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State Fiscal Year 2023
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) within MDHHS administers and oversees the Michigan Behavioral Health Managed Care program, which contracts with 10 prepaid inpatient health plans (PIHPs) in Michigan to provide Medicaid waiver benefits for people with intellectual and developmental disabilities (I/DD), serious mental illness (SMI), and serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs). The PIHPs contracted with MDHHS during state fiscal year (SFY) 2023 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

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

Member Population	Abbreviation
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 and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1-1,1-2] The purpose of the EQR activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate State efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2023 assessment, HSAG used findings from the mandatory and optional 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.

Table 1-3—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a PIHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects (CMS EQR Protocol 1)
Performance Measure Validation (PMV)	This activity assesses whether the performance measures reported and/or calculated by a PIHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures (CMS EQR Protocol 2)

1-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

1-2 HSAG updated the EQR methodologies to align with the 2023 CMS EQR Protocols published in February 2023. However, for the SFY 2023 activities initiated with the PIHPs prior to the release of the 2023 CMS EQR Protocols, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols (https://www.medicaid.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf) and initiated discussions with MDHHS, as appropriate, to align the methodologies to the 2023 CMS EQR Protocols.

Activity	Description	CMS Protocol
Compliance Review	This activity determines the extent to which a PIHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations (CMS EQR Protocol 3)
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by a PIHP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)

Michigan Behavioral Health Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2023 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)[1-3] and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care 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:** MDHHS has established the Michigan Mission-Based Performance Indicator System (MMBPIS) that measures performance in the domains of access to care, adequacy and appropriateness of services provided, efficiency, and outcomes and set minimum performance standards (MPSs) for a subset of the performance indicators. Specifically, MDHHS set an MPS of 95 percent for indicators #1, #4a, and #4b, and an MPS of	☒ Quality ☒ Timeliness ☒ Access

