which was done historically. This process accurately captures "new" members per the codebook definition for the PIHP PI #2 and #3 calculations for both individual CMHSPs and PIHP reporting. • NorthCare also continues to monitor all SUD performance indicators and have seen improvement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Because there is no State benchmark, NorthCare has set a goal for our region of 80% for PI #2 and PI #3 and compares against the State total. For PI 2e, percent of SUD admissions within 14 days of non-emergent request for service, NorthCare has exceeded the State total for five of the past eight consecutive quarters with percentages ranging from 70.13% to 82.90%.
c. Identify any barriers to implementing initiatives: • A significant barrier to ensuring timely access to care is the staffing shortages we are experiencing across our region.
HSAG Assessment: HSAG has determined that **NorthCare Network** partially addressed the prior year's recommendations. While **NorthCare Network** has engaged in efforts to address HSAG's recommendations, the SFY 2022 PMV audit confirmed continued opportunities for improvement in some areas. **NorthCare Network** put forth effort to work with PCE systems to implement inpatient hospital submission in order to allow for inpatient services to be directly entered into ELMER (the PIHP's IS), and also indicated during the SFY 2022 PMV that PCE had finished programming for inpatient hospital electronic submission as of July 2022, currently in the testing phase. However, the updates were not fully implemented for the SFY 2022 PMV audit. Therefore, once the testing phase is complete and the updates have been rolled out to one of the PIHP's larger hospitals, HSAG recommends that **NorthCare Network** evaluate the impact of the updates on the quality and completeness of inpatient services claims data for assurance of timely identification of any further potential updates for future reporting. **NorthCare Network** fully addressed the prior year's recommendation to review all applicable performance indicator data each time logic is updated to assess the impact on previously reported data. **NorthCare Network** successfully fully addressed the recommendation, as during the SFY 2022 PMV audit HSAG did not have any

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
findings related to the recommendation and did not identify any MI Health Link mild to moderate members who were incorrectly included in the PIHP's indicator data. **NorthCare Network** fully addressed the prior year's recommendations to implement an additional level of validation to ensure future member-level data provided to HSAG align with the final reported rates to MDHHS and to confirm its reporting logic is accurately capturing new members for indicators #2 (i.e., #2a through #2e) and #3, as defined in the MDHHS Codebook (i.e., never seen by the PIHP for mental health services or for services for I/DD, or it has been 90 days or more since the individual has received mental health or I/DD services from the PIHP). **NorthCare Network** changed its reporting process so that data are reported in a PIHP-level report versus a consolidated report from the CMHSP data, which further ensured new members were being accurately captured for indicators #2 and #3. Additionally, during the SFY 2022 PMV audit, HSAG noted alignment between the data counts and rates from the member-level data provided to HSAG and the final rates reported to MDHHS. Lastly, **NorthCare Network**'s reporting logic appeared to be accurately capturing new consumers for indicators #2 and #3, in alignment with the MDHHS Codebook, as no issues were identified during the SFY 2022 PMV audit. **NorthCare Network** fully addressed the prior year's recommendations to evaluate its contracted SUD providers and explore further options to increase timely access to follow-up care for members discharged from a substance abuse detox unit. **NorthCare Network** continued its process to monitor all SUD performance indicators and demonstrated improvement in the SFY 2022 indicator #2e (*The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs)* rate when compared to SFY 2021.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **NorthCare Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **NorthCare Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.
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):** • NorthCare requested a due date for the Network Adequacy report from MDHHS which has been established as February 28th annually. NorthCare has also implemented a process to gather details about provider accommodations for the Provider Directory which is also available and will be included with the network adequacy standards.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• NorthCare's single case agreement template was updated in November 2021 to include prohibition on balance billing. • Through regional and/or internal committee standing agendas, items reviewed include PI data, Incident Report (IR) data, Behavior Treatment Committee (BTC) data, Grievance & Appeal (G & A) data, policies, provider performance review data, managed care standards, and other information as necessary with action taken as appropriate. As a result of the regional CMH CEO group, NorthCare has initiated a regional Call-to Action with a charge to discuss and evaluate concerns related to access to service. This group has identified a need to review documentation and data collected during the screening process for a more efficient and effective process. Performance indicator data has been and will continued to be shared with this group to assist with process improvement initiatives. • NorthCare has also implemented both Opioid and Behavioral Health Homes to expand our network capacity and enhance integration of services. • NorthCare has implemented additional data capture and reporting mechanisms to improve monitoring of access timeliness for SUD priority populations. A report has been developed that shows compliance with timeliness standards for all SUD priority populations. This report was deployed on April 15, 2022, has been out for review, and will be used for audit of 4th quarter data.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NorthCare's annual Demand and Network Adequacy Report was enhanced to address all standards and submitted to MDHHS by the 2/28/22 due date. This report also reflected staffing challenges noted herein. • Service integration as evidenced by increased enrollment in health home programs.
c. Identify any barriers to implementing initiatives: • A significant barrier is the staffing shortages we are experiencing across our region although we continue to look at alternatives such as staffing agencies and telehealth.
HSAG Assessment: HSAG has determined that **NorthCare Network** addressed the prior year's recommendations related to MDHHS-set network adequacy standards, single case agreements, and MDHHS-set appointment standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete. However, if not already included in **NorthCare Network**'s time/distance analysis, HSAG continues to stress that the PIHP ensure that the locations of provider types/services outside of a CMHSP physical location are also incorporated into the time/distance analysis.

Region 2—Northern Michigan Regional Entity

Table 4-2—Prior Year Recommendations and Responses for NMRE

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Northern Michigan Regional Entity** should ensure data are collected accurately and its interpretation of the results is described appropriately. • **Northern Michigan Regional Entity** should develop evaluation methods for each intervention to demonstrate its effectiveness on the study indicator outcomes and guide decisions for QI efforts. Further, **Northern Michigan Regional Entity** should conduct a root cause analysis to identify the reasons for the decrease in performance rates.
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):** • Issue #1: Data variability between study years. Each year data was dropping significantly from the previous year. Issue #1 identified: The issue is with a file import failure. MDHHS sent NMRE a CC360 file that caused the NMRE's import process to fail. Remediation: File import issue resolved, and the database was rebuilt. New information with all data was updated and AFIA [Afia, Inc.] was provided the information to update their database tables. • Issue #2: NMRE identified there was an issue with AFIA seeing the right data though the data was available in the right table. It was unclear why this was happening. Issue #2 identified: AFIA not being able to see the data was causing the data to be off on the reports as the job that pulls the data for the reports was not pulling updated data. Remediation: Database issue was resolved; the temp table had a transaction lock that was not clearing. The lock was cleared, and data calculation was processed and copied to the NMRE's database. However, data variation continued from year to year in the denominator with no valid explanation. • Issue #3: Results continued to vary from year to year. Issue #3 identified: NMRE in collaboration with AFIA began to review the data more closely and was able to identify that there was a substantial amount of prescription data missing from CY2018 that would have possibly been used for rate production for the 2019 measurement period. Remediation: NMRE re-imported old data into the data warehouse, and AFIA recreated the HEDIS measure with the re-imported data. IT has taken steps to avoid this happening in the future. The maintenance task that was culling data from the database inaccurately has been deleted and double checked to make sure there are no other tasks removing data. IT also developed the HEDIS measures in PowerBI portal and gave access to the other NMRE staff other than IT. The quality department will be monitoring the reports monthly in PowerBI.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • By re-measurement 2 the NMRE began to see more accurate data. Though the original goal was never met due to the data accuracy issues, there were significant system improvement initiatives that resulted in better data collection and collaboration with the third-party vendor.
c. Identify any barriers to implementing initiatives: • When dealing with a third party vendor, sometimes certain changes/implementations are out of NMRE's control.
HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** partially addressed the prior year's recommendations. The PIHP described data collection issues identified and system improvement initiatives to correct those issues. However, the PIHP did not describe its process for conducting a root cause analysis to determine reasons for the decrease in performance. As such, HSAG recommends that **Northern Michigan Regional Entity** reassess barriers linked to the targeted population and develop active interventions to address those barriers to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Northern Michigan Regional Entity** should continue to provide additional training to its SUD providers regarding proper documentation for exclusions for indicator #4b. Since HSAG does not have access to the SUD providers' systems during the PSV, all notes and proper documentation need to be stored within RECON. This will further ensure data completeness and quality when reporting the indicator. • The CMHSPs should do additional spot checks on indicators (i.e., indicators #4a, #4b, and #10) when discharge information is sent over from a facility to properly identify the correct date of discharge. Follow-up with the facility may be necessary if the date is not clear.
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 SUD Treatment Coordinator has been providing ongoing trainings to providers around properly documenting exceptions on indicator 4b. In addition, there are as needed trainings. This gives providers the opportunity to request training whenever the need arises or when there is a change in staffing. However, the NMRE does not store clinical documents in RECON (NMRE's internal system) unless necessary for authorizations because RECON is not an EHR. The NMRE does request documentation of dates and reasons within the RECON system. All documentations for the PMV review are requested ahead of time for review or as needed. • To address accuracy of discharge dates for indicators 4a and 10, staff gets the discharge paperwork from the hospitals and enters the discharge date and follow up information into the end of episode in the consumer's chart. That is the only way that it is pulled into indicator reports. It does not pull into reports without the discharge date. At the time, there were only 3 dedicated staff for access/hospitalizations. Within the past year, the responsibility for entering end of episodes has shifted from this small department to a new department with more resources.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
• There is also a clerical staff who tracks all hospitalizations, discharges, and follow ups on a tracking spreadsheet that is sent to the Quality Director weekly as opposed to monthly. This allows the Quality Director to cross-reference to ensure that all hospital discharges have been entered into the Electronic Medical Record (EMR) accurately. With the weekly tracking, the quality Director can stay on top of it more regularly. The Quality Director has also started ensuring that the discharge dates on the spreadsheet match the discharge dates on the end of episodes and have also gone into the charts to confirm that the discharge paperwork from the hospital also shows the same date. • For another CMHSP, the data validation/analyst staff added a filter that eliminates when there is an exception like in the case that resulted in the inaccurate data. The incident that caused the inaccurate data was that the individual was being seen by another provider. That should have been excluded but it wasn't. The perimeter for this measure was established that being seen by another provider is an exception, not to be overridden as in compliance. Previous reports were also updated accordingly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • End of episodes are being entered timely and the data is more accurate. There is hardly a need to reach out to ask about a missing end of episode due to the changes in the process. • This resulted in more reliable data on current and future reports.
c. Identify any barriers to implementing initiatives: • The only barriers that tend to delay the entering of the end of episodes is that a couple of hospitals struggle getting the discharge paperwork in a timely fashion to the CMHSP. • For SUD providers, high staff turnover makes it difficult to maintain the same standard for a long period of time.
HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** fully addressed the prior year's recommendations. In regard to HSAG's recommendation to complete additional training for SUD providers on indicator #4b as well as implement additional validation checks, **Northern Michigan Regional Entity** provided ongoing trainings to providers around properly documenting exceptions for indicator #4b along with additional provider trainings upon request. In addition, during the SFY 2022 PMV audit, **Northern Michigan Regional Entity** indicated that it met with two providers per quarter and reviewed exceptions and compliance quarterly. The PIHP also discussed seeing progress and less need for corrective action as a result of the additional validation checks. **Northern Michigan Regional Entity** fully addressed HSAG's recommendation for its CMHSPs to do additional spot checks on indicators (i.e., indicators #4a, #4b, and #10) when discharge information is sent over from a facility to properly identify the correct date of discharge. **Northern Michigan Regional Entity** shifted the responsibility of entering end of episodes to another department with more resources within the past year. **Northern Michigan Regional Entity** also discussed an enhanced validation process that involved providing a weekly tracking spreadsheet to its quality director, which was reviewed to confirm appropriate discharge dates based on review discharge paperwork from the facility. In addition, during the SFY 2022 PMV audit, the PIHP noted that it had been working with the CMHSPs to improve the accuracy of their data, including discharge dates. HSAG did not identify any discharge discrepancies during the SFY 2022 PMV audit.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Northern Michigan Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Northern Michigan Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD [adverse benefit determination] notice 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):** • Northern Michigan Regional Entity (NMRE) has updated our reporting system to ensure that each zip code in the NMRE region has multiple client residential addresses across the zip code for analysis (as different residences may have differing coverages). In addition, we are able to group the analysis to determine coverage levels for each county, by service, and overall levels for the region. We have also now incorporated drive time as a reportable feature. To ensure that the reporting is consistent with MDHHS Network Adequacy standards, NMRE has assigned areas geographical designations based upon past MDHHS county reporting, and US Census Bureau reporting guidance. • The ABD notices have been standardized and implemented throughout the PCE platform utilized by the CMHSPs and the NMRE. NMRE will continue to monitor the CMHSPs' use of the state-mandated templates as well as use of taglines via the annual site review process. The NMRE will update the annual site review monitoring tool to reflect these changes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NMRE is able to determine the percentage coverage of zip codes using client addresses from across the code itself. We have integrated drive time as a reportable metric. Our new dashboard compares each of the client residential addresses to our network providers; we are able to determine drive time for all providers in our network, using the closest providers to cross examine against the MDHHS standard.
c. Identify any barriers to implementing initiatives: • NMRE's main barrier was determining the best way to use Microsoft Power Bi to do analysis for many thousands of client records.
HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** addressed the prior year's recommendations related to MDHHS-set network adequacy standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and considered HSAG's recommendations included as part of the progress updates.