[1-3] The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the SFY 2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	15 percent (lower performance is better) for indicator #10. The SFY 2023 statewide rate met the MPS for three performance indicators: • *#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.* • *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.* • *#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.* The rates for these performance indicators also remained relatively stable year over year, with an increase or decrease in performance of 1.28 percentage points or less compared to SFY 2022, indicating that most members receive a timely pre-admission screening and timely follow-up care following an inpatient stay from a substance use detox unit. Additionally, most child and adult members are not being readmitted within 30 days after discharge from a psychiatric hospitalization. MDHHS has also established quantitative network adequacy standards and SUD admission standards for priority populations to assure PIHPs provide timely and accessible care. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), all PIHPs demonstrated gaps in their processes related to their annual network adequacy analysis, and most PIHPs demonstrated gaps in monitoring SUD priority population admission standards. However, the current SFY 2023 compliance review activity, which consisted of a corrective action plan (CAP) review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies in these program areas (i.e., Availability of Services and Assurances of Adequate Capacity and Services). MDHHS has also updated SFY 2024 contract language to require the PIHPs to submit an annual network adequacy report as opposed to a certification report. MDHHS is also requiring the PIHPs to participate in a new network adequacy validation (NAV) activity in SFY 2024. The purpose of the NAV activity is to assess and validate the adequacy of each PIHP's network in accordance with MDHHS' established network adequacy standards. The findings	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	from the NAV activity will provide MDHHS insight into whether the PIHPs maintain provider networks that are sufficient to provide timely and accessible care to Medicaid members across the continuum of services the PIHPs are responsible for and if the data being submitted to MDHHS are accurate and valid. However, while the rates for indicators #4b and #10 suggest that the Behavioral Health Managed Care program effectively provided transition of care planning, the results for indicator #4a indicate a need to improve timely follow-up care for children and adults following discharge from a psychiatric inpatient hospitalization. The MPS was not met for either the child or adult populations for indicator #4a, and while the rate for children declined by less than 1 percentage point, the rate for adults declined by 3.44 percentage points. Lack of timely and effective follow-up care may result in poorer outcomes, readmissions, and increased costs. Indicators #2, #2e, and #3 also measure timely access to care, but no MPSs have yet been established by MDHHS. However, all indicator rates experienced a decline from the prior year, with rates declining from 1.78 to 18.37 percentage points. These results indicate that fewer new members received a timely biopsychosocial assessment, received a timely face-to-face SUD service, and started medically necessary ongoing services timely. **Recommendations:** To further support its efforts to effectively monitor the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members, HSAG recommends that if MDHHS continues to require the PIHPs to report these indicators that performance benchmarks are established for performance indicators #2, #2e, and #3. MDHHS should also consider requiring the PIHPs to submit CAPs for any deficiencies identified through MDHHS' monitoring processes for all performance indicators with an established MPS or benchmark. Setting an MPS or another type of benchmark and requiring remediation for underperformance may incentivize the PIHPs to improve rates for these indicators. Additionally, MDHHS should consider requiring the PIHPs to calculate and report on national performance measures, such as Child and Adult Core Set and HEDIS measures. This will allow MDHHS to assess performance against national benchmarks and will allow MDHHS to compare the PIHPs and the Behavioral Health Managed Care program's performance to other MCEs nationally.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS places a strong emphasis on person-centered planning though contract provisions and practice guidelines. Additionally, care management processes, including person-centered service planning, is reviewed as part of the compliance review activity. The SFY 2023 compliance review activity confirmed the PIHPs remediated all but one deficiency in the Coordination and Continuity of Care program area. MDHHS also requires that member service or treatment plans be developed in a manner consistent with the principals of person-centered planning, which should reflect the member's services, supports, preferences, and needs, such as employment and living arrangements. Two indicators of the MMBPIS focus on member employment and member residence. While MDHHS has not established MPSs for these indicators, the results of the PMV activity demonstrated that more adults diagnosed with an intellectual or developmental disability, or dually diagnosed with a mental illness and intellectual disability, were competitively employed and earned minimum wage or more from any employment activities compared to the prior year. Additionally, the percentage of adults diagnosed with an intellectual or developmental disability, or mental illness, who lived in a private residence remained relatively stable year over year. Choice of living arrangements and employment opportunities can improve the quality of life for members. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and identified two performance metrics to determine the impact the Behavioral Health Managed Care program has on meeting Goal #2: *Percentage of Mobile Crisis Response Parent/Caregiver Experience Survey responses* and *Percentage of responses of a 3 or 4 on the following Mobile Crisis Response Parent/Caregiver Experience Survey item: "Do you feel you had voice and choice in the development of the follow-up plan?*" However, a statewide baseline performance rate and a statewide performance target have yet to be established. HSAG recommends that MDHHS proceed with establishing baseline rates and performance targets for these metrics.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	**Conclusions:** One of MDHHS' objectives to support Goal #3 is to promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. This objective aligns with CMS' goal to advance interoperability with the mission of promoting the secure exchange, access, and use of electronic health information to support better informed decision making and a more efficient healthcare system. During the SFY 2022 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), all PIHPs had not implemented the Patient Access and Provider Directory Application Programming Interface (API) requirements in accordance with all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed that none of the PIHPs had fully remediated all deficiencies in the Health Information Systems program area. Most of the PIHPs challenged the applicability of the interoperability requirements, suggesting that the PIHPs were not required to implement the requirements as MDHHS' contract with the PIHPs did not specifically include the requirements of 42 CFR 438.242(b)(5,6). However, the PIHPs, being an MCE, are required to comply with the Medicaid managed care rule and guidance issued by CMS, including the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. While HSAG's concerns related to the PIHPs' lack of accountability were communicated to MDHHS, the absence of guidance from MDHHS for the PIHPs to proceed with implementation of the API requirements contributed to the PIHPs' lack of urgency to fully implement the interoperability requirements. **Recommendations:** While MDHHS' contract with the PIHPs already includes a provision requiring the PIHPs to comply with all State and federal laws, statutes, regulations, and administrative procedures, HSAG recommends that MDHHS issue guidance to the PIHPs on the expectation that they adhere to all federal Medicaid managed care rules regarding interoperability, including the Patient Access and Provider Directory APIs. Additionally, HSAG recommends this guidance include contacts for subject matter experts at MDHHS for the PIHPs to contact should additional guidance or consultation be needed to ensure the PIHPs, and therefore MDHHS, come into compliance with the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. Further, as CMS has enhanced interoperability and API requirements as described in the CMS	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F), MDHHS should proceed with also mandating the PIHPs to implement these new requirements.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2023, the PIHPs were responsible for continuing their PIP topics 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 PIHP-specific topics and performance indicator(s). Through the PIHPs' analyses of their data, eight of the 10 PIHPs identified existing racial and ethnic disparities. As demonstrated through the SFY 2023 PIP validation, all 10 PIHPs designed a methodologically sound PIP and implemented interventions based on the barriers identified through each PIHP's data analysis and quality improvement processes. MDHHS also requires the PIHPs to participate in a withhold program with the Medicaid health plans (MHPs). As part of the SFY 2023 program, for two joint performance metrics, *J.2 Follow-Up After Hospitalization (FUH) for Mental Illness Within 30 Days* and *J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence*, data are stratified by race/ethnicity and provided to the PIHPs. The PIHPs are incentivized to reduce the disparity between the index population and at least one minority group. While results of the withhold program are not available to HSAG through the aggregated findings for the EQR activities, this program and the initiatives implemented through the PIHP's PIPs support improvement in health outcomes and reduce disparities within the Behavioral Health Managed Care program. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included three performance metrics for 2026. MDHHS has identified three performance metrics to allow an evaluation of the Behavioral Health Managed Care program: *Percentage of Persons of Color, aged 0-21, receiving a completed biopsychosocial assessment from specialty behavioral health system*; *Percentage of Persons of Color, aged 0-21, starting any medically necessary ongoing covered service from specialty behavioral health system after receiving a biopsychosocial assessment*; and *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*. However, a statewide baseline performance rate and a statewide performance target have yet to be established. HSAG	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	recommends that MDHHS proceed with establishing baseline rates and performance targets for these metrics. Additionally, while MDHHS posts MMBPIS quarterly reports on its website, these reports do not include results stratified by race/ethnicity. If MDHHS continues to use MMBPIS to assess PIHP performance, or implements alternative measures to assess performance, HSAG recommends that MDHHS consider the benefit of requiring the PIHPs to report performance measure results, or a subset of results, by race/ethnicity. Analysis of these data could assist in identifying PIHP-specific or statewide health disparities to focus future performance improvement initiatives.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has established PIHP performance bonuses, through Withhold Arrangements, the Performance Bonus Incentive Pool (PBIP), the Opioid Health Home Benefit, the Behavioral Health Home Benefit, and the Certified Community Behavioral Health Clinics (CCBHC) Demonstration Quality Bonus Payment. The aggregated findings for 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. However, the *Effectiveness Evaluation Appendix C—Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments*, as reported through the 2023–2026 CQS, confirmed that the Behavioral Health Managed Care program met Objective 5.1, *Promote the use of value-based payment models to improve quality of care*, under Goal #5, as performance bonus withholds are currently included in the PIHP contract, and the PIHPs are required to submit an annual summary of efforts, activities, and achievements to increase participation in patient-centered medical homes. MDHHS, through its contract with the PIHPs, administers Opioid Health Home and Behavioral Health Home programs to provide comprehensive care management and coordination services to Medicaid members diagnosed with an opioid use disorder, or an SMI or SED. Health homes receive reimbursement for providing mandated core services such as care management, health promotion, and individual and family support, and are designed to improve member health outcomes while decreasing costs. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included four performance metrics with baseline performance and performance targets for 2026 for two of the Medicaid managed care programs in Michigan. However, no	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	performance metrics related to the Behavioral Health Managed Care program were included. HSAG recommends that MDHHS add a performance metric for the Behavioral Health Managed Care program under Goal #5 or clarify the rationale for not including the Behavioral Health Managed Care program in MDHHS' evaluation of Goal #5 when value-based initiatives and payment reform are being implemented through the Behavioral Health Managed Care program.	

2. Michigan Behavioral Health Managed Care Program

Managed Care in Michigan

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

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	Managed Care Organization (MCO)	1915(b)	July 1997	MHPs provide comprehensive healthcare services to low-income adults and children.
• MIChild (CHIP)		1915(b)	January 2016	MIChild is a Medicaid program for low-income uninsured children under the age of 19.
• Children's Special Health Care Services (CSHCS)		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.
MI Choice Waiver Program (Prepaid Ambulatory Health Plans [PAHPs])	PAHP	1915(c) since 1992 1915(b) since 2012	1992	The elderly or disabled adults (aged 18+) who meet the nursing facility level of care.

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

Behavioral Health Managed Care

BPHASA within MDHHS administers and oversees the Behavioral Health Managed Care program, which operates under Section 1115 waivers. Behavioral health managed care services and supports in Michigan are delivered through county-based CMHSPs. Michigan uses a managed care delivery structure including 10 PIHPs who contract for service delivery with 46 CMHSPs and other 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 quality improvement activities related to clinical service delivery.

Overview of Prepaid Inpatient Health Plans

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

Table 2-2—PIHP Profiles

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

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

Quality Strategy

The 2020–2023 MDHHS CQS[2-1] provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, long-term services and supports (LTSS), dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 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—2020–2023 MDHHS CQS Goals and Ojectives

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.

[2-1] The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the SFY 2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
		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.
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.

Michigan CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
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.
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 quality improvement. Examples of these initiatives and interventions include:

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

- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.
- **National Core Indicators (NCI) Adult Consumer Survey**—Michigan participates in the NCI survey, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with I/DD. Performance indicators within the survey assess individual outcomes, health, welfare, and rights (e.g., safety and personal security, health and wellness, and protection of and respect for individual rights); and system performance (e.g., service coordination, family and individual participation in provider-level decisions, the utilization of and outlays for various types of services and supports, cultural competency, and access to services).

3. Assessment of Prepaid Inpatient Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2023 review period to evaluate the performance of the PIHPs on providing quality, timely, and accessible healthcare services to Behavioral Health Managed Care program members. Quality, as it pertains to EQR, means the degree to which the PIHPs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS' network adequacy standards) and §438.206 (adherence to MDHHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the PIHPs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2023 PIP activity, the PIHPs continued PIP topics that focused on disparities within their populations, as applicable, and reported quality improvement strategies for each performance indicator. HSAG conducted validation on the PIP Design stage (Steps 1 through 6) and Implementation stage (Steps 7 and 8) of the selected PIP topic for each PIHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS EQR 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 2023 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 EQR Protocol 2) and included a PIHP information systems capabilities assessment (ISCA) and a review of data reported for the first quarter of SFY 2023.