Region 3—Lakeshore Regional Entity

Table 4-3—Prior Year Recommendations and Responses for LRE

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Lakeshore Regional Entity** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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):** • At the onset and during the height of the coronavirus disease 2019 (COVID-19) pandemic, Beacon Health Options (BHO) implemented a reminder program, via postcards, emails, text messages, and telephone calls, to encourage consumers to engage in diabetes monitoring, which requires bloodwork. On November 1, 2021, Lakeshore Regional Entity (LRE) transitioned the Quality Managed Care Function from BHO to the LRE. Since November 1, 2021, the COVID-19 has subsided allowing for in-person diabetes monitoring services and consumers to engage with healthcare providers to render diabetes monitoring services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • Potential Barriers include: 1) cost of materials and staff to operationalize the reminder program; 2) the effectiveness of the reminder program when healthcare providers were not open to the public for non-emergent services such as diabetes monitoring/bloodwork, and 3) lack of consumer engagement due to public fear caused by the COVID-19 pandemic.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** addressed the prior year's recommendations. The PIHP developed interventions to address the barriers associated with the COVID-19 pandemic and also noted that the pandemic effect has subsided and appears to no longer be a significant barrier to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Lakeshore Regional Entity** and the CMHSPs should make additional enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in wage and income values. • While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to mitigate future reporting issues, the PIHP should deploy reporting logic that identifies all cases wherein the service request date is equal to the assessment completion date and require each CMHSP to manually review for accuracy.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Additionally, **Lakeshore Regional Entity** should track each CMHSP's confirmation of this review as part of its routine CMHSP oversight. • While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to require timeliness of encounter data submissions, the PIHP was not readily able to identify the potential performance indicator-specific rate impact. The PIHP therefore should identify and implement a mechanism through which it can monitor the encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future. • While **Lakeshore Regional Entity** required a CAP from each CMHSP for any performance indicator that did not meet the MPS, the PIHP should work with its CMHSPs to closely monitor adults' discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator #4a.
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):** • Behavioral Health Treatment Episode Data Set (BH-TEDS) Validation Process: At the beginning of FY22, LRE reminded all CMHSP to edit check BH-TEDS for these types of "disconnects" prior to submission to LRE. All CMHSPs agreed to perform BH-TEDS edit checks. In addition, several CMHSPs confirmed that due to the required edit checks, each implemented programming changes to their EMRs to prevent such erroneous entries. On a more global stage, LRE requested and PCE Systems applied changes to the PIHP system to add reject edits for mis-matching fields in the event that any were uploaded by the CMHSPs into the PIHP system. • MMBPIS Request for Service Date is Equal to Assessment Date: For the past two years, LRE's practice is for the CMHSPs to validate accuracy for each instance where the Request for Service Date is Equal to Assessment Date. LRE also requires the CMHSP reviewer to attest, in writing, that 100% of these instances are reviewed and validated. • Timeliness of Encounter Data Submissions: HealthWest implemented internal reporting to more closely monitor both encounters as well as services delivered/billed that were not yet reported in the encounters, which assisted in keeping their data submissions on track. As if March 1, 2022, HealthWest fully implemented its PCE Systems ("Latitude 43") EMR. LRE continues to closely monitor encounter volumes and anticipates a timely encounter submission for HealthWest due to the Latitude 43 implementation. LRE implemented Microsoft Power BI at the PIHP level to allow more real-time monitoring of encounter data. As of the 2022 PMV review, LRE had already developed multiple dashboards and demonstrated these dashboards during the live virtual audit. The Power BI dashboard technology enables LRE to access detailed encounter volume via drill-downs for routine monitoring of services at a CMHSP and provider level. Additionally, LRE hired a full-time analyst dedicated to working solely with CMHSP data. • CAPs for MMBPIS below the MPS: For years, LRE's practice, regardless of the indicator, requires that LRE issue a CAP to any CMHSP that fails to meet the MPS for any MMBPIS indicator. LRE

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
continues this practice today. Additionally, LRE daily provides each CMHSP with a list of discharges for follow-up following discharges, both adult and children.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BH-TEDS Validation Process: Not applicable • MMBPIS Request for Service Date is Equal to Assessment Date: Not applicable • Timeliness of Encounter Data Submissions: HealthWest encounter submissions have become much more regular. LRE also improved monitoring of all CMHSP data submissions, including the routine tracking of when date submissions are made and whether they were received timely or late. • CAPs for MMBPIS below the MPS: LRE has been compliant with MPSs for the last six quarters.
c. Identify any barriers to implementing initiatives: • BH-TEDS Validation Process: None noted by any CMHSPs. However, LRE acknowledges that during the 2022 HSAG PMV audit, HSAG identified additional discrepancies in LRE's data regarding Employment Status and Minimum Wage. LRE identified those records and is following up on those records with each CMHSP. LRE also required that each CMHSP correct those specific records and identify how those specific records made it into the LRE and MDHHS systems. • MMBPIS Request for Service Date is Equal to Assessment Date: Due to the care delivery models utilized in Region 3, such as the Certified Community Behavioral Health Clinic (CCBHC) and "same day" models, LRE recognizes that some CMHSPs have almost 500 chart reviews for each MMBPIS reporting quarter, which is not sustainable. • Timeliness of Encounter Data Submissions: not applicable. • CAPs for MMBPIS below the MPS: not applicable.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** fully addressed the prior year's recommendations. In regard to HSAG's recommendation to make additional enhancements to its BH-TEDS validation process to ensure there are no discrepant data entered, **Lakeshore Regional Entity** reminded all CMHSPs to edit check BH-TEDS prior to submission to **Lakeshore Regional Entity**, which influenced some CMHSPs to implement programming changes to their EHRs to prevent erroneous entries. In addition, during the SFY 2022 PMV audit the PIHP confirmed that it made changes to its PCE system to identify mismatches between wage and income statuses to avoid discrepant BH-TEDS entries. Additionally, the PIHP deployed enhancements for its monitoring of BH-TEDS submission timeliness and volume to ensure completeness. The data are trended, and **Lakeshore Regional Entity** followed up on any anomalies during its routine meetings with its CMHSPs and evaluated the CMHSPs' BH-TEDS data entry processes during the annual site review it conducted of each CMHSP, which included an evaluation of the CMHSPs' information systems technology. **Lakeshore Regional Entity** fully addressed HSAG's recommendations for the PIHP to deploy reporting logic that identifies all cases wherein the service request date is equal to the assessment completion date and require each CMHSP to manually review for accuracy and track each CMHSP's confirmation of this review as part of its routine CMHSP oversight. **Lakeshore Regional Entity** had CMHSPs validate accuracy for each instance wherein the service request date is equal to the assessment completion date and required the CMHSPs to provide written attestation that 100 percent of the instances were reviewed and validated. Additionally, during the SFY 2022 PMV audit, the PIHP confirmed it deployed this process; and throughout the PMV period under review, the PIHP required 100 percent manual review of all indicator #2a cases wherein the service request date is equal to the assessment completion date.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Lakeshore Regional Entity fully addressed HSAG's recommendation for the PIHP to identify and implement a mechanism through which it can monitor the encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future. One of **Lakeshore Regional Entity**'s CMHSPs implemented internal reporting to more closely monitor encounters as well as services delivered/billed that were not yet reported in encounters. In addition, during the SFY 2022 PMV audit, **Lakeshore Regional Entity** indicated that it began implementation of Microsoft Power BI to allow more real-time monitoring of encounter data. As of the PMV review, the PIHP had already developed multiple dashboards, and during the live virtual audit review, **Lakeshore Regional Entity** displayed samples of these dashboards. The dashboard technology will allow detailed encounter volume drilldowns for routine monitoring of services at the CMHSP and provider levels. Additionally, the PIHP hired a full-time analyst dedicated to working solely with the PIHP's CMHSP data. Lastly, **Lakeshore Regional Entity** fully addressed HSAG's recommendation for the PIHP to work with its CMHSPs to closely monitor adults' discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements for indicator #4a. **Lakeshore Regional Entity** issued a CAP to any CMHSP that failed to meet the MPS for any MMBPIS indicator, and provided each CMHSP with a daily list of discharges for follow-up for both adults and children. **Lakeshore Regional Entity** also demonstrated improvement in the SFY 2022 indicator #4a rate for the adult population when compared to SFY 2021.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Lakeshore Regional Entity** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice 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):** • Network Adequacy Standards: LRE is on track to complete a regional Provider Network Adequacy Report (PNAR) by September 30, 2022. The PNAR will ensure adequate capacity of network services

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
or identify areas requiring additional resources to ensure capacity meets service needs across the seven-county LRE region. • Appointment Standards: LRE created a new server to allow for geo-mapping of beneficiary addresses and provider locations to calculate compliance with time and distance standards that provides ongoing monitoring of regional compliance with time and distance standards for network adequacy. By cross-referencing consumer and provider locations, LRE can quickly and accurately note compliance by county for each time and distance standard for each service for which there is a defined standard per MSA [Medical Services Administration]18-49. The dashboards include all services identified in the MDHHS Network Adequacy Policy (MSA 18-49) and applicable procedures, as well as all levels of SUD services. This evaluation is displayed as a % of people meeting the time and distance standards per MSA 18-49. The geo-mapping process required manual processing by IT/IS [information technology/information systems] staff, involving nearly 163,000 consumer and nearly 100 provider location addresses being entered into the system for calculation. Each address took an estimated 3-7 seconds per record. • Service Authorization and ABD Notice Requirements: During its Annual CMHSP Site Review process, LRE requires CMHSPs to provide proofs demonstrating policies, procedures, and adherence to said policies and procedures. If a CMHSP fails to meet any element of the Site Review, LRE issues a CAP to the CMHSP. LRE also analyzes the Service Authorization and ABD Notice reports provided to MDHHS. LRE then distributes the data analyses via the QI ROAT [Quality Improvement Regional Operations Advisory Team] and CS ROAT [Customer Service Regional Operations Advisory Team]. When necessary, LRE convenes working meetings, and, if necessary, subsequent CAPs to any CMHSP struggling with meeting the expectations for Service Authorizations and ABD Notice Requirements. Following the HSAG Audit, LRE determined it should develop a quarterly review process in lieu of the annual Site Review process to better oversee the implementation of the Service Authorization and ABD Notice Requirements. LRE is finalizing its the policy and procedure to implement quarterly service authorizations and adverse benefit determination audits that will touch each CMHSP and review a random sample of service authorizations and ABD from the quarterly state report, which will be operational during FY23 Q [quarter] 1.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Network Adequacy Standards: LRE staff have developed a process for obtaining local network information from Member CMHSPs in a timely and consistent manner to ensure broad monitoring of network services. LRE has begun to explore a regional provider database/module contained within LIDS [Lakeshore Integrated Data Solutions] (PCE EHR) to provide real-time provider information across the regional network. This module would be cross-functional, serving the departmental needs of provider network (provider information and locations), quality (provider list for up-to-date provider lists and locations), and IT/IS (encounter and other data reporting needs). • Appointment Standards: LRE is more accurately able to assess compliance with time and distance standards required by MSA 18-49. • Service Authorization and ABD Notice Requirements: not applicable.
c. Identify any barriers to implementing initiatives: • Network Adequacy Standards: In the past, LRE did not maintain a master provider list within LIDS. LRE is currently finalizing an accurate provider list that includes all regional providers. LRE will make this master provider list, which is vetted through primary source credentialing documentation, National

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
Plan and Provider Enumeration System (NPPES), USPS, the Department of Licensing and Regulatory Affairs (LARA), etc., available to all Region 3 CMHSPs in a standardization attempt. • Appointment Standards: Geo-coding the consumer addresses (nearly 163,000) and provider addresses required significant staff resources. The manual process makes ongoing assessment challenging without the resources and planning to automate the process. LRE will begin exploring automation of geo-mapping for more efficient and timely monitoring of time and distance standards. • Service Authorization and ABD Notice Requirements: not applicable.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** addressed the prior year's recommendations related to MDHHS-set network adequacy standards and single case agreements. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and considered HSAG's recommendations included as part of the progress updates. Of note, while **Lakeshore Regional Entity**'s narrative did not mention single case agreements, HSAG's assessment of the PIHP's follow-up to this recommendation was determined through the SFY 2021 compliance review CAP progress updates. HSAG has determined that **Lakeshore Regional Entity** partially addressed the prior year's recommendations related to MDHHS-set appointment standards. The PIHP's narrative implied that appointment standards were related to time/distance standards, which is inaccurate. While **Lakeshore Regional Entity**'s original SFY 2021 compliance review CAP for this requirement appropriately addressed the appointment standards (i.e., "…LRE site review will include monitoring specific to timeliness in service to verify policy and process are in place for screening, referral, and admission time frame standards, including the time frames for priority populations…"), based on the PIHP's narrative, it appears that the PIHP is interchanging the time/distance standards and appointment standards, which are two different sets of standards. As such, HSAG recommends that **Lakeshore Regional Entity** review its original action plan and MDHHS' Access Standards policy (last revised October 28, 2021) and ensure its original action plan is appropriately implemented. HSAG has determined that **Lakeshore Regional Entity** addressed the prior year's recommendations related to service authorization and ABD notice requirements. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and addressed HSAG's recommendations included as part of the progress updates. Of note, HSAG fully supports **Lakeshore Regional Entity**'s decision to implement quarterly audits (as opposed to annual reviews) of service authorizations and ABD audits of its CMHSPs using MDHHS' quarterly report.

Region 4—Southwest Michigan Behavioral Health

Table 4-4—Prior Year Recommendations and Responses for SWMBH

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Southwest Michigan Behavioral Health** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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):** • We determined that individuals were less likely to get non-essential medical services, like diabetes screening lab work, during the initial phases of the pandemic, including throughout 2020 and into 2021. As medical providers opened up in 2021, we sent mailings to individuals who were missing their labs, reminding them of the importance of the screening. SWMBH personnel sent out 253 mailings on or around April 6, 2021, and 330 mailings on or around October 4, 2021.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • By the end of calendar year 2021, we saw an improvement in diabetes screening rates as compared to 2020. However, at 76% for CY 2021, rates were still lower than our baseline of 79-81%.
c. Identify any barriers to implementing initiatives: • COVID-related concerns persisted throughout calendar year 2021, albeit to a lesser effect than at the outset of the pandemic, driving continued hesitancy to engage with medical providers for non-essential services such as diabetes screenings. Access trends are routinely discussed during Regional Quality and Clinical Committee meetings, to ensure consumers are receiving timely care.
HSAG Assessment: HSAG has determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations. The PIHP developed interventions to address the barriers associated with the COVID-19 pandemic and also noted that the pandemic effect has subsided and appears to be less of a barrier to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • While **Southwest Michigan Behavioral Health** provided updated files, the PIHP should implement additional validation checks to ensure requirements within the MDHHS Codebook are being met with regard to appropriate populations being included in performance indicator reporting. • As part of **Southwest Michigan Behavioral Health**'s monthly review of performance indicator rates, the PIHP should conduct a detailed review of CMHSP-reported compliant cases to ensure the CMHSPs are appropriately categorizing cases as compliant and noncompliant for future reporting. • Although Van Buren CMHSP indicated that it will be switching to a new EHR in October 2021, which will allow tracking of disposition start and stop times for future reporting of indicator #1, all disposition start and

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
stop time data reported from Van Buren CMHSP until October 2021 will not be able to be included in reporting for indicator #1. **Southwest Michigan Behavioral Health** should work with Van Buren CMHSP on appropriate tracking of disposition start and stop times and ensure validation checks are in place to confirm the accuracy of drop-down selections based on manually tracked disposition start and stop times. • As recommended during the prior year's PMV activity, **Southwest Michigan Behavioral Health** should extract and lock member-level data for the indicator counts reported to MDHHS. In addition, **Southwest Michigan Behavioral Health** should provide additional oversight to ensure CMHSPs are providing all pertinent details in its member-level data for future reporting. • To improve overall performance, **Southwest Michigan Behavioral Health** should work with its CMHSPs to ensure that accurate and complete member-level data are provided for future reporting for all performance indicators and that these data align with the indicator counts reported to MDHHS. In addition, **Southwest Michigan Behavioral Health** should monitor members' discharges from a substance abuse detox unit within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator #4b.
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):** • HSAG noted that some CMHSPs included non-Medicaid members in their performance indicator reporting. SWMBH completes additional validation checks during annual CMH site reviews to ensure only the appropriate Medicaid populations per the MDHHS Codebook are included in the performance indicator data. SWMBH's current process is to review 10% of total cases against enrollment and quality standards. This is a recommendation that was received from HSAG in 2019 and has been utilized effectively. During these reviews, SWMBH also verifies the CMHSPs process for ensuring only Medicaid populations are included. • SWMBH monitors indicator #4b data monthly for completeness, including Medicaid IDs, and all non-compliant cases are reviewed for quality and accuracy. SWMBH is currently in the process of revising the PIHP indicator 4b report in our Tableau analytics system to simplify the process for validating compliant cases to occur on a quarterly basis. • SWMBH continues to ensure CMHSPs utilize the locked MMBPIS template to supply monthly performance indicator data to the PIHP. These results are reviewed and monitored monthly during internal and external Quality Management Committee meetings to ensure completeness, accuracy and quality of the data. To further ensure integrity of the performance indicator data used to calculate final reported rates to MDHHS, final CMHSP MMBPIS templates are locked down in a secure folder on SWMBH's server. These files are retained with only limited SWMBH staff access and the data is directly supplied to HSAG by SWMBH for future reviews and to MDHHS for quarterly reports. This approach allows SWMBH to ensure each indicator's numerator and denominator do not change and detailed record of the final data that was submitted to MDHHS is retained. • SWMBH's QAPI department created a job aid available for CMHSPs that outlines accurate definitions of compliance and exceptions for each indicator per the current codebook (v2020) to assist in

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
appropriately categorizing events. The MMBPIS template utilized by CMHSPs includes formulas matching codebook standards and calculates automatically per the data entered. • Upon identification of a data integrity risk in the existing process, SWMBH immediately requested a CAP for Van Buren CMH to remedy the deficiency related to not recording a disposition date in the pre-admission screening field. Van Buren indicated that it will be adding signature validations to disallow unpopulated data in the pre-admission screening field. Effective 10/1/2021, Van Buren changed EHR systems from Smartcare to PCE. PCE requires a disposition date to be entered in the required field before it allows the user to proceed to the next module. SWMBH monitors this data via monthly MMBPIS data submissions, through site reviews and through data quality and completeness reports available through our Tableau analytics system.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • 2022 PMV draft results indicate improvement overall with 37/37 or 100% of the total elements evaluated receiving a designation score of met, reportable or accepted compared to 34/38 (or 89.4%) in 2021.
c. Identify any barriers to implementing initiatives: • [no narrative provided by the PIHP]
HSAG Assessment: HSAG has determined that **Southwest Michigan Behavioral Health** partially addressed the prior year's recommendations. While **Southwest Michigan Behavioral Health** has engaged in efforts to address HSAG's recommendations, the SFY 2022 PMV audit confirmed continued opportunities for improvement in some areas. As related to HSAG's recommendation to implement additional validation checks to ensure requirements within the MDHHS Codebook are being met with regard to appropriate populations being included in performance indicator reporting, **Southwest Michigan Behavioral Health** indicated that it has since put additional validation checks in place to ensure only the appropriate Medicaid populations are included in performance indicator reporting, including review of 10 percent of total cases against enrollment and quality standards and verification that the CMHSPs' process for ensuring only Medicaid populations are included in the performance indicator reporting. In addition, during the SFY 2022 PMV audit, **Southwest Michigan Behavioral Health** reported evaluating validation processes and programming code during annual CMHSP site reviews to ensure that non-Medicaid members were excluded from CMHSP reporting to the PIHP on the performance indicators, and an extra validation step was added to its own process prior to submission of the data. However, HSAG noted for two events during the SFY 2022 PMV audit that non-Medicaid members were being included in reporting for indicator #4b. The CMHSP reported that for the two events, full assessments were not completed, and the programming logic used for pulling source data for the indicator pulled in historical assessment dates. Therefore, HSAG recommends that the PIHP implement visual validation checks on the raw data in the aggregated reporting template prior to MDHHS submission to ensure requirements within the MDHHS Codebook are being met. This will help ensure that appropriate populations are being included in performance indicator reporting but will also help to identify additional types of errors, such as reporting historical service dates that occur prior to a service request. **Southwest Michigan Behavioral Health** fully addressed HSAG's recommendation to conduct a detailed review of CMHSP-reported compliant cases to ensure the CMHSPs are appropriately categorizing cases as compliant and noncompliant for future reporting. **Southwest Michigan Behavioral Health** developed a job aid

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
for CMHSPs that outlines appropriate definitions of compliance and exceptions for performance indicators in alignment with the MDHHS Codebook specifications. Additionally, during the SFY 2022 PMV audit, **Southwest Michigan Behavioral Health** reported that it created a reporting template for CMHSP submissions of performance indicator data that includes formulas for calculating compliance with each indicator based on service date and, therefore, does not rely on the report from the CMHSP regarding compliance. The PIHP reported that it continues to conduct comprehensive annual reviews of CMHSP reporting processes using audit protocols observed during HSAG's PMV review. Additionally, HSAG noted that a new Tableau dashboard which matches encounters to BH-TEDs records has been very helpful for improving the accuracy of numerator-compliant counts. **Southwest Michigan Behavioral Health** fully addressed HSAG's recommendations for the CMHSP to begin appropriately tracking disposition start and stop times and ensure validation checks are in place to confirm the accuracy of drop-down selections based on manually tracked disposition start and stop times. The applicable CMHSP added signature validations to avoid unpopulated data in the pre-admission screening field; and, effective October 1, 2021, the CMHSP switched EHR systems (SmartCare to PCE) to allow for disposition dates to be entered in a required field before proceeding. Additionally, **Southwest Michigan Behavioral Health** monitored the data monthly, through site reviews, and by reviewing completeness reports through its Tableau analytics system. During the SFY 2022 PMV audit, HSAG did not identify any issues with the indicator #1 data reported by the CMHSP or its tracking of disposition start and stop times. **Southwest Michigan Behavioral Health** fully addressed HSAG's recommendations for the PIHP to extract and lock member-level data for the indicator counts reported to MDHHS and for providing all pertinent details in its member-level data for future reporting. **Southwest Michigan Behavioral Health** had its CMHSPs use a locked reporting template for population of monthly performance indicator data to the PIHP. Results were reviewed and monitored monthly during internal and external Quality Management Committee meetings for completeness, accuracy, and quality of the data. Additionally, during the SFY 2022 PMV audit, HSAG confirmed use of the locked reporting template by the CMHSPs with the inclusion of additional formulas used to calculate the performance indicator rates for MDHHS reporting. The PIHP confirmed that the template was locked down after file transfer protocol submission for each quarter to ensure that the counts reported could be validated during audit activities. Lastly, **Southwest Michigan Behavioral Health** fully addressed HSAG's recommendation for the PIHP to monitor members' discharges from a substance abuse detox unit within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator #4b. **Southwest Michigan Behavioral Health** monitored indicator #4b data monthly for completeness, as well as revised the indicator #4 report within the Tableau analytics system for simplifying the quarterly validation process. Additionally, **Southwest Michigan Behavioral Health** demonstrated improvement in the SFY 2022 indicator #4b rate when compared to SFY 2021.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Southwest Michigan Behavioral Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards.
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 continues to work internally on the development of a real time automated report for network adequacy. In the interim, SWMBH Provider Network prepared a Network Adequacy Report based on the MDHHS published Network Adequacy Standards, which was submitted to MDHHS on June 1, 2022 via email to [name of person] and MDHHS BHDDA [Behavioral Health and Developmental Disabilities Administration] Contracts MNGMT [management] email, receipt confirmed. SWMBH will be completing formal annual Network Adequacy evaluations for submission to MDHHS by the new contractually required due date. Additionally, beginning in FY23, "Network Adequacy Standards" will be a standing agenda item on the Regional Provider Network Management Committee meeting agenda, and the Regional Committee will review current network status in the areas outlined by MDHHS. This is an improvement from our previous process where monthly the Regional Committee discussed provider changes and network info but did not formally tie these discussions back to the MDHHS standards.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Please see above explanation.
c. Identify any barriers to implementing initiatives: • Lack of communication from MDHHS in early 2022 on final report expectations and who SWMBH should be communicating with and send the final report to at MDHHS. This delayed the PIHP in obtaining answers to our questions and further direction on report submissions and timeliness. This has since been resolved.
HSAG Assessment: HSAG determined that **Southwest Michigan Behavioral Health** has addressed the prior year's recommendations related to MDHHS-set network adequacy standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plan for this requirement was complete and addressed HSAG's recommendations included as part of the progress updates. Of note, while **Southwest Michigan Behavioral Health** has implemented an annual network adequacy report, it continues to work on the development of a real-time automated report. As such, HSAG recommends that the PIHP proceed with this plan accordingly.

Region 5—Mid-State Health Network

Table 4-5—Prior Year Recommendations and Responses for MSHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although no weaknesses were identified, **Mid-State Health Network** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
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 Quality Improvement council revisited the causal/barrier analysis for the 2nd remeasurement period to determine if there were any new barriers requiring the development of interventions. • Barrier: Access to labs. March of 2020-Epidemic/Emergency orders implemented limiting/discontinuing public transportation, non-essential treatments, contact with individuals outside of your household. (see epidemic/emergency orders) o Intervention 1: Implement process to improve transportation availability. This will include developing an information sheet to provide consumers at the time of their appointment with instructions for accessing transportation through what is available in each CMHSPs geographical location. This may vary by location but should include any of the following: list of vendors, process for scheduling transportation with the Department of Human Services, provision of bus tokens and/or vouchers, other transportation services based on each specific location. o Status: The public transportation was suspended throughout the region beginning March 2020, continuing operations at varied times throughout the region as a result of the epidemic/ emergency orders. Transportation information was not provided to consumers due to in office services being suspended. • This intervention will continue with revisions. Revisions-Case by case based on need, until organizations / services open safely, and public transportation is reinstated. open and services. o Intervention 2: Implement process for labs services to be obtained onsite at the CMHSP location. This may include mobile lab, trained medical staff, on-site lab draw station. o Status: Organizations developed alternative methods of operations to be consistent with the epidemic orders. The Essential Service only order was issued March 24, 2020 (Executive Order 2020-21). Six organizations provided onsite or mobile laboratories beginning in 2019 through January of 2020. Onsite laboratories, including mobile laboratories, were discontinued in March 2020. Additional barriers identified include, however, not limited to the following: physical illness, quarantined staff and quarantined individuals served. See the Epidemic, Executive, and Emergency Rules listed above. • Intervention 2 was discontinued March 2020 and will be evaluated for reinstatement once communities safely open consistent with local health department guidance. • Barrier: Information of completed labs not available. o Intervention: CMHSP will utilize the care alerts to determine who does not have a claim for a

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
completed lab. A record review is completed to identify if lab was ordered. If ordered, is it in the record or can it be obtained. If the results are in the record and a claim was submitted to Medicare the CMHSP can enter "addressed" into ICDP [Integrated Care Data Platform]. o Status: The number of CMHSPs with a process for staff to complete care alerts increased from 8 to 12 during measurement period 2. • Intervention was effective and will continue. • Barrier: Data inaccurate and untimely. o (New Effective Measurement Period 2) Intervention: Develop and implement a process of data validation quarterly to ensure the data received from the Care Connect 360 extract and processed by Zenith Technologies in the Integrated Care Data Platform is consistent with the HEDIS specifications and is completed within the expected timeframes. o Status: Data Validation Occurred two times during the measurement period. The data processed through ICDP was matched against the specifications within the PIP, any mismatches would be investigated to determine the cause. Actions would then be identified to address areas that would potentially threaten the validity of the project. • Intervention was effective and will continue, with revisions of 1 time annually.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Barrier: Information of completed labs not available. o Status: The number of CMHSPs with a process for staff to complete care alerts increased from 8 to 12 during measurement period 2. Sixty percent of the eligible population include individuals with dual coverage (Medicare /Medicaid). Seventy-three percent (241) of those not screened had dual coverage (Medicare /Medicaid). The results of the lab work are dependent on the ability to receive the required evidence of the completed lab work from the physician offices, therefore promoting increased coordination among providers. Without a record review 120 individuals would have not been reported as receiving the required tests for inclusion in the numerator. • Intervention was effective in accurately identifying those who have received a lab and will continue with no revisions. • Barrier: Data inaccurate and untimely. o Status: Data Validation Occurred two times during the measurement period. o December 2020 -Consistent with the PIHP/HEDIS specifications resulting in a 97% accuracy rate. o April 2021 -Consistent with the PIP/HEDIS specifications resulting in a 98% accuracy rate. • Intervention will continue, with revisions of 1 time annually.
c. Identify any barriers to implementing initiatives: • The barriers that continue to impact the initiatives are related to regulatory changes / modifications as a result of the Public Health Orders. This is assessed as needed to address the impact.
HSAG Assessment: HSAG has determined that **Mid-State Health Network** addressed the prior year's recommendations. The PIHP revisited the causal/barrier analysis process and initiated interventions to address those barriers. The PIHP evaluated the effectiveness of each intervention and used the outcomes to drive each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • CEI CMHSP should consider adding a validation step to its source code to look for billed services associated with the service date in the service activity log (SAL). If a nonbillable code is associated with no-show appointments in the SAL, this code should be excluded in the source code from identifying compliant records. **Mid-State Health Network** should consider performing additional validation of the quarterly submissions against its own encounter data prior to MDHHS submission to ensure that no-show appointments are not being confused for follow-up services. • Newaygo CMHSP should consider reviewing the two cases to identify factors that led to the source code not excluding the records from the final submission (e.g., retroactive eligibility changes, source code limitations) and use that information to update the source code. **Mid-State Health Network** should consider performing a final validation step of the quarterly submissions against its own eligibility data to ensure that all non-Medicaid members are excluded from the measures.
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 reviewed the recommendation to address the programming issues and the process for excluding records from the submitted data set. o CEI CMHSP modified the programming code to ensure accurate account of records that are "in compliance." MSHN required a full validation of all CEI CMHSP records within the reported data set for FY21Q3 to ensure the programing change was effective. o Newaygo CMHSP reviewed the methodology used for Medicaid verification to ensure accuracy within the reported data set. o MSHN incorporated an additional validation, utilizing the 834 enrollment data and the 270/271 data, to ensure Medicaid eligibility prior to submission of the data set to MDHHS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MSHN noted the following improvements based on the initiatives implemented to address the recommendations. o CEI performed a 100% validation prior to submitting FY21Q3. 1 out of 349 was unable to be validated. The changes made to programming language did correct the issue identified. o The additional Medicaid eligibility check prior to submission resulted in the denominator including an accurate account of Medicaid eligible consumers.
c. Identify any barriers to implementing initiatives: • No current barriers identified.
HSAG Assessment: HSAG has determined that **Mid-State Health Network** partially addressed the prior year's recommendations. While **Mid-State Health Network** has engaged in efforts to address HSAG's recommendations, the SFY 2022 PMV audit confirmed continued opportunities for improvement in some areas. Regarding HSAG's recommendations to have CEI CMHSP consider adding a validation step to its source code to look for billed services associated with the service data in the SAL and have the PIHP consider performing