Based on all validation methods used to collect information during the Michigan SFY 2023 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.*
#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.*

Indicator Number and Description	
#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

The SFY 2023 compliance review is the third year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for 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). This SFY 2023 (Year Three) review consisted of a review of the standards and elements that required a CAP during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities. 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 EQR 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)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of PIHPs' implementation of Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	

Compliance Review Standards	Associated Federal Citations[1, 2]		Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
	Medicaid	CHIP			
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[3]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[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 MHPs. 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 systems (IS) capabilities.

Encounter Data Validation

In SFY 2023, HSAG conducted and completed EDV activities for all 10 PIHPs. The EDV activities included:

- IS review—assessment of MDHHS' and the PIHPs' IS and processes. The goal of this activity was to examine the extent to which MDHHS' and the PIHPs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the PIHPs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-4 displays the overall validation rating 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 Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring Treatment from a Network Provider	*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%	—	—	NA

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).
Not Applicable (NA) = The PIHP did not identify an existing disparity within its population for this PIP during the Design stage of the PIP; therefore, the results do not include an assessment of a disparity.

The goal for **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 barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-5—Barriers and Interventions for NCN

Barriers	Interventions
Lack of qualified, trained staff across multiple populations and providers.	Training specific to co-occurring disorders was encouraged for all clinical staff. **NorthCare Network** is paying for clinical staff training via grant funding.
	NorthCare Network offered consultation to each CMH provider to increase general knowledge of medication assisted treatment and treating CODs.

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 that met State and federal requirements. A methodologically sound design created the foundation for **NorthCare Network** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: NorthCare Network used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

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

Recommendation: Although there were no identified weaknesses, HSAG recommends that **NorthCare Network** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort.

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 2023 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-6—Performance Measure Results for NCN

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	100%	+/- 0.00%	95.00%
Adults—Indicator #1b	98.99%	100%	+1.01%	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%	65.33%	-6.55%	NA
MI–Adults—Indicator #2b	64.63%	55.94%	-8.69%	NA
I/DD–Children—Indicator #2c	55.56%	51.85%	-3.71%	NA
I/DD–Adults—Indicator #2d	63.64%	53.33%	-10.31%	NA
Total—Indicator #2	66.79%	59.20%	-7.59%	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%	64.61%	-9.95%	NA

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	70.73%	-2.00%	NA
MI–Adults—Indicator #3b	67.38%	69.09%	+1.71%	NA
I/DD–Children—Indicator #3c	78.57%	65.22%	-13.35%	NA
I/DD–Adults—Indicator #3d	55.00%	88.24%	+33.24%	NA
Total—Indicator #3	69.21%	70.28%	+1.07%	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%	100%	+4.35%	95.00%
Adults	97.30%	96.74%	-0.56%	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%	97.06%	-2.94%	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%	6.64%	-0.20%	—
#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%	98.06%	+5.09%	—
#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%	20.27%	+2.88%	—
I/DD–Adults—Indicator #8b	7.90%	9.01%	+1.11%	—
MI and I/DD–Adults—Indicator #8c	8.14%	8.90%	+0.76%	—
#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%	100%	+/-0.00%	—
I/DD–Adults—Indicator #9b	92.75%	92.00%	-0.75%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
MI and I/DD–Adults—Indicator #9c	95.24%	91.30%	-3.94%	—
#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	20.83%	5.71%	-15.12%	15.00%
MI and I/DD–Adults—Indicator #10b	10.23%	9.82%	-0.41%	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%	17.31%	+0.38%	—
MI and I/DD–Adults	20.56%	22.67%	+2.11%	—
#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%	54.54%	+0.81%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 demonstrated efforts toward improving its seven-day follow-up rate for indicator #4a and partnership with its CMHSPs. During the SFY 2023 audit, **NorthCare Network** discussed that seven-day follow-up was a topic of focus during its quarterly meetings. Due to the enhanced focus on this topic, **NorthCare Network** reported that many of its CMHSPs continued to take necessary steps and were diligent in scheduling seven-day follow-up appointments for members, even if the member already had a case management appointment scheduled within

seven days. **NorthCare Network** noted improvements with increased awareness and attempts in making follow-up appointments happen within seven days. [**Quality**, **Timeliness**, and **Access**]