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
additional validation of the quarterly submissions against its own encounter data prior to MDHHS submission to ensure that no-show appointments are not being confused for follow-up services, **Mid-State Health Network** indicated that CEI CMHSP modified its programming code to further ensure accurate reporting and that it required a full validation of all CEI CMHSP records to confirm the programming changes were effective. In addition, during the SFY 2022 PMV audit, CEI CMHSP confirmed the programming code changes to ensure that no-show appointments were not being identified as compliant follow-up services and that testing of the code changes was successful. However, similar discrepancies were identified for another CMHSP (Lifeways) related to indicator #3, as Lifeways' programming code was including no-show appointments as compliant follow-up service dates. Therefore, HSAG recommends that **Mid-State Health Network** ensure that programming code for all delegated CMHSPs is not identifying no-show appointments as a compliant record for the performance indicator. Additionally, HSAG recommends that the PIHP continue using the Encounters-to-BH-TEDS report as an additional check of any records that show as compliant in the BH-TEDS record but do not have a corresponding encounter for the same date. **Mid-State Health Network** fully addressed HSAG's recommendations for Newaygo CMHSP to consider identifying factors that led to its source code not excluding records from the final submission (e.g., retroactive eligibility changes, source code limitations) and use the information to make updates to source code, as well as have the PIHP consider performing a final validation step of the quarterly submissions against its own eligibility data to ensure all non-Medicaid members are excluded. Newaygo CMHSP reviewed the methodology used for Medicaid verification to ensure accuracy within the reported data set. In addition, during the SFY 2022 PMV audit, **Mid-State Health Network** reported that it added an extra step of validation of CMHSP data prior to MDHHS submission to check eligibility using the 834 enrollment file data as well as 270/271 data for all consumers being reported. The PIHP reported that the testing was successful and that it continues to use the additional validation step each quarter.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Mid-State Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Mid-State Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.
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, in addition to the actions below review the regulatory standards and PIHP contract to ensure changes are incorporated into the relevant documents.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• Standard 1: MSHN Customer Service will ensure that CMHSP and SUDSP [Substance Use Disorder Service Program] providers, along with subcontracted providers, include the required Tagline language for all written materials that are critical to obtaining services. CMHSP providers have worked with their Electronic Health Record (EHR) venders to program Tagline language within the appeal and grievance notices, and denial and termination notices. MSHN's SUDSP providers are required to use MSHN's managed care information system (REMI) for appeal and grievance notices, and denial and termination notices and the REMI system has been updated to include Tagline language. This has been completed. • The MSHN Customer Service Policy has been updated to include the required language found within the federal requirement and will be reviewed by the MSHN Customer Service Committee, the MSHN Operations Council, the MSHN Policy Committee, and will receive final approval during the MSHN Board of Directors meeting on July 5, 2022. This has been completed. • The FY23 CMHSP subcontracting agreement, as well as the FY23 SUDSP subcontracting agreement, will be updated to include the updated language. Specific language for the FY23 Medicaid Subcontract will be: "CMHSP shall make a good faith effort to give written notice of termination of a contracted provider (organizational) by the later of 30 calendar days prior to the effective date of the termination, or 15 days after receipt or issuance of the termination notice, to each consumer who received his or her services from the terminated provider." Specific Language to be added to the SUDSP FY23 agreements will be: "The PROVIDER must make a good faith effort to give written notice of termination of a contracted service to each member who received his/her primary care from, or was seen regularly by, the terminating providers program. Notice to the member must be provided by the later of thirty (30) calendar days prior to the effective date of termination, or fifteen (15) calendar days after receipt or issuance of the termination notice." This has been completed. • MSHN will add a search filter to its provider directory webpage for Americans with Disabilities Act (ADA) accommodations available and will update its provider application to allow for a text field for providers to add specific accommodations available. MSHN will also incorporate a category header in its on-line provider directory to identify "Cultural Capabilities." MSHN's provider directory webpage will be updated to add the statement "*All providers will arrange for physical access, reasonable accommodations, and accessible equipment for people with physical or mental disabilities. Please contact the provider at the number listed to ensure any special needs can be accommodated.*" This has been completed. • Standard III: MSHN will add language to its FY23 single case agreement template identifying the requirements of and compliance with 42 CFR §438.106 related to "balance billing" restrictions. The language to be added shall be: "The Provider agrees to follow all applicable MDHHS policies to ensure the beneficiary is not liable for costs greater than would be expected for in network services including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116 and the Medicaid Provider Manual. • MSHN will develop a standard report within REMI (Managed Care Information System) to monitor the timeliness of the priority populations quarterly, in addition to the MMBPIS monitoring. (2/28/2022) • MSHN will implement a QI process, requiring corrective action for those that are out of compliance with the standard. This has been completed. • MSHN will revise and update the Network Adequacy Assessment (NAA) to include Time/Distance standards in accordance with MDHHS requirements, timely appointments languages spoken, physical accessibility/ADA compliance and cultural capabilities, inclusive of inpatient psychiatric and other providers.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• Geo mapping will be contracted out, MSHN will annually submit the Network Adequacy Assessment (NAA) to MDHHS and as necessary to address significant changes. • In addition, the annual submission and assurances will be included in the Provider Network Management Policy. • The Provider Network Management (PNM) Policy will be updated and reviewed by Provider Network Committee (PNC), presented to Operations Council in January 2022, reviewed by Policy Committee in February and approved by the Board in March, 2022. This has been completed. • Standard V: MSHN will establish a board-approved conflict free case management policy for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. This has been completed. • Standard VI: MSHN will continue to monitor the CMHSP and SUDSP provider issued Adverse Benefit Determination (ABD) notices through the delegated managed care review process to ensure ABD notices contain all the required elements with an emphasis on ABD notices including the requested services, a clear explanation for why the services were impacted, and making sure the ABD is understandable if/when multiple citations are included. The MSHN Customer Service Committee committed to developing a regional Customer Service training during FY22 for the Adverse Benefit Determination process to assist provider staff in properly completing ABD notices. Target date for completion will be May 31, 2022 and will be deployed for CMHSP and SUDSP provider staff to be trained by the close of FY22 on September 31, 2022. Training will be completed during FY23Q1.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MSHN has completed the interventions as indicated above. The impact of the interventions will be assessed and demonstrated through the internal and external monitoring and compliance reviews during FY22 and FY23.
c. Identify any barriers to implementing initiatives: • Standard VI: A delay has occurred in recording the ABD training narration due to staff availability. Training is scheduled to be completed FY22 Q4 for use and implementation beginning in FY23 Q1. • No other barriers.
HSAG Assessment: HSAG has determined that **Mid-State Health Network** addressed the prior year's recommendations related to MDHHS-set network adequacy standards, single case agreements, and MDHHS-set appointment standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and addressed HSAG's recommendations included as part of the progress updates.

Region 6—Community Mental Health Partnership of Southeast Michigan

Table 4-6—Prior Year Recommendations and Responses for CMHPSM

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Community Mental Health Partnership of Southeast Michigan** (CMHPSM) should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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 Regional Clinical Performance Team as the performance improvement (PI) oversight entity of CMHPSM delegated a regional Integrated Health Workgroup, comprised of health professionals across the region with an expertise in the aspects of the CMHPSM FY18-FY Performance Improvement Process (PIP) project, to address barriers and interventions related to this PIP. The workgroup revisited its causal/barrier analysis process and added interventions that would: • Assist coordination efforts to help consumers attend a lab appointment including transportation supports as some access to transportation became limited during the pandemic, and • Provide staff training in documenting these efforts under #1 and revise the workflow to include these changes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The interventions required an enhancement to the regional electronic health record (EHR), called the Confidential Record of Consumer Treatment (CRCT) which is used by all four CMHSPs in the PIHP region. The ability to have this enhancement implemented was delayed due to other priority projects for system updates. Therefore, while data showed an increase in labs being completed from Quarter II to Quarter III of fiscal year 2021, the enhancement was not implemented in a timely way and did not bring the region back to the required threshold. • The enhancement remains a standard part of the consumer record.
c. Identify any barriers to implementing initiatives: • The limited time to conduct the intervention was a barrier to show sustained improvement as this project was sunset 9/30/2021 and a new state required PIP project was initiated.
HSAG Assessment: HSAG has determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis and developed an intervention to address a barrier associated with the COVID-19 pandemic.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Community Mental Health Partnership of Southeast Michigan** and the CMHSPs should employ enhancements to their BH-TEDS validation process to ensure no discrepant data are entered. This validation process should account for discrepancies in wage and income values. • Upon identification of this weakness during the PMV process, **Community Mental Health Partnership of Southeast Michigan** confirmed corrective action was completed with three of the four CMHSPs, including additional training of staff members responsible for documenting the pre-admission decision time within the system. Two CMHSPs also implemented enhanced oversight for reviewing cases with an indicator #1 elapsed time of zero prior to submission to the PIHP. One CMHSP did not implement corrective action as its zero elapsed minutes case was determined to be accurately documented; however, the CMHSP did communicate the difference between the different system fields to its staff members. In alignment with the PIHP's documented steps provided to HSAG after the virtual review, the PIHP should monitor the corrective action which was implemented as a result of these findings and conduct additional final review of the detailed data for all indicator #1 cases with zero minutes reported as the elapsed time. HSAG also supports the PIHP's plan to explore any system changes that PCE (the PIHP's EHR vendor) could complete, which could assist in preventing inaccurate data entry of the time of decision for reporting indicator #1. • **Community Mental Health Partnership of Southeast Michigan** should confirm member enrollment time frames in comparison to its internally housed Medicaid member enrollment data to ensure only members who qualify for reporting in alignment with the MDHHS Codebook are included in the indicator #1 data prior to submitting results to MDHHS.
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):** • BH-TEDS validation process: The PIHP initiated a focus on real time monitoring through increased access/usability of outcome dashboards that include BH-TEDS completeness and accuracy. The PIHP information management team continuously reviews these dashboards monthly in regional committees to easily identify areas of concern and address corrections and data cleaning in a timely manner. • Education: All staff are provided local TEDS hands-on training led by the CMHSP BH-TEDS liaison (as a member of the Regional Electronic Record Operations Committee) and provided with written guides for ongoing use that include updating data such as income and wage. Training includes the need to validate each field with the consumer and updated appropriately. The EHR also has built in reference text for direction on expected data entry for each field. • System Checks: the CMHPSM EHR CRCT system has internal validations that identify if data entry does not align with other documented fields, much of which are connected to the state error reports. Some require the author to update the form before completion, others are reminders to check any documentation that may not align with other fields; if the author does not edit that documentation it will show up on a monitoring report. • Monitoring: The PIHP has three local reports to assist the PIHP and CMHSP partners in reviewing BH-TEDS information and monitor for accuracy across documentation that supports TEDS, including any inconsistencies for further review (ex. income and wage inconsistencies). CMHSP staff would address

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
these issues through further chart and staff reviews, with data reports noted above used to check if the errors were corrected, and actions plans developed for improvement. • Indicator #1 elapsed time of zero: Enhanced review of indicator #1 data was conducted by the PIHP to review true indicator #1 cases that would be an elapsed time of zero versus those that appeared to be staff data entry error through a specific data report that captured elapsed time. CMHSPs completed monthly and quarterly analysis. Data review enhancements and staff training showed a decrease in inaccurate data. The PIHP included this PI indicator in a FY22 review of Access practices and case review of the CMHSPs. • Ensuring inclusion of only qualifying members for indicator #1 submissions: CMHPSM has identified the report error in confirming member enrollment time frames in comparison to its internally housed Medicaid member enrollment data and has made the necessary corrections.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BH-TEDS validation process: The CMHPSM has remained largely above the 95% state requirements for all BH-TEDS submissions. • Indicator #1 elapsed time of zero: There has been a reduction in the number of cases with an inaccurate elapsed time of zero. • Ensuring inclusion of only qualifying members for indicator #1 submissions: The current report has cleaning instructions that accurately confirm Medicaid member enrollment data per enrollment timeframes.
c. Identify any barriers to implementing initiatives: • BH-TEDS validation process: None identified to date • Indicator #1 elapsed time of zero: None identified to date • Ensuring inclusion of only qualifying members for indicator #1 submissions: None
HSAG Assessment: HSAG has determined that **Community Mental Health Partnership of Southeast Michigan** partially addressed the prior year's recommendations. While **Community Mental Health Partnership of Southeast Michigan** has engaged in efforts to address HSAG's recommendations, the SFY 2022 PMV audit confirmed continued opportunities for improvement in some areas. Regarding HSAG's recommendation for the PIHP and the CMHSPs to employ enhancements to their BH-TEDS validation process to ensure no discrepant data are entered and account for discrepancies in wage and income values, **Community Mental Health Partnership of Southeast Michigan** put forth effort to implement several enhancements to its BH-TEDS validation process. The enhancements included real-time monitoring for BH-TEDS completeness and accuracy using dashboards, staff education, internal system validation checks, and monitoring through chart reviews. Additionally, HSAG confirmed during the SFY 2022 PMV audit that **Community Mental Health Partnership of Southeast Michigan** created strong tracking mechanisms through its use of Power BI dashboards, and that additional oversight mechanisms to evaluate for discrepant BH-TEDS data were deployed by the PIHP as it obtained more granular BH-TEDS details from MDHHS during the measurement period. However, during the SFY 2022 PMV audit, HSAG identified four member records with discrepant employment and minimum wage BH-TEDS data. While the errors were not impactful to the reported rates, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** and the CMHSPs continue to employ additional enhancements to their BH-TEDS validation process to ensure that no discrepant data are entered.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Community Mental Health Partnership of Southeast Michigan fully addressed HSAG's recommendations for the PIHP to conduct additional final review of detailed data for all indicator #1 cases with zero minutes reported as the elapsed time and explore any system changes that PCE completed, which could assist in preventing inaccurate data entry of the time of decision for reporting indicator #1. **Community Mental Health Partnership of Southeast Michigan** enhanced its review of indicator #1 data, having its CMHSPs complete monthly and quarterly analyses and providing staff training. In addition, during the SFY 2022 PMV audit, **Community Mental Health Partnership of Southeast Michigan** confirmed that necessary corrective action was completed with the applicable CMHSPs, including additional training of staff members responsible for documenting the pre-admission decision time within the system. Two CMHSPs also implemented enhanced oversight for reviewing indicator #1 elapsed time of zero cases prior to submission to the PIHP. **Community Mental Health Partnership of Southeast Michigan** confirmed it continued monitoring these corrective actions, and HSAG determined a reduced count of zero elapsed time frame cases reported for indicator #1 for the period under scope of the SFY 2022 PMV audit. **Community Mental Health Partnership of Southeast Michigan** fully addressed HSAG's recommendation for the PIHP to confirm member enrollment time in comparison to its internally housed Medicaid member enrollment data to ensure only members who qualify for reporting in alignment with the MDHHS Codebook are included in the indicator #1 data prior to submitting results to MDHHS. **Community Mental Health Partnership of Southeast Michigan** identified the reporting error and made necessary corrections. In addition, during the SFY 2022 PMV audit, **Community Mental Health Partnership of Southeast Michigan** indicated that it had determined that the error was an isolated error in the prior year and that additional validation steps had been deployed to ensure only Medicaid beneficiaries enrolled with the PIHP for at least one month in the reporting period were included in indicator #1 reported data.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Community Mental Health Partnership of Southeast Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Community Mental Health Partnership of Southeast Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.
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):** • Network Adequacy Standards: The PIHP and Network Management Committee conducted a regional network adequacy plan and completed a template to comply with the MDHHS annual Network Adequacy Report, with both submitted to MDHHS on 2/28/22. The PIHP and Network Management

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
Committee developed a system and written process to ensure both a network adequacy plan and the state the contract requirements/data structure is reviewed annually for compliance in submitting the Network Adequacy Report to MDHHS prior to the next annual submission to the state for subsequent years, including any necessary changes in policy/procedure, and ensuring any relevant aspects of the report related to quality of or access to care are incorporated in the CMHPSM Quality Assessment and Performance Improvement Plan (QAPIP). • Single Case Agreements and MDHHS-set appointment standards: A single service case agreement template was drafted by PIHP staff January 2022, completed February 2022, and distributed to all regional partners who use the agreements for immediate implementation by March 16, 2022. The revised agreement includes the requirement that out-of-network providers coordinate with the PIHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, including a prohibition on balance billing in compliance with 42 CFR §438.106, 42 CFR §438.116, and the Medicaid Provider Manual.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None applicable to date.
c. Identify any barriers to implementing initiatives: • None.
HSAG Assessment: HSAG has determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations related to MDHHS-set network adequacy standards, single case agreements, and MDHHS-set appointment standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and addressed HSAG's recommendations included as part of the progress updates. Of note, while **Community Mental Health Partnership of Southeast Michigan**'s narrative did not mention appointment standards, HSAG's assessment of the PIHP's follow-up to this recommendation was determined through the SFY 2021 compliance review CAP progress updates.

Region 7—Detroit Wayne Integrated Health Network

Table 4-7—Prior Year Recommendations and Responses for DWIHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Detroit Wayne Integrated Health Network** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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):** • Through the Quality Assurance Performance Improvement Plan (QAPIP) workplan, DWIHN has engaged in several Performance Improvement Projects (PIP's) to identify opportunities to improve coordination across the continuum of behavioral healthcare services by collecting data and conducting quantitative and causal analysis of data to identify improvement opportunities. These efforts are reviewed and discussed through various committees which are inclusive of stakeholder feedback, Improvement Practice Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through DWIHN's aforementioned process, as a result of initiatives implemented, performance improvements were noted with the (SSD) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. DWIHN's results for FY 2020 diabetic screening was 64.38% and the results for FY 2021 was 64.86%. This is a 0.48 percentage point increase. DWIHN will continue through noted performance improvement initiatives, to compare our outcomes to the Medicaid Weighted Average with a targeted goal of 78.01%.
c. Identify any barriers to implementing initiatives: • COVID continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of COVID. • Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies. • Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on this issue. • Post COVID has caused staff shortages within our provider network. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care. • Post COVID agencies are trying to reorganize to include recruitment strategies, development of employee incentive programs and ongoing trainings.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Detroit Wayne Integrated Health Network** addressed the prior year's recommendations. The PIHP revisited its causal/barrier analysis, determined barriers associated with the COVID-19 pandemic, and stated that initiatives were implemented to address those barriers to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • While **Detroit Wayne Integrated Health Network** did acknowledge the issues related to capturing additional member notes and has recently asked for additional member detail from providers regarding indicator #1, **Detroit Wayne Integrated Health Network** should continue to monitor and provide guidance to providers on notating additional details in regard to member interactions, documenting follow-up requests with members, and denoting any circumstances that may cause services to be out of compliance based on the MDHHS Codebook specifications. • While no other cases reviewed during PSV contained this anomaly, to improve rates related to indicator #2a and meet MDHHS Codebook requirements, **Detroit Wayne Integrated Health Network** should continue to monitor quarterly reporting to MDHHS and review member-level detail data to ensure established source code is still viable and capturing the components necessary to report accurate rates to MDHHS. • While HSAG noted that **Detroit Wayne Integrated Health Network** has implemented a workplan, which includes current reporting being sent to the providers to review the status of the indicator and missing gaps of information that need to be populated by the provider, **Detroit Wayne Integrated Health Network** should conduct an additional root cause analysis to determine why members are not receiving follow-up services within 14 days of a completed assessment. • The PIHP should closely monitor children's discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of performance indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter who were seen for follow-up care within 7 days—Children*. Additionally, while **Detroit Wayne Integrated Health Network** reduced the number of inpatient psychiatric unit readmissions for its MI and I/DD Adult population when compared with the prior year's rate for indicator #10, **Detroit Wayne Integrated Health Network** should continue to work toward reducing the number of inpatient psychiatric unit readmissions and follow any best practices that led to the decrease in inpatient psychiatric unit readmissions from the prior year.
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):** • DWIHN has worked with PCE systems to revise the Pre-admission Review (PAR), enabling staff to document the reason for exceeding the 3-hours disposition prior to signing the PAR. The PCE platform is a Behavioral Health Electronic Medical Record (EMR) system that is widely utilized by Behavioral Health providers in Michigan. In August of 2021, through DWIHN's performance improvement initiatives, Providers are required to submit a monthly report to the Access Unit to include reasons for cases exceeding 3 hour dispositions. This process will enable providers to monitor the time requirements, along with correcting any errors prior to data being submitted to DWIHN for accurate

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
and complete reporting to MDHHS. It will also enable DWIHN to work with providers to identify and address any causal barriers. • Each DWIHN assigned provider has the ability to review and monitor performance indicator data through the "View Only" Module via our PCE MH-WIN (EMR) system. This process allows for Providers to review trends and analysis of member level detailed data. DWIHN also monitors data for accuracy and completion prior to submission to MDHHS. This overarching process ensures that the established source codes are viable while capturing the components necessary to report accurate and complete performance rates to MDHHS. • DWIHN has conducted a review of our provider network to determine why members are not receiving a completed Biopsychosocial (IBPS) within 14 days of request. Review, meetings and analysis has determined that the staffing shortages are the most relevant barrier noted with members not receiving a completed IBPS within the required timeframe. DWIHN will continue to implement initiatives and collaborate efforts with our provider network to try and alleviate this ongoing challenge/barrier. • DWIHN Quality Improvement, Crisis Service and Children's Units are meeting with our Children Provider network, no less than every 30-45 days, to review and monitor the seven day post-discharge time frames to ensure timely follow-up is scheduled in alignment with reporting requirements. DWIHN will also continue ongoing collaboration and efforts with providers to target recidivist individuals thorough our internal and external recidivist workgroups. These efforts include DWIHN's Crisis Services team utilizing reports via Mental Health Wellness Information Network (MHWIN) specific to PI#10 to review cases weekly that meet criteria for hospitalizations within the 30 calendar days prior to requests for service. The reviewed cases are presented to the contracted screening entities and leadership to give an opportunity to problem solve and identify interventions. In addition, the hospital liaisons within the Crisis Service Unit will be charting cases that were recidivistic in order to track continuous follow up to solidify efforts to improve recidivism numbers via the Clinically Responsible Service Provider (CRSP).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The MMBPI (PI # 1) Adult and Children have met compliance of 95% or better for Quarters 1-3 (FY-2022). • Monitoring of MMBPI data and source codes prior to submission to MDHHS has allowed DWIHN to receive "Reportable" scores for all indicators during the 2022 Performance Measurement Validation (PMV) review. • Root Cause Analysis (RCA) of PI# 2a which is inclusive of collaboration efforts with the Provider network, has led to DWIHN receiving a score of 59.8% for Quarter 2 (FY-2022). This is a noted increase of 6.38 percentage points from Quarter 1 (52.85%). The state average for Quarter 2 was noted at 54.10%. This measurement allows for no exceptions. • During FY-2022 for Quarter 1, DWIHN met all of the performance indicators measures including PI # 4a (95.09%) and PI# 10 (14.05%). DWIHN will continue ongoing collaboration efforts to sustain noted improvements.
c. Identify any barriers to implementing initiatives: • Provider network staffing shortages continues to be an identified barrier. DWIHN continues to review and meet with the provider network every 30-45 days to discuss/review their staffing recruitment strategies, member engagement and making same day appointments to avoid member no-show and cancellations.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG Assessment: HSAG has determined that **Detroit Wayne Integrated Health Network** fully addressed the prior year's recommendations. Regarding HSAG's recommendation to continue to monitor and provide guidance to providers on notating additional details related to member interactions, documenting follow-up requests with members, and denoting circumstances that may cause services to be out of compliance based on the MDHHS Codebook specifications, **Detroit Wayne Integrated Health Network** indicated that, beginning in August 2021, providers were required to submit a monthly report including reasons for cases exceeding three hour dispositions to enable providers to monitor the time requirements, along with correct any errors prior to data being submitted to **Detroit Wayne Integrated Health Network**. Additionally, during the SFY 2022 PMV audit, **Detroit Wayne Integrated Health Network** reported that the region worked in conjunction with PCE to add additional edits to the pre-admission screen module so that if a disposition went over three hours, the providers could not sign off on the screening until case notes were added to document why the disposition took more than three hours to complete. In addition, **Detroit Wayne Integrated Health Network** sent a memo to all of its providers detailing the expectations of capturing the documentation for any cases that were not compliant for the indicator. **Detroit Wayne Integrated Health Network** fully addressed HSAG's recommendation for the PIHP to continue to monitor quarterly reporting to MDHHS and review member-level detail data to ensure established source code is still viable and capturing the components necessary to report accurate rates to MDHHS. **Detroit Wayne Integrated Health Network** gave providers the ability to review and monitor performance indicator data using a module within the EHR system, as well as review trends and analysis of member-level data. **Detroit Wayne Integrated Health Network** also continued to monitor data for accuracy and completeness prior to submission to MDHHS. Additionally, during the SFY 2022 PMV audit, **Detroit Wayne Integrated Health Network** discussed that throughout the year it held technical assistance sessions with internal staff members as they reviewed the reporting detail module in the EHR. **Detroit Wayne Integrated Health Network** fully addressed HSAG's recommendation for the PIHP to conduct an additional root cause analysis to determine why members are not receiving follow-up services within 14 days of a completed assessment. **Detroit Wayne Integrated Health Network** conducted a review of its provider network to determine why members were not receiving a completed assessment within 14 days of the request, which resulted in identifying that staffing shortages were the most relevant barrier noted. **Detroit Wayne Integrated Health Network** also noted continued implementation of initiatives and collaborative efforts to attempt to alleviate the staffing shortages barrier. Additionally, during the SFY 2022 PMV audit, **Detroit Wayne Integrated Health Network** mentioned that another barrier identified was that members were cancelling and not showing to appointments and having to be rescheduled outside of 14 days, along with members choosing initial appointments outside of the 14-day window. **Detroit Wayne Integrated Health Network** tried to remedy some of these issues by providing bonuses/incentives to providers to help with member costs for transportation and to help with staffing shortages. **Detroit Wayne Integrated Health Network** also met with providers every 30 to 45 days to help address any issues and raise performance indicator rates. **Detroit Wayne Integrated Health Network** fully addressed HSAG's recommendation for the PIHP to closely monitor children's discharges within the critical seven day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator #4a. **Detroit Wayne Integrated Health Network** held Crisis Service and Children's Units meetings with its Children Provider network no less than

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
every 30 to 45 days to review and monitor the seven-day post-discharge time frames to ensure timely follow-up, and continued ongoing collaboration and efforts with providers to target recidivist individuals thorough its internal and external recidivist workgroups. Additionally, **Detroit Wayne Integrated Health Network** demonstrated improvement in the SFY 2022 indicator #4a rate when compared to SFY 2021.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Detroit Wayne Integrated Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Detroit Wayne Integrated Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice 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):** • DWIHN's Quality Unit is working and coordinating with each assigned Unit to ensure that we are reviewing and implementing the Corrective Action Plan (CAP) to ensure compliance with federal and State obligations specific to MDHHS-set network adequacy standards. • DWIHN's UM Unit has implemented a quality assurance process to review the ABD notices prior to sending to the members to ensure the notices are free from grammatical errors, the font is consistent throughout the letter and the narratives/reason for denial are in easy-to-understand language. The UM Unit has also collaborated with DWIHN's IT Unit to add the additional documented actions (reduction in services, partial denial) within the notices that are auto populated in MHWIN.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The aforementioned process was implemented in April of 2022.
c. Identify any barriers to implementing initiatives: • There are no identified barriers to implementing these initiatives.
HSAG Assessment: HSAG has determined that **Detroit Wayne Integrated Health Network** addressed the prior year's recommendations related to MDHHS-set network adequacy standards, service authorization, and ABD notice requirements. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and the PIHP addressed the recommendations HSAG made as part of the progress updates. However, if not already included in **Detroit Wayne Integrated Health Network**'s network adequacy analysis, HSAG continues to stress that the PIHP ensure member/provider ratio standards are also incorporated into the time/distance analysis.

Region 8—Oakland Community Health Network

Table 4-8—Prior Year Recommendations and Responses for OCHN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Oakland Community Health Network** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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):** • OCHN has mailed reminder letters to individuals served on a quarterly basis for notification of overdue diabetes screenings. Secure e-mails were also sent to Case Managers/Supports Coordinators for notification of overdue diabetes screenings. OCHN continues to monitor on a quarterly basis, individuals who received a reminder letter and results of the diabetes testing rates during 2022. OCHN continues to monitor data following Provider data training and has provided written directions on manual data entry of health metrics, such as diabetes screenings. Written instruction is detailed within the population health tool's reference manual. OCHN will continue to conduct a minimum of one annual training on the manual data entry for health metrics.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance rate increased from 72.2% in the final measurement period of 2020, to a rate of 76% in 2021, and remains at this rate through June of 2022.
c. Identify any barriers to implementing initiatives: • Going forward into 2022, OCHN will determine if an electronic health record notification and/or banner can assist Provider Case Managers with identifying health and wellness needs and goals. This initiative is not complete due to limited Information Technology staff resources.
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** partially addressed the prior year's recommendations. The PIHP described an intervention it had initiated and a process for evaluating that intervention; however, the PIHP did not describe its process for capturing barriers associated with the COVID-19 pandemic. It is unclear if the intervention implemented addressed a barrier to care linked to the pandemic. **Oakland Community Health Network** should have a process to determine each intervention's impact on the indicator outcomes and whether identified barriers were successfully eliminated or mitigated through implementation of the intervention. The outcomes of this process should be clearly documented.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Oakland Community Health Network** should conduct additional spot checks when calculating days or hours to produce indicator rates, to ensure that all members are properly marked as in compliance, out of compliance, or as an exception. These additional spot checks can help ensure that the indicators are being calculated correctly.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
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):** • OCHN revised the process for reviewing performance indicators to include the review of 5% of *in compliance* and *exception* cases beginning 10/1/2021. OCHN already had an existing process to review all *out of compliance* cases.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • An in-depth review to verify that logic within Oakland Data Information Network (ODIN) is accurately marking *out of compliance, in compliance*, and *exception* cases did not result in a change in performance rates.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** fully addressed the prior year's recommendation regarding the PIHP conducting additional spot checks when calculating days or hours to produce indicator rates, to ensure that all members are properly marked as in compliance, out of compliance, or as an exception. **Oakland Community Health Network** indicated that it revised its process for reviewing performance indicators beginning in October 2021 to include review of 5 percent of compliant and exception cases, as well as continued its process to review all out-of-compliance cases. Additionally, during the SFY 2022 PMV audit, HSAG did not identify any new calculation errors related to completing an assessment within the 14-day time frame.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Oakland Community Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Oakland Community Health Network** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the content of single case agreements and MDHHS-set appointment standards.
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):** • OCHN amended provider contract language for Fiscal Year 2022 to ensure compliance with all federal and State obligations specific to MDHHS network adequacy standards. OCHN has updated processes

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
and procedures to align with MDHHS network adequacy standards, such as development of Access and network adequacy policies and procedures. In addition, OCHN is in the process of completing reports and dashboards to monitor priority population timeliness to services and assess capabilities regarding language, cultural competency, and physical accessibility. • OCHN amended single case agreements for Fiscal Year 2022 to ensure compliance with all federal and State obligations specific to MDHHS network adequacy standards.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Based on the FY21 Network Adequacy Report, provider performance goals were set for Opioid Treatment Programs and Wrap-Around Services for Children. OCHN is in the process of conducting an RFP [request for proposal] for SED-W [Serious Emotional Disturbance Waiver] services, which includes capacity for Wrap-Around Services. Due to network capacity issues, ten Applied Behavior Analysis (ABA) providers were added to the OCHN network in January 2022. As OCHN direct service providers have struggled to ensure adequate staffing given the need and the current cultural milieu, OCHN has engaged in multiple efforts to recruit and retain Direct Support Professionals such as increasing Direct Support Professional wages to $15/hour. • N/A for single case agreements.
c. Identify any barriers to implementing initiatives: • Due to barriers related to technology and/or staffing, reports to monitor priority population timelines to ensure timely access to services and the physical and linguistic/cultural accessibility are still in process with anticipated completion dates of December 2022. OCHN is still completing the SED-W RFP to increase Wrap-Around Service providers, and additional providers are expected to be added to the OCHN network by October 2022. OCHN continues to review provider network capacity and add contracted providers as needed. • N/A for single case agreements.
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** addressed the prior year's recommendations related to single case agreements and MDHHS-set appointment standards. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete. Of note, while **Oakland Community Health Network**'s narrative indicated that its single case agreements were amended to include network adequacy standards, HSAG's assessment of the PIHP's follow-up to this recommendation was determined through the SFY 2021 compliance review CAP progress updates and confirmed that the single case agreements were updated to include a prohibition on balance billing, which was the reason for the deficiency as opposed to provisions related to network adequacy standards. HSAG has determined that **Oakland Community Health Network** partially addressed the prior year's recommendations related to MDHHS-set network adequacy standards. While **Oakland Community Health Network** developed a network adequacy plan, the PIHP's narrative and the SFY 2021 Compliance Review CAP progress updates confirmed that the PIHP continues to implement measures to adequately assess the physical, linguistic, and cultural accessibility of its provider network. As such, HSAG recommends that **Oakland Community Health Network** continue to actively implement its action plans to ensure timely completion of its CAP.