Strength #2: NorthCare Network's reported rate for SFY 2023 for indicator #1a was 100 percent, and the rate for indicator #1b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that children and adults receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #3: NorthCare Network's reported rate for indicator #4a for the child population increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that children discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days) most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: NorthCare Network's reported rates for indicators #10a and #10b decreased from SFY 2022 to SFY 2023, with the rate for indicator #10a decreasing by over 15 percentage points from SFY 2022 to SFY 2023, demonstrating improvement, as a lower rate indicates better performance for these performance indicators. In addition, indicator #10a exceeded the established MPS for SFY 2023, and indicator #10b exceeded the established MPS for both SFY 2022 and SFY 2023, indicating that there were less readmissions for MI and I/DD children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During primary source verification (PSV), for indicator #4b, HSAG identified one case that was categorized as "In-Compliance"; however, the performance indicator event screen showed the case was overridden to be an exception. **NorthCare Network** further researched the issue, reviewed all reported cases per HSAG's request, and identified an additional case with the wrong discharge date noted that was incorrectly categorized. [**Quality**]

Why the weakness exists: It was indicated during the virtual review that there was a system glitch on the detox discharge date. **NorthCare Network** had to reach out to all providers to have them fix the discharge dates from detox, which resulted in overrides and corrections within ELMER (health information system). Due to the timing of pulling the performance indicator report for reporting to MDHHS, the report did not capture all system overrides.

Recommendation: While these findings did not have a significant impact on the rate, HSAG recommends that **NorthCare Network** implement quality assurance steps to ensure it captures accurate discharge dates and categorization of members for future reporting.

Weakness #2: Upon review of **NorthCare Network**'s member-level detail file submission, HSAG identified one "NorthCare Dual" member incorrectly reported in indicator #2. [**Quality**]

Why the weakness exists: The CMHSP found that this member was approved by the access center staff as most likely "mild/moderate." Upon further review of MDHHS Codebook specifications, it

was noted that this case should have been excluded from the data since mild to moderate beneficiaries covered under MI Health Link are not included in the performance indicator.

Recommendation: **NorthCare Network** indicated that it is working with Peter Chang Enterprises, Inc. (PCE) and has submitted a ticket to update its system logic to identify and remove members admitted to the access center with a mild/moderate radio button selection within the system. While this finding did not have a significant rate impact, HSAG recommends that **NorthCare Network** continue its efforts toward working with PCE on the system logic updates. HSAG also recommends that additional validation checks be incorporated to ensure appropriate populations are included in future performance indicator reporting.

Compliance Review

Performance Results

Table 3-7 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **NorthCare Network**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **NorthCare Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

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

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	5	2	0	**71%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	13	1	0	**93%**
Standard VI—Coverage and Authorization of Services	11	11	9	2	0	**82%**
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	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	**184**	**183**	**153**	**30**	**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] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **NorthCare Network** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **NorthCare Network** was responsible for implementing each action plan in a timely manner. Table 3-8 presents an overview of the results of the SFY 2023 compliance review for **NorthCare Network**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-8—SFY 2023 Summary of CAP Implementation for NCN

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	1	1	**0**
Standard VI—Coverage and Authorization of Services	2	2	**0**
Standard VII—Provider Selection	4	2	**2**
Standard IX—Grievance and Appeal Systems	8	8	**0**
Standard X—Subcontractual Relationships and Delegation	1	1	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard XIII—Quality Assessment and Performance Improvement Program	3	2	**1**
Total	**30**	**25**	**5**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: NorthCare Network demonstrated that it successfully remediated 25 of 30 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **NorthCare Network** remediated all elements for eight of the 11 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Practice Guidelines.

Weaknesses and Recommendations

Weakness #1: NorthCare Network did not remediate two of the four elements for the Provider Selection standard, indicating continued gaps in the PIHP's credentialing processes. Timely credentialing activities verify education, training, practice history, liability history, licensing, and certification to ensure providers are qualified to perform the services for which the providers are seeking to be paid. [**Quality** and **Timeliness**]

Why the weakness exists: Discrepancies were identified in the acceptable sources for PSV of education during the initial practitioner credentialing process and the time frame for calculating credentialing timeliness for both practitioners and organizations.

Recommendation: HSAG required **NorthCare Network** to submit an action plan to address these findings. Specifically, HSAG recommended that **NorthCare Network** revise its credentialing policy

and onboarding checklist to identify the acceptable sources of PSV for education, as well as the time frame for calculating timely credentialing to comply with, and ensure delegates performing credentialing activities comply with, all initial credentialing requirements as outlined in its contract with MDHHS. Additionally, **NorthCare Network** should continue to strengthen oversight and monitoring of the credentialing processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with the Provider Selection standard requirements.

Weakness #2: NorthCare Network did not remediate the two elements for the Health Information Systems standard. **NorthCare Network** has not made the Patient Access API accessible to its members in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **NorthCare Network** has not made its entire provider directory publicly accessible via the Provider Directory API in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: NorthCare Network has not implemented all requirements of the Patient Access API, such as developing a member-facing website with educational resources in nontechnical, simple, and easy-to-understand language explaining how members can access their health information via the API, including information on how members can protect the privacy and security of their health information. **NorthCare Network** also claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, an audit of the PIHP for compliance with these standards was not appropriate. However, as a Medicaid MCE, **NorthCare Network** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **NorthCare Network** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-1] Lastly, while the Provider Directory API digital endpoint was available on **NorthCare Network**'s website, the PIHP has not linked its entire regionwide provider directory to the API.

Recommendation: HSAG continues to recommend that **NorthCare Network** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **NorthCare Network** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **NorthCare Network** consider proactive ways to solicit developers to register their third-party

[3-1] While the APIs were required to be implemented by January 1, 2021, due to the coronavirus 2019 (COVID-19) public health emergency (PHE), CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **NorthCare Network** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **NorthCare Network**'s original questionnaire responses, and **NorthCare Network** responded to these specific questions. To support its questionnaire responses, **NorthCare Network** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **NorthCare Network** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-9 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-9—EDV Results for NCN

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **NorthCare Network** uses PCE Systems as its primary software for claim adjudication and encounter preparation. • **NorthCare Network** has processes in place to detect and identify duplicate claims, and process and submit denied and adjusted claims. • **NorthCare Network** shared responsibility with its subcontractor for collecting and maintaining its provider and enrollment data.
Payment Structures	• **NorthCare Network** relies on one payment methodology for inpatient encounters (per diem) and outpatient encounters (capitation). • **NorthCare Network** adequately described its processes to collect and verify third-party liability (TPL) information and noted that it does not submit zero-paid claims.

Analysis	Key Findings
Encounter Data Quality Monitoring	• **NorthCare Network** and/or its subcontractors conducted the field-level completeness and validity data quality check on the encounter data collected by the subcontractors. • For encounters collected by **NorthCare Network**, it only conducted data quality checks by evaluating whether the payment fields in the claims align with the financial reports.
Administrative Profile	
Encounter Data Completeness	• **NorthCare Network** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **NorthCare Network** had a low volume of duplicate encounters, with 0.4 percent of professional encounters and 0 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **NorthCare Network** demonstrated timely submission of professional and institutional encounters. Within 30 days, **NorthCare Network** submitted 97.7 percent of professional encounters to MDHHS after the payment date. • For institutional encounters, **NorthCare Network** submitted 96.5 percent of encounters to MDHHS within 60 days of payment and submitted 100 percent of encounters to MDHHS within 90 days of payment.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **NorthCare Network**'s submitted data. For professional encounters, 96.8 percent of populated member IDs were valid, whereas 95.7 percent of populated institutional member IDs were valid. • All other data elements in **NorthCare Network**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **NorthCare Network**'s submitted data, 97.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **NorthCare Network**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **NorthCare Network**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: NorthCare Network displayed timely submission of both professional and institutional encounters after payment date, with greater than 99.9 percent of encounters submitted within 90 days. [**Quality** and **Timeliness**]

Strength #3: Across all encounters, most key data elements for **NorthCare Network** were populated at high rates, and most data elements were over 99.9 percent valid.

Weaknesses and Recommendations

Weakness #1: NorthCare Network did not indicate claim volume or timeliness quality checks performed for claims/encounters from its subcontractors' data. [**Quality**]

Why the weakness exists: Claim volume checks are crucial to validating that the submitted data align with the expected volume, helping identify any discrepancies or missing information. Timeliness quality checks ensure that the claims/encounters are submitted within the specified time frames, meeting MDHHS' minimum monthly requirements. The lack of these checks increases the risk of errors, omissions, or delays in data submission, which can impact the reliability and effectiveness of the overall encounter data system.

Recommendation: NorthCare Network should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness and timeliness of encounter data. By implementing such measures, **NorthCare Network** can enhance the overall quality and reliability of the encounter data that it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.

Weakness #2: While several PIHPs recognized the labor- and resource-intensive nature of medical record review (MRR) as a method for conducting data quality checks and reported its usage, **NorthCare Network** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. [**Quality**]

Why the weakness exists: The absence of MRR in **NorthCare Network**'s data quality checks may stem from resource constraints, a lack of awareness about the benefits of MRR, or possibly a reliance on alternative methods for data quality assurance.

Recommendation: Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **NorthCare Network** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process.