Region 9—Macomb County Community Mental Health

Table 4-9—Prior Year Recommendations and Responses for MCCMH

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Macomb County Community Mental Health** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific, targeted interventions to address those 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 created dashboard reports to better track trends associated with inpatient hospitalizations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • The PIP was written prior to the COVID pandemic and shortages in staffing and limitations placed on service delivery impacted the ability to effectively implement the defined process improvement plan.
HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations. It appears that the PIHP developed a dashboard to track trends within the data but did not describe barriers identified that are associated with the COVID-19 pandemic or develop targeted interventions to address those barriers to care. As such, **Macomb County Community Mental Health** should revisit its causal/barrier analysis process and document barriers that may still exist related to the pandemic and develop specific, targeted interventions to address those barriers.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • Although only two member records were identified with an elapsed time of zero minutes, in the future the PIHP should conduct an additional final review of the detailed data for indicator #1 members with zero minutes reported as the elapsed time. Also, the PIHP should explore potential system changes that PCE could implement which may assist in preventing inaccurate data entry of the time of decision for reporting indicator #1. • Since there was a rate bias of greater than 5 percent for indicator #2, the reported rates for indicator #2 were considered to be materially biased. For future reporting, **Macomb County Community Mental Health** should implement an additional validation check to ensure that the appropriate data counts and rates are data entered, and that the data entered align with the appropriate indicator and population before reporting the final rates to MDHHS. • The PIHP indicated that it reviewed all out-of-compliance member records and 20 compliant member records from each PIHP-calculated indicator, as well as omissions and exclusions. However, based on the

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
findings for indicator #2, the PIHP should implement additional validation checks to further ensure data accuracy for future reporting periods. This additional level of validation could involve thoroughly reviewing records listed in the member-level data to look for discrepancies for indicator #2, such as biopsychosocial assessments completed outside of the 14-day time frame and no biopsychosocial assessment dates listed for records marked as compliant. • With these cases recategorized as noncompliant or omitted, the I/DD Child population had a difference in rates reported to MDHHS and the final rates calculated by HSAG greater than 5 percent. However, the difference in reported rates was not significant enough to consider the overall total indicator 3 rate materially biased. For future reporting, **Macomb County Community Mental Health** should employ enhancements to its BH-TEDS validation process to ensure that the appropriate ongoing service time frames are included in the indicator #3 data before submitting results to MDHHS. • **Macomb County Community Mental Health** should closely monitor adults' and children's discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator *#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*. Additionally, **Macomb County Community Mental Health** should identify the root cause of the continued decrease in timely access to follow-up care for members discharged from a substance use detox unit, as the rate decreased from the prior year. Lastly, **Macomb County Community Mental Health** should focus its efforts on reducing the number of inpatient psychiatric unit readmissions by working with providers on adequate discharge planning and coordination of services post-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 PIHP did not provide any narrative and, in follow-up to HSAG's request for clarification, confirmed it had no information to add]
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [the PIHP did not provide any narrative and, in follow-up to HSAG's request for clarification, confirmed it had no information to add]
c. Identify any barriers to implementing initiatives: • MCCMH has had significant staffing changes since the 2021 PMV. MCCMH will take a look at the above recommendations, and implement if still applicable.
HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations. Additionally, the SFY 2022 PMV audit confirmed continued opportunities for improvement in some areas. Although no process or system changes were implemented, **Macomb County Community Mental Health** appeared to fully address the prior year's recommendations to conduct an additional final review of the detailed data for indicator #1 members with zero minutes reported as the elapsed time and explore potential system changes that PCE could implement which may assist in preventing inaccurate data entry of the time of decision

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
for reporting indicator #1. During the SFY 2022 PMV audit, no issues or members with zero minutes reported as the elapsed time were identified. **Macomb County Community Mental Health** did not address the prior year's recommendation for the PIHP to implement an additional validation check to ensure that the appropriate data counts and rates are data entered, and that the data entered align with the appropriate indicator and population before reporting the final rates to MDHHS. During the SFY 2022 PMV audit, the PIHP confirmed that there were no additional validation checks implemented based on the prior recommendation. **Macomb County Community Mental Health** still has opportunities for improvement in this area; therefore, the recommendation remains in place for future reporting since a mismatch in numerator and denominator counts between what was reported to MDHHS and what was reported in the PIHP member-level detail file provided to HSAG was also identified for indicator #2 and indicator #2e during the SFY 2022 PMV audit. **Macomb County Community Mental Health** did not address the prior year's recommendation for the PIHP to implement additional validation checks to further ensure data accuracy for future reporting periods, including thoroughly reviewing records listed in the member-level data to look for discrepancies for indicator #2, such as biopsychosocial assessments completed outside of the 14-day time frame and no biopsychosocial assessment dates listed for records marked as compliant. During the SFY 2022 PMV audit, the PIHP confirmed that there were no additional validation checks implemented based on the prior recommendation. **Macomb County Community Mental Health** still has opportunities for improvement in this area; therefore, this recommendation remains in place for future reporting since there was one case reported as an exception in error and five cases reported as compliant with a biopsychosocial assessment date outside of 14 calendar days of a non-emergency request for service during the SFY 2022 PMV audit. **Macomb County Community Mental Health** did not address the prior year's recommendation for the PIHP to employ enhancements to its BH-TEDS validation process to ensure that the appropriate ongoing service time frames are included in the indicator #3 data before submitting results to MDHHS. During the SFY 2022 PMV audit, the PIHP confirmed that there were no additional validation checks implemented based on the prior recommendation. **Macomb County Community Mental Health** still has opportunities for improvement in this area; therefore, this recommendation remains in place for future reporting since the incorrect ongoing covered service was identified for four cases due to an issue identified with PCE's performance indicator logic during the SFY 2022 PMV audit. **Macomb County Community Mental Health** did not address the prior year's recommendation for the PIHP to closely monitor adults' and children's discharges within the critical seven-day post-discharge time frame to ensure timely follow-up is scheduled in alignment with the requirements of indicator #4a, and the adult and children SFY 2022 rates significantly decreased in comparison with the SFY 2021 rates. Therefore, the PIHP still has opportunities for improvement in this area, and this recommendation remains in place for future reporting. Although no root cause analysis was conducted and no process changes were noted, **Macomb County Community Mental Health** appeared to address the prior year's recommendations for indicators #4b and #10, as the SFY 2022 rates improved in comparison with the SFY 2021 rates, and both rates met the MPS.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Macomb County Community Mental Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Macomb County Community Mental Health** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice 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):** • MCCMH developed a formalized procedure that describes the operational guidelines for monitoring and maintaining network adequacy and created a network adequacy report that covers the required areas of time and distance, timely appointments, language and cultural competence, physical accessibility, service area review, and provider ratios. The network adequacy report was submitted to MDHHS as required. MCCMH continues to work on developing methods to meaningfully assess its network adequacy. • MCCMH implemented ongoing audits to monitor the completion of service authorizations and Adverse Benefit Determinations (ABDs). Trainings have been administered that focus on ensuring consistency between staff on content included in notices, appropriate citations, and standardized language to be used. A formalized procedure on ABDs was also developed to ensure ongoing consistency in service authorizations and issuances of ABDs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MCCMH has increased its focus on finding meaningful ways to assess its network adequacy. A new network adequacy workgroup has been established that is responsible for ongoing monitoring and implementation of actions when opportunities for improvement are identified. • Audits on the ABD notices must meet a 95% compliance rate. When audits do not meet the designated compliance rate, staff receive individual training and a corrective action plan (CAP) is established, when needed.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations related to MDHHS-set network adequacy standards, and service authorization and ABD notice requirements. While the PIHP has developed and submitted to MDHHS a network adequacy plan, the SFY 2021 compliance review CAP progress updates confirmed that the PIHP has not formalized processes to monitor MDHHS-set network adequacy standards (i.e., time/distance standards and member/provider ratios). Additionally, the SFY 2021 compliance review CAP progress update confirmed that the PIHP continues to work on system enhancements for ABD time frame extensions. As such, HSAG strongly

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
recommends that **Macomb County Community Mental Health** prioritize its action plans to correct these deficiencies. Further, it should be noted that the delay in **Macomb County Community Mental Health**'s implementation of its CAP appears excessive and is concerning.

Region 10 PIHP

Table 4-10—Prior Year Recommendations and Responses for Region 10

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although no weaknesses were identified, **Region 10 PIHP** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
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):** • In October 2021, Region 10 PIHP received the 2020-2021 Validation Report for the Medical Assistance for Tobacco Use Cessation performance improvement project (PIP). The results indicated the resubmitted PIP had an overall Met validation status with all evaluation elements and critical elements met. • In January 2022, CMH affiliates revisited and reevaluated their improvement action plans, which included root cause analyses and identified barriers for the PIP. Region 10 PIHP and CMH affiliates determined the PIP demonstrated stability and increased rates of medication assisted treatment for tobacco use cessation within the region. • Following the conclusion of remeasurement 3 for the PIP, Region 10 PIHP consulted with HSAG regarding discontinuing the PIP. HSAG confirmed the PIP had concluded with no additional submissions required. The PIP was discontinued in February 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The rate of individuals receiving medical assistance for tobacco use cessation increased from 6.9% at baseline to 17.4% at remeasurement 3.
c. Identify any barriers to implementing initiatives: • There were no identified barriers to evaluating the effectiveness of the Medical Assistance for Tobacco Use Cessation PIP interventions.
HSAG Assessment: HSAG has determined that **Region 10 PIHP** addressed the prior year's recommendations. The PIHP revisited the causal/barrier analysis and reevaluated the improvement strategies initiated to address barriers to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • **Region 10 PIHP** should consider working with the CMHSPs on adding a level of validation for the review of compliant records for indicator #1 and indicator #3 to ensure accuracy of the assessment dates and times, and the PIHP is also encouraged to consider front-end validation edits wherever possible. Additionally,

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
Region 10 PIHP should consider talking with the CMHSPs about updating source code to look for the manually entered diagnosis date within the biopsychosocial assessment to ensure alignment with the MDHHS Codebook in cases when the diagnosis was completed after the assessment date. • **Region 10 PIHP** is encouraged to consider having ongoing discussions and review of MDHHS Codebook specifications along with MDHHS guidance during its internally established Quality Management Committee meetings or another similar venue that includes CMHSP representation, the **Region 10 PIHP** performance indicator team, and IT/systems representatives.
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 SFY2021 Performance Measure Validation Review Report, Region 10 PIHP staff presented findings to the Quality Management Committee (QMC). The QMC includes representatives from CMH affiliates. • The Region 10 PIHP Performance Indicator (PI) Team incorporated review and spot checking for out of compliance, in compliance, and omissions for all indicators. The PIHP PI Team also focuses on weaknesses identified by HSAG and reviews available documentation for PI #1, if start times and dispositions times are the same; PI #2, spot check for any differences in assessment appointment date compared to the date the diagnosis was completed; PI #3, spot check any differences in assessment appointment date compared to the date the diagnosis was completed; PI #4b, disciplinary discharges are not rationale for exceptions because the consumer did not refuse follow-up services; and PI #10, check for readmissions and review whether the inpatient admission was for a state psychiatric facility. • Ongoing, Region 10 PIHP facilitates QMC meetings with CMH affiliate partners. PIs are a standing agenda item.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The weaknesses identified during the SFY2021 Performance Measure Validation Review were not identified as weaknesses during the SFY2022 Performance Measure Validation Review.
c. Identify any barriers to implementing initiatives: • Although Region 10 PIHP staff meet monthly with CMH affiliate representatives during QMC meetings, many PI Codebook specification interpretation discussions occur outside of QMC meetings and with individual CMH affiliate contacts. The PIHP PI Lead staff will improve on facilitating focused discussions on PI Codebook specifications during QMC Meetings. The Region 10 PIHP QMC enhanced the committee's FY2023 goal related to PIs to promote enhanced discussions and follow up action on Performance Measure Validation Review findings, recommendations, and guidance.
HSAG Assessment: HSAG has determined that **Region 10 PIHP** fully addressed the prior year's recommendations. Regarding HSAG's recommendations that the PIHP work with the CMHSPs to add a level of validation for the review of compliant records for indicator #1 and indicator #3 to ensure accuracy of the assessment dates and times, during the SFY 2022 PMV audit, **Region 10 PIHP** indicated that its management committee met shortly after HSAG provided the recommendation and instituted a manual process of review to the rate reporting process to identify any anomalies within the supporting event-level details. **Region 10 PIHP** staff members now perform sample checks quarterly at the performance indicator event level detail to ensure

2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation
accuracy and compliance for the indicators. For indicator #1, staff members spot check start and stop times, and for indicators #2 and #3, staff members review service and diagnosis dates as part of the spot check. **Region 10 PIHP** fully addressed the prior year's recommendation for the PIHP to consider having ongoing discussions and review of MDHHS Codebook specifications along with MDHHS guidance during its internally established Quality Management Committee meetings due to HSAG observing some interpretations about compliance for indicator #10 and exceptions for indicator #4b that did not align with MDHHS Codebook specifications and led to incorrect reporting of some records. During the SFY 2022 PMV audit, **Region 10 PIHP** reported that for indicator #4b, it agrees that exceptions for disciplinary discharges do not provide an appropriate rationale for exceptions, and this expectation has now carried forward into **Region 10 PIHP**'s internal indicator #4b event level detail. **Region 10 PIHP** has also updated process documents for its staff members and CMHSPs in order to create a clear definition of acceptable exceptions for this indicator. For indicator #10, **Region 10 PIHP** now asks CMHSPs to identify whether a member was in a community hospital, institution for mental disease, or a State hospital in order to meet MDHHS guidance for the indicator.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Region 10 PIHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set network adequacy standards. • In addition to implementing its MDHHS-required CAP to mitigate the gaps within its processes and documentation, **Region 10 PIHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to service authorization and ABD notice 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):** • Regarding MDHHS-set network adequacy standards, Region 10 PIHP submitted the Network Adequacy Plan to MDHHS on March 30, 2022. Ongoing, staff are reviewing and updating appropriate and relevant policies to ensure alignment with current requirements and practices, with the barrier of staffing changes. These policies will be reviewed annually to ensure all requirements align consistently. Region 10 PIHP staff have also begun documenting practices and processes to address network changes that negatively affect member access to care. Region 10 PIHP will continue to review its practices to potentially address changes in the composition of the provider network that could affect access to care other than provider terminations (e.g., for example, temporary closures, relocation of a provider). Lastly, Region 10 PIHP added a Network Adequacy Certification Report to the PIHP-CMH Reporting Requirements Contract Attachment. CMH affiliates are required to respond with information