Weakness #3: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 96.8 percent and 95.7 percent, respectively. Additionally,

97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **NorthCare Network**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: NorthCare Network should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

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 3-10 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 3-10—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality** and **Access**—**NorthCare Network** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. However, **NorthCare Network** was unable to identify a statistically significant disparity. While not statistically significant, **NorthCare Network** did identify a slight difference between members ages 12 to 25 compared to members ages 26 and older receiving integrated treatment services. **NorthCare Network** determined that the goal of its PIP is to improve over its baseline rate of 17.78 percent and increase the percentage of individuals ages 12 and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment. **NorthCare Network** reported a lack of qualified, trained staff as a barrier to care. In an effort to achieve the PIP goal and address this barrier, **NorthCare Network** is paying for clinical staff training on co-occurring disorders and offered consultation to each CMHSP to increase general knowledge of medication assisted therapy and treating co-occurring disorders. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), integrating screening and treatment for mental health and SUDs leads to better quality of care and health outcomes for individuals living with co-occurring disorders, such as increased chance for successful treatment and recovery for both disorders, decreased hospitalizations, and increased housing stability.

Performance Area	Overall Performance Impact
	Therefore, successful implementation of this PIP should result in improved outcomes for **NorthCare Network**'s members with co-occurring disorders. **NorthCare Network** could consider if implementing interventions targeted toward a barrier to care for a specific age group would be appropriate (e.g., is there a barrier to care for members ages 12 to 25 that is not prevalent for members ages 26 and older).
Timely Access to Care and Services	**Quality**, **Timeliness**, and **Access**—The PMV activity identified strengths of **NorthCare Network**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • All members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a). • Most members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). **NorthCare Network** also demonstrated marked improvement in indicator #10 for MI and I/DD children. These results suggest that **NorthCare Network** and/or its contracted CMHSPs implemented effective transitional care planning when a member experienced an inpatient psychiatric or substance use detox admission. **NorthCare Network** and/or its contracted CMHSPs also rendered final pre-admission screening dispositions within three hours for members who were experiencing symptoms serious enough to warrant evaluation for inpatient care or were potentially at risk of danger to themselves or others. Additionally, through its Access Standards policy, MDHHS has outlined admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **NorthCare Network** did not demonstrate a process to actively monitor adherence to all SUD access standards, including admission standards for priority populations. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **NorthCare Network** implemented actions to monitor priority population admission standards for SUD treatment. However, **NorthCare Network** demonstrated varying results for new members starting timely services. For indicator #3d, the rate of new adults with I/DD starting services timely increased substantially by a rate of 33.24

Performance Area	Overall Performance Impact
	percentage points. In contrast, for indicator #3c, the rate of new children with I/DD starting services timely fell by 13.35 percentage points. Additionally, fewer new members received a timely biopsychosocial assessment and fewer new members received a timely face-to-face service for treatment or supports, as all rates for indicator #2 and indicator #2e demonstrated a decline from the previous year ranging from 3.71 to 10.31 percentage points. While MDHHS has not established MPSs for indicator #2, indicator #2e, or indicator #3, the results of the PMV activity confirmed that **NorthCare Network** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Timeliness** and **Access**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **NorthCare Network** demonstrated that it conducted a comprehensive annual network adequacy evaluation. However, the evaluation did not fully align with MDHHS' time/distance and member-to-provider ratio standards. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that **NorthCare Network** made efforts to align its analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **NorthCare Network** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **NorthCare Network**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **NorthCare Network** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings and follow-up care following discharge from an inpatient psychiatric hospital or SUD detox unit, as **NorthCare Network** met the MPS for all rates under indicators #1, #4a, #4b, and #10. However, **NorthCare Network** demonstrated lower performance for all rates under indicator #2, the rate for indicator #2e, and the rates for indicators #3a and #3c, as performance declined from the prior year and all rates were below 89 percent (rates ranged from 51.85 percent to 88.24 percent). While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services.

Performance Area	Overall Performance Impact
	The presence of network adequacy gaps is also supported by the data gleaned through the PIP activity. The primary barrier reported by **NorthCare Network** for members receiving co-occurring treatment was the lack of qualified, trained staff. **NorthCare Network**'s interventions are focused on increasing the knowledge of current staff. **NorthCare Network** should continue these efforts and explore other options for increasing provider capacity to provide integrated treatment services.
Health Information Systems and Technology	**Quality** and **Access—NorthCare Network** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **NorthCare Network** received a *Reportable* indicator designation for all applicable indicators,[3-2] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that adhered to measure specifications and MDHHS' reporting requirements, with minimal errors. Additionally, through the EDV activity, **NorthCare Network** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **NorthCare Network** has not implemented the Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **NorthCare Network** suggested that the requirements of the API were not applicable to the PIHP, as MDHHS had not put forth a requirement related to the API, **NorthCare Network**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **NorthCare Network** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **NorthCare Network** should begin preparing for the development and implementation of these new requirements. Also, as indicated through the EDV activity, **NorthCare Network** has opportunities to further ensure the quality and reliability of its encounter data submissions to MDHHS by conducting more robust quality data checks of its encounter data prior to submitting to MDHHS. Enhancing its current encounter data quality checks will help ensure that the encounter data continues to be reliable for MDHHS to use to effectively monitor the services provided under the Medicaid managed care program.