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
regarding maximum time and distance standards, Medicaid enrollee-to-provider ratios, timely appointments, and language, cultural competence, and physical accessibility. • Regarding service authorizations and Adverse Benefit Determination (ABD) Notices, Region 10 PIHP is reviewing and revising the Utilization Management Program Policy 01.05.01 to include the requirements associated with issuing an ABD Notice. Region 10 PIHP also implemented the FY2022 Utilization Management Program Plan which outlines the responsibilities of the PIHP and network related to utilization management. Several enhancements have been made to the electronic health record (EHR) module that align the requirements of the ABD Notice to the capabilities of the EHR. These enhancements include, but are not limited to, adding taglines to the ABD Notice, added options for the reason for the ABD Notice, modifications to legal citations, and including the availability of written translation or oral interpretation. These module enhancements have also been made available to CMH affiliates. Furthermore, Region 10 PIHP has implemented a FY2022 Annual Record Review of CMH & SUD Treatment ABD Notices to audit the content of providers' ABD Notices. Lastly, Region 10 PIHP has been actively working on a Utilization Management Redesign project which would include the PIHP being responsible for issuing all ABD Notices.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Regarding MDHHS-set network adequacy standards, Region 10 PIHP completed the Network Adequacy Plan and submitted the plan to MDHHS. • Regarding service authorizations and ABD notices, enhancements made to Region 10 PIHP's ABD Notice within the EHR improve compliance with ABD Notice requirements. Regarding CMH and SUD Treatment ABD Notices, Region 10 PIHP will review the results of the FY2022 Annual ABD Notice Record Review to determine additional performance improvement.
c. Identify any barriers to implementing initiatives: • Regarding MDHHS-set network adequacy standards, an identified barrier is staff turnover resulting in changes to the lead staff assigned to oversee and implement initiatives. • Regarding service authorizations and ABD Notices, there are no identified barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Region 10 PIHP** partially addressed the prior year's recommendations related to MDHHS-set network adequacy standards. While the PIHP's progress updates to the SFY 2021 compliance review CAP indicated that its action plans related to network adequacy were on track for completion, and therefore not yet complete, the PIHP has made significant progress in its implementation and has developed and submitted a network adequacy plan to MDHHS. Therefore, HSAG has no further recommendations at this time. HSAG determined that **Region 10 PIHP** has addressed the prior year's recommendations related to service authorization and ABD notice requirements. The PIHP's progress updates to the SFY 2021 compliance review CAP also confirmed that its action plans for these requirements were complete and addressed HSAG's recommendations included as part of the progress updates.

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 EQR activities across the PIHPs.

Validation of Performance Improvement Projects

For the SFY 2022 validation, the PIHPs submitted baseline data for their PIHP-specific PIP topic. HSAG's validation evaluated the technical methods the PIHPs' PIPs (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of each PIHP's PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 5-1 provides a comparison of the overall PIP validation statuses and the scores for the PIP Design stage (Steps 1 through 6) and Implementation stage (Step 7), by PIHP.

Table 5-1—Comparison of Validation Statuses and Scores, by PIHP

PIP Topics and Overall PIP Validation Status, by PIHP			Design and Implementation Scores		
			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*	*Met*	100%	0%	0%
NMRE	*The Percentage of Individuals Who are Eligible for OHH Services, Enrolled in the Service, and are Retained in the Service*	*Met*	100%	0%	0%
LRE	*FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black*	*Met*	100%	0%	0%
SWMBH	*Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	*Met*	100%	0%	0%

PIP Topics and Overall PIP Validation Status, by PIHP			Design and Implementation Scores		
			Met	Partially Met	Not Met
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 Black/African American Population and the White Population*	*Met*	100%	0%	0%
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*	*Met*	100%	0%	0%
DWIHN	*Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit*	*Met*	100%	0%	0%
OCHN	*Improving Antidepressant Medication Management—Acute Phase*	*Met*	100%	0%	0%
MCCMH	*Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations*	*Not Met*	41%	35%	24%
Region 10	*Reducing Racial/Ethnic Disparities in Access to SUD Services*	*Met*	100%	0%	0%

Performance Measure Validation

Table 5-2 presents the PIHP-specific results for the SFY 2022 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). No red or green font is shown for PIHPs' rates for performance indicators #5 and #6 since the rates do not indicate best or worse performance among PIHPs.

Table 5-2—SFY 2022 PIHP-Specific Performance Measure Rate Percentages

Performance Indicator		Region 1 NorthCare	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	100.00%	98.78%	99.71%	99.36%	96.73%	98.80%	97.78%	97.92%	100.00%	100.00%
	Adults—Indicator #1b	98.99%	98.86%	98.82%	99.32%	99.19%	99.30%	97.14%	93.04%	99.41	100.00%
#2	MI–Children—Indicator #2a	71.88%	53.15%	71.73%	71.97%	65.77%	68.15%	44.40%	45.54%	32.73%	66.80%
	MI–Adults—Indicator #2b	64.63%	50.63%	78.94%	70.75%	62.59%	63.95%	57.14%	50.43%	45.09%	51.83%
	I/DD–Children—Indicator #2c	55.56%	55.74%	73.33%	83.50%	62.21%	72.06%	47.90%	53.33%	57.78%	67.68%
	I/DD–Adults—Indicator #2d	63.64%	46.88%	47.22%	82.35%	64.56%	59.38%	53.45%	42.86%	45.16%	57.41%
	Total—Indicator #2	66.79%	51.61%	73.41%	72.12%	63.73%	66.17%	52.85%	48.61%	42.22%	58.64%
#2e	Consumers[1]	74.56%	64.41%	68.48%	64.26%	74.92%	61.98%	62.96%	92.21%	87.56%	66.52%

Performance Indicator		Region 1 NorthCare	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
#3	MI–Children—Indicator #3a	72.73%	63.22%	75.59%	64.99%	57.60%	73.08%	80.61%	99.63%	**DNR**	95.19%
	MI–Adults—Indicator #3b	67.38%	68.30%	70.29%	67.04%	63.07%	81.28%	81.15%	99.77%	**DNR**	88.60%
	I/DD–Children—Indicator #3c	78.57%	86.44%	80.00%	52.94%	68.00%	85.29%	90.54%	100.00%	**DNR**	92.73%
	I/DD–Adults—Indicator #3d	55.00%	81.82%	79.73%	80.00%	56.58%	57.14%	88.00%	100.00%	**DNR**	84.31%
	Total—Indicator #3	69.21%	68.13%	74.35%	65.64%	61.27%	77.25%	82.36%	99.74%	**DNR**	91.25%
#4a	Children	95.65%	100.00%	96.51%	98.11%	96.81%	89.74%	98.15%	100.00%	52.63%	95.77%
	Adults	97.30%	100.00%	97.28%	96.21%	94.93%	95.95%	94.80%	95.56%	55.44%	92.65%
#4b	Consumers	100.00%	95.65%	97.66%	97.93%	95.48%	98.77%	100.00%	100.00%	100.00%	91.49%
#5	Medicaid Recipients[2]	6.84%	7.66%	5.33%	5.90%	7.47%	6.11%	5.90%	7.00%	4.48%	6.66%
#6	HSW Enrollees[2]	92.97%	88.57%	77.22%	88.13%	86.95%	85.33%	91.02%	91.40%	92.81%	90.56%
#8	MI–Adults—Indicator #8a	17.39%	21.76%	17.70%	19.14%	19.46%	16.40%	14.00%	19.14%	17.21%	13.78%
	I/DD–Adults—Indicator #8b	7.90%	11.08%	8.79%	8.46%	7.52%	9.63%	8.23%	12.57%	5.03%	6.33%
	MI & I/DD–Adults—Indicator #8c	8.14%	15.55%	8.92%	8.45%	9.38%	8.97%	6.02%	8.62%	6.42%	7.58%

Performance Indicator		Region 1 NorthCare	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
#9	MI–Adults—Indicator #9a	100.00%	99.85%	99.78%	99.74%	99.72%	99.52%	99.77%	99.60%	100.00%	99.84%
	I/DD–Adults—Indicator #9b	92.75%	69.58%	92.57%	92.70%	89.20%	88.95%	93.69%	77.84%	94.17%	93.57%
	MI & I/DD–Adults—Indicator #9c	95.24%	94.59%	91.06%	88.75%	92.76%	91.43%	96.69%	62.42%	93.94%	92.59%
#10	MI & I/DD–Children—Indicator #10a*	20.83%	5.00%	6.03%	7.69%	3.85%	5.13%	5.06%	0.00%	10.00%	10.53%
	MI & I/DD–Adults—Indicator #10b*	10.23%	11.95%	9.81%	12.27%	11.44%	12.39%	14.93%	5.96%	14.83%	9.86%
#13	I/DD–Adults	16.93%	20.85%	15.31%	20.06%	18.55%	25.61%	21.69%	18.99%	16.74%	16.89%
	MI & I/DD–Adults	20.56%	32.93%	23.60%	21.99%	26.64%	34.35%	27.84%	27.18%	22.14%	24.40%
#14	MI–Adults	53.73%	50.58%	46.66%	51.68%	49.78%	36.31%	38.15%	33.13%	46.20%	47.38%

* 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 2021 and SFY 2022 statewide results for the validated performance indicators with year-over-year comparative rates. MDHHS defined an MPS for seven performance indicators. For these performance indicators, the statewide rates that met or exceeded the MPS are denoted by green font, while those that did not meet the MPS are denoted by red font. Performance indicators in black font do not have an established MPS.

Table 5-3—SFY 2021 and SFY 2022 Statewide Performance Measure Rates

Performance Indicator	2021 Rate	2022 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. *MPS = 95%*		
Children—Indicator #1a	99.22%	98.40%
Adults—Indicator #1b	97.75%	97.90%
#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. *No standard for second year of implementation*		
MI–Children—Indicator #2a	64.31%	60.48%
MI–Adults—Indicator #2b	61.57%	59.27%
I/DD–Children—Indicator #2c	69.19%	62.06%
I/DD–Adults—Indicator #2d	72.51%	56.33%
Total—Indicator #2	64.60%	59.78%
#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] *No standard for second year of implementation*		
Consumers	74.88%	70.34%
#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. *No standard for second year of implementation*		
MI–Children—Indicator #3a	78.59%	72.27%
MI–Adults—Indicator #3b	81.17%	73.90%
I/DD–Children—Indicator #3c	80.50%	80.39%
I/DD–Adults—Indicator #3d	82.85%	76.05%
Total—Indicator #3	80.38%	73.95%

Performance Indicator	2021 Rate	2022 Rate
#4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *MPS = 95%*		
Children	96.01%	92.07%
Adults	95.32%	89.91%
#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. *MPS = 95%*		
Consumers	97.59%	98.43%[2]
#5: The percent of Medicaid recipients having received PIHP managed services. *An MPS was not established.*		
The percentage of Medicaid recipients having received PIHP managed services.	6.48%	6.07%
#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. *An MPS was not established.*		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	94.51%	88.22%
#8: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively. [3] *An MPS was not established.*		
MI–Adults—Indicator #8a	15.17%	17.05%
I/DD–Adults—Indicator #8b	9.13%	8.61%
MI and I/DD–Adults—Indicator #8c	8.27%	8.41%
#9: The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. [4] *An MPS was not established.*		
MI–Adults—Indicator #9a	98.81%	99.66%
I/DD–Adults—Indicator #9b	55.03%	79.93%
MI and I/DD–Adults—Indicator #9c	55.19%	82.77%
#10: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* *MPS = 15%*		
MI and I/DD–Children—Indicator #10a	8.57%	6.53%
MI and I/DD–Adults—Indicator #10b	14.40%	12.34%
#13: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). *An MPS was not established.*		
I/DD–Adults	19.48%	19.39%
MI and I/DD–Adults	26.14%	26.24%

Performance Indicator	2021 Rate	2022 Rate
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). *An MPS was not established.*		
MI–Adults	43.31%	44.11%

The statewide rates that met or exceeded the MPS are denoted in green font for performance indicators that have an MPS.

The statewide rates that did not meet the MPS are denoted in red font for performance indicators that have an MPS.

* 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] MDHHS reported that indicator #4b may have demonstrated inflated compliance due to the PIHPs' use of allowable exceptions. While HSAG determined that the PIHPs receiving a *Reportable* designation for indicator #4b did report the indicator in alignment with the MDHHS Codebook, HSAG agrees with MDHHS' assessment that PIHP reliance on exception criteria likely resulted in overall increased compliance with the indicator #4b MPS.

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

[4] 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 13 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 2021 and SFY 2022. Green font is used to denote the highest-performing PIHP(s), while red font is used to denote the lowest-performing PIHP(s). For Standard II, since all PIHPs performed the same, no red or green font is shown.

Table 5-4—PIHP and Statewide Compliance Review Scores for SFYs 2021 and 2022

Standard[1, 2]	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	84%	84%	89%	84%	84%	84%	84%	89%	84%	79%	**85%**
II[3]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
III	71%	100%	71%	86%	71%	71%	86%	71%	100%	86%	**81%**
IV	25%	50%	50%	25%	25%	25%	0%	50%	25%	25%	**30%**
V	93%	100%	79%	86%	93%	79%	79%	93%	79%	86%	**86%**
VI	82%	64%	73%	100%	91%	82%	64%	82%	73%	73%	**78%**
SFY 2021 Total	**83%**	**86%**	**82%**	**86%**	**85%**	**80%**	**77%**	**86%**	**82%**	**80%**	**83%**
VII	75%	75%	81%	75%	75%	75%	75%	75%	75%	75%	**76%**
VIII[3]	100%	91%	82%	91%	91%	91%	91%	91%	82%	91%	**90%**
IX	79%	84%	87%	87%	84%	76%	84%	84%	89%	87%	**84%**

Standard[1, 2]	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
X	80%	80%	60%	100%	100%	80%	80%	40%	20%	100%	**74%**
XI	86%	57%	86%	71%	100%	86%	86%	100%	57%	100%	**83%**
XII[4]	82%	82%	82%	82%	92%	82%	82%	82%	73%	82%	**82%**
XIII	90%	70%	87%	67%	93%	73%	83%	93%	67%	90%	**81%**
SFY 2022 Total	**84%**	**78%**	**84%**	**80%**	**88%**	**78%**	**83%**	**85%**	**75%**	**87%**	**82%**
Combined Total	**84%**	**81%**	**83%**	**82%**	**87%**	**79%**	**81%**	**85%**	**77%**	**85%**	**82%**

Standard I—Member Rights and Member Information
Standard II—Emergency and Poststabilization Services
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
Standard VII—Provider Selection
Standard VIII—Confidentiality
Standard IX—Grievance and Appeal Systems
Standard X—Subcontractual Relationships and Delegation
Standard XI—Practice Guidelines
Standard XII—Health Information Systems
Standard XIII—Quality Assessment and Performance Improvement Program

Highest-performing PIHP(s) in each program area.