[3-2] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

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 rating (i.e., *Met, Partially Met, Not Met).* Table 3-11 displays the overall validation rating 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 3-11—Overall Validation Rating for NMRE

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

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).
Not Applicable (NA) = The PIHP did not identify an existing disparity within its population for this PIP during the Design stage of the PIP; therefore, the results do not include an assessment of a disparity.

The goal for **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 3-12 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-12—Barriers and Interventions for NMRE

Barriers	Interventions
Staff shortage	**Northern Michigan Regional Entity** made funding available for providers to provide more training opportunities for community health workers to expand the workforce.

Barriers	Interventions
	Northern Michigan Regional Entity advocated for MDHHS to expand qualifications to licensed practical nurses and registered nurses to provide qualifying services.
Provider capacity	**Northern Michigan Regional Entity** verified claims flow, timeliness, and accuracy to avoid inaccuracies that may lead to retractions or delay in payment.
	Northern Michigan Regional Entity provided support to current providers to ensure financial sustainability.
	Northern Michigan Regional Entity monitored providers who have not submitted claims or who are providing services without billing to remind them to bill in a timely manner.
	Northern Michigan Regional Entity monitored payment recoupments for providers to ensure that they are providing the monthly services, billing for the services, and are being paid appropriately.
Provider's concern around managing protected health information (PHI).	**Northern Michigan Regional Entity** provided education to providers and their staff on how to safely share PHI for care 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: Northern Michigan Regional Entity designed a methodologically sound PIP that met State and federal requirements. A methodologically sound design created the foundation for **Northern Michigan Regional Entity** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Northern Michigan Regional Entity used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Northern Michigan Regional Entity** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort.

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 2023 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 3-13 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-13—Performance Measure Results for NMRE

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	99.20%	+0.42%	95.00%
Adults—Indicator #1b	98.86%	98.87%	+0.01%	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	53.15%	59.24%	+6.09%	NA
MI–Adults—Indicator #2b	50.63%	51.29%	+0.66%	NA

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
I/DD–Children—Indicator #2c	55.74%	66.67%	+10.93%	NA
I/DD–Adults—Indicator #2d	46.88%	45.71%	-1.17%	NA
Total—Indicator #2	51.61%	54.43%	+2.82%	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%	65.43%	+1.02%	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%	62.33%	-0.89%	NA
MI–Adults—Indicator #3b	68.30%	62.89%	-5.41%	NA
I/DD–Children—Indicator #3c	86.44%	71.67%	-14.77%	NA
I/DD–Adults—Indicator #3d	81.82%	50.00%	-31.82%	NA
Total—Indicator #3	68.13%	62.89%	-5.24%	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%	96.88%	-3.12%	95.00%
Adults	100%	94.87%	-5.13%	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%	90.08%	-5.57%	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%	7.43%	-0.23%	—
#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%	95.47%	+6.90%	—
#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%	25.30%	+3.54%	—
I/DD–Adults—Indicator #8b	11.08%	10.74%	-0.34%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
MI and I/DD–Adults—Indicator #8c	15.55%	15.67%	+0.12%	—
#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%	99.88%	+0.03%	—
I/DD–Adults—Indicator #9b	69.58%	69.13%	-0.45%	—
MI and I/DD–Adults—Indicator #9c	94.59%	93.50%	-1.09%	—
#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%	14.63%	+9.63%	15.00%
MI and I/DD–Adults—Indicator #10b	11.95%	10.25%	-1.70%	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%	21.85%	+1.00%	—
MI and I/DD–Adults	32.93%	32.76%	-0.17%	—
#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%	50.36%	-0.22%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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: For one CMHSP, **Northern Michigan Regional Entity** demonstrated improved responsiveness to its members for timeliness and access to care. Centra Wellness Network implemented additional training and process improvements for the call center intake assessment and scheduling. Additionally, AuSable Valley Community Mental Health Authority implemented process improvements to ensure the accuracy of its data submissions, including a review of all members for each performance indicator. [**Quality**, **Timeliness**, and **Access**]

Strength #2: While leveraging technology strategically across all CMHSPs, **Northern Michigan Regional Entity** continued to strengthen its partnership with the CMHSPs by improving the streamlining of data submissions to **Northern Michigan Regional Entity**. The implementation of new performance indicator monitoring, data verification, and submission processes for the CMHSPs continued to leverage technology to reduce manual data entry and ease of administrative burden. [**Quality**]

Strength #3: Northern Michigan Regional Entity's reported rates for indicators #1a and #1b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed most of the time. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, for indicator #3, HSAG identified that one CMHSP was counting pre-planning meetings as medically necessary, ongoing covered services within 14 days, while another CMHSP was not counting pre-planning meetings as medically necessary, ongoing covered services. [**Quality** and **Access**]

Why the weakness exists: HSAG identified inconsistencies