Lowest-performing PIHP(s) in each program area.

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

[2] 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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[3] Performance in these standards should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in these program areas is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[4] The Health Information Systems standard includes an assessment of each PIHP's IS capabilities.

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—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Ensure high quality and high levels of access to care	**Conclusions:** Through its contract with the PIHPs, MDHHS established network adequacy standards for the Michigan Behavioral Health Managed Care program that supports the needs of its members with mental illness and SUD diagnoses. These standards include time and distance standards as well as Medicaid member-to-provider ratios for services provided to both adult and child members. The PIHPs were required to have a plan for how they effectuated each network adequacy standard, and plans had to address maximum time and distance; timely appointments; and language, cultural competence, and physical accessibility. The PIHPs were also required to report performance measure data to MDHHS on a scheduled basis using the specifications documented in the PIHP Reporting Codebooks included as part of MMBPIS. Performance measure data were published to MDHHS' website approximately 30 days after the reporting due date. Through the EQR PMV, HSAG determined that all but one PIHP had reportable rates, indicating that MDHHS could use most of the data reported by the PIHPs in its QI efforts. Additionally, of the 13 performance measures included under MMBPIS, four measures have an MDHHS-established MPS, and three of the four measures are further stratified by populations for a total of seven indicators having an established MPS. Programwide, the MPS of 95 percent was met for performance 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*, for both the child and adult populations; the MPS of 95 percent was met for performance indicator #4b, *the percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*, for the eligible population; and the MPS of 15 percent was met for performance indicator #10, *the percentage of readmissions of MI*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge, for both the child and adult populations. These findings indicate that most members receiving services through the PIHPs received timely pre-admission screening dispositions for psychiatric inpatient care, and that members discharged from a substance abuse detox unit were seen by a SUD provider in a timely manner after discharge. Overall, there was also a low prevalence of members being readmitted to an inpatient psychiatric unit within 30 days of hospital discharge. However, programwide, performance indicator #4a, *the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*, did not meet the MPS of 95 percent for either the children or the adult population, and performance declined substantially from the 2021 rates for this indicator. These findings suggest that members were not being seen at all or were not being seen in a timely manner after being discharged from psychiatric inpatient units. This could be the result of ineffective transitions of care processes or an insufficient network of mental health providers to provide services to the Medicaid members with diagnosed mental illnesses. Further, although no MPS was established by MDHHS for performance indicators #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*.; and #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*, these indicators specifically assess how quickly new members requesting non-emergency services can obtain biopsychosocial assessments and access SUD and/or mental health treatment. Statewide rates show a decline in performance from 2021 to 2022 for all three performance indicators and all applicable populations, indicating substantial opportunities for MDHHS and its PIHPs to ensure new child and adult Medicaid members can access timely SUD and mental health treatment. **Recommendations:** To further support its efforts to effectively monitor the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members, MDHHS should establish MPSs for performance indicators #2, #2e, and #3 and require the PIHPs to submit CAPs for any deficiencies identified through MDHHS' monitoring processes for all performance indicators with	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	an established MPS. Additionally, although HSAG conducted validation of the SFY 2022 Q1 performance indicator rates, MDHHS published performance indicator reports quarterly, which occurred prior to the completion of PMV. Through the data validation process, one PIHP received a designation of *DNR* for indicator #3, indicating the PIHP did not calculate this indicator in compliance with MDHHS' PIHP Codebook specifications. Therefore, the rate published on MDHHS' website was inaccurate and incomparable to the other PIHPs and should not be used by MDHHS in its QI activities. MDHHS may want to consider only publishing performance indicator data that have been validated by its EQRO or by MDHHS through other validation activities. Additionally, when the rates are published prior to PMV completion, a PIHP could potentially correct an identified deficiency and submit an accurate rate to MDHHS instead of receiving a *DNR* designation. Therefore, to provide MDHHS with the opportunity to obtain the most accurate data possible in support of the evaluation of PIHP performance indicators, MDHHS could also consider allowing the PIHPs to resubmit the updated, accurate performance indicator data to MDHHS when issues are identified through PMV. Further, MDHHS could consider requiring the PIHPs to report final, updated quarterly performance indicator data to MDHHS, upon conclusion of the annual PMV, so that these final rates can be used to assess overall progress with achieving the related CQS goals and objectives. Through MDHHS' process to review and update its CQS, HSAG also recommends that MDHHS consider adding a table within the CQS that outlines the specific performance measures and performance targets associated with each objective listed under each of the five Quality Strategy goals. Because the CQS includes all managed care programs in the State, MDHHS should specify each program's specific performance measure(s) that align to each of the objectives as they are applicable to the program or programs (i.e., what metric is used to assess the performance of each objective at the program level to determine overall progress with achieving each Quality Strategy goal.) For the existing objectives that are not able to be supported through standardized performance measures, MDHHS could consider developing new objectives, or revise its existing objectives, to be SMART.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS, through its contract with the PIHPs, requires that all PIHP staff members are trained and possess current, working knowledge of the populations served, person-centered planning, self-determination, recovery and resiliency, cultural competency, etc. MDHHS also requires the PIHPS to work in collaboration with the MHPs on several P4P measures, including that each MHP and PIHP must document joint care plans for members with appropriate severity/risk, who have been identified as receiving services from both entities. The PIHPs must also work in collaboration with the MHPs on *Follow-Up After Hospitalization for Mental Illness within 30 Days and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* performance measures. Further, for SFY 2022, the PIHPs were required to report performance measure data to MDHHS in support of Goal 2, that was validated through the PMV, including MMBPIS performance indicator #8, *the percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively*; performance indicator #9, *the percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the* CMHSPs *and PIHPs who earned minimum wage or more from any employment activities*; performance indicator #13, *the percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s)*; and performance indicator #14, *the percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* Although MDHHS has not set benchmarks for these performance indicators, since the prior year, more MI Adults and I/DD Adults are employed competitively, and more MI Adults and I/DD Adults earn at least minimum wage from employment activities. There was also a slight increase in the percentage of adults with SMI who lived in a private residence alone, with a spouse, or with a non-relative than the prior year. The percentage of I/DD Adults and MI and I/DD Adults who lived in a private residence alone, with a spouse, or with a non-relative remained stable over the last two years. **Recommendations:** MDHHS could consider developing initiatives for the PIHPs related to performance indicators #8, #9, #13, and #14 that will support an increase in the prevalence rates related to employment, minimum wage pay, and housing particularly when	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	these areas are identified as goals through members' person-centered care plans. As part of the initiatives, MDHHS could require the PIHPs to report successes and any noted barriers through the QAPI program evaluation that PIHPs are required to submit to MDHHS annually.	
Goal 3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	**Conclusions:** Many Medicaid members receiving services from PIHPs are also enrolled in an MHP for their healthcare services. The MHP is responsible for non-specialty-level mental health services. Therefore, MDHHS requires the PIHPs to have a written agreement with each MHP serving any part of the PIHPs' service areas. The written agreement must describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination, and dispute resolution. At a minimum, these arrangements must address the integration of physical and mental health services provided by the MHP and the PIHP for their shared members. In addition to MDHHS requiring collaborative activities with the MHPs to support coordinated care (e.g., shared performance measures), MDHHS requires the PIHPs to calculate and report MMBPIS performance indicators that demonstrate the effectiveness of the PIHPs' care coordination efforts. For example, as indicated through the SFY 2022 PMV activity, MDHHS evaluated these efforts under performance indicator #10, *the percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.* Statewide, the PIHPs performed better than the MPS of 15 percent (i.e., rates are lower than 15 percent) for both the children and the adult populations, and performance improved from the 2021 rates for the associated indicators. Strong performance in this program area implies that the PIHPs implemented effective care coordination processes, such as ensuring members had effective transition plans prior to discharge, including appointments for follow-up services, crisis or relapse prevention plans, discharge medications, and referrals to other services as necessary to prevent readmission. Further, through the compliance review activity, the Behavioral Health Managed Care program demonstrated moderate performance in the Practice Guidelines standard, indicating that most providers providing mental health and SUD services were informed of the MDHHS-required policies that support these services. **Recommendations:** MDHHS has established common program-specific quality metrics across the PIHPs and MHPs to support the integration of services. However, HSAG recommends that the CQS be revised to specifically tie these metrics to the objectives under Goal 3.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, the PIHPs were responsible for initiating a new PIP to address healthcare disparities. While MDHHS did not mandate a statewide topic, the PIHPs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicator(s). Through the PIHPs' analyses of their data, eight of the 10 PIHPs identified existing racial and ethnic disparities. Through the PIP activity, the PIHPs will implement interventions aimed at eliminating those racial and ethnic disparities. As demonstrated through the SFY 2022 PIP validation, nine of the 10 PIHPs designed a methodologically sound PIP that should support improvement in health outcomes and reduce disparities within the Behavioral Health Managed Care program. **Recommendations:** MDHHS has required PIPs to support the reduction in racial and ethnic disparities. As the PIPs progress and the PIHPs identify interventions, MDHHS should review the planned interventions to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. Additionally, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal 3.	☒ Quality ☐ Timeliness ☒ Access
Goal 5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** Contract withhold arrangements and the Performance Bonus Incentive Program have been established by MDHHS to support program initiatives as specified in the MDHHS CQS. The Performance Bonus Incentive Pool includes PIHP/MHP joint metrics that require collaboration between the two entities for the ongoing coordination and integration of behavioral health and physical health services. The PIHPs and MHPs are also responsible for collectively reporting data pertaining to the follow-up after hospitalization for mental illness within 30 days and follow-up after an ED visit for alcohol and other drug dependence. However, the aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reform had on improving quality outcomes. **Recommendations:** MDHHS should consider revising the CQS to include the specific performance metrics MDHHS uses to evaluate progress toward achieving Goal 5. While MDHHS stipulates its expectations related to value-based initiatives and payment reforms within its contract with the PIHPs, HSAG did not evaluate the results of these activities as part of this EQR since they are not included as part of the annual EQR activities. Therefore, no additional recommendations can be provided in support of Goal 5.	☒ Quality ☐ Timeliness ☐ Access

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 QI.
- 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 QI 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 QI 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 2022, the PIHPs submitted baseline data for their plan-specific PIP topics. HSAG conducted validation on the PIP Design stage (Steps 1 through 6) and Implementation stage (Steps 7 through 8, as applicable) 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, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[A-1]

Using this protocol, 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 2022 submissions, the PIHPs reported baseline data and were validated for Steps 1 through 7, and Step 8 as applicable, 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.

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

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 11, 2023.

"critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The PIHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Feedback* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Not Met*.

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 2022, the PIHPs submitted baseline data. 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 *Met*, *Partially Met*, or *Not Met*. 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 2022, which began October 1, 2021, and ended December 31, 2021. Table A-4 lists the performance indicators calculated by the PIHPs and 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 PMV Protocol 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' information systems; 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 2021 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 information systems, 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 the CMS EQR PMV protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool—**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 Frame

Data Sources	Period to Which Data Applied
ISCAT (from PIHPs)	SFY 2021
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2021
Previous performance measure results reports (from MDHHS)	SFY 2021
Performance measure results (from PIHPs and MDHHS)	1st Quarter SFY 2022
Supporting documentation (from PIHPs and MDHHS)	SFY 2021
Virtual interviews and systems demonstrations (from PIHPs)	During Virtual Review

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 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	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers	1st Quarter SFY 2022
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI & I/DD–Adults • MI & I/DD–Children	1st Quarter SFY 2022

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 a non-emergency request for service for persons with Substance Use Disorders (SUDs).	• Consumers	1st Quarter SFY 2022
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2022

Indicator		Sub-Populations	Measurement Period
#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	1st Quarter SFY 2022
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2021
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2021
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• I/DD–Adults • MI & I/DD–Adults	SFY 2021
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	• MI–Adults	SFY 2021

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 10 PIHPs contracted with MDHHS to deliver services to Michigan 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 SFY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focused 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. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021), and a review of the remaining seven standards in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as Not Met during the SFY 2021 and SFY 2022 compliance reviews.

Table A-5 outlines the standards reviewed over the three-year review cycle.

Table A-5—Division of Standards Over Review Periods

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.10 §438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[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 standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

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

[3] This standard includes a comprehensive assessment of the PIHPs' 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 compliance review tools was selected based on applicable federal and State regulations and laws, and the requirements set forth in the contract between MDHHS and the PIHPs as they related to the scope of the review. The review processes used by HSAG to evaluate the PIHPs' compliance were consistent with CMS EQR Protocol 3.

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 detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the PIHP.
- Hosted a pre-site review preparation session with all PIHPs.
- Generated a sample of records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegation.

- Conducted a desk review of supporting documentation 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 site review interview sessions 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 practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the PIHP used in its operations, applicable to the standards 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 (*Met*, *Not Met*, or *NA* as described in the below Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an PIHP-specific 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 performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an PIHP during the period covered by HSAG's review. This scoring methodology, displayed in Table A-6, is consistent with CMS EQR Protocol 3.

Table A-6—Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1 point	*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.

Compliance Score	Point Value	Definition
Not Met	Value = 0 points	*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 Not Met findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

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 all 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 PIHP records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegation to verify that the PIHP had put into practice the processes and procedures documented in its policies. HSAG selected 10 records each for practitioner and organizational credentialing, grievances, appeals, and three delegated entities 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 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.

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.

Corrective Action Plan Process:

HSAG created a CAP template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to MDHHS and HSAG, the PIHP must use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s). The CAP process included the following activities:

- PIHPs completed the CAP template describing the action plans to be implemented to remediate each deficient element.
- HSAG and MDHHS reviewed the PIHPs' action plans for each deficient element and assigned each element a designation of *Accepted*, *Accepted With Recommendations*, or *Not Accepted*.
- For any deficient element that received a designation of *Not Accepted*, the PIHPs were required to revise the CAP until HSAG and MDHHS determined the action plan is sufficient to ensure compliance with the requirements of the element.
- PIHPs were required to submit periodic progress updates to report the status of each action plan to HSAG and MDHHS.

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 practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the PIHP's key staff members. Table A-7 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-7—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 and after the site review	October 1, 2021–March 31, 2022
Information obtained through interviews	July 11, 2022–July 26, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process during Quarter (Q) 3 and Q4 of SFY 2021 (i.e., April to September 2021)
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances during Q4 of SFY 2021 (i.e., July to September 2021) and Q1 of SFY 2022 (i.e., October to December 2021)
Information obtained from a review of a sample of member appeal files	Listing of all closed member appeals during Q4 of SFY 2021 (i.e., July to September 2021) and Q1 of SFY 2022 (i.e., October to December 2021)
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Michigan Behavioral Health Managed Care program between October 1, 2021, through March 31, 2022

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each PIHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated for each standard. As any standard or program area not achieving 100 percent compliance required a formal CAP, HSAG determined each PIHP's substantial strengths and weaknesses as follows:

- Strength—Any program area that achieved 100 percent compliance.[A-2]
- Weakness—Any program area that received less than 80 percent compliance.

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.

[A-2] For Standard VIII—Confidentiality, there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR, and the PIHPs' progress in implementing HSAG's recommendations in this program area will be further assessed for continued compliance in future reviews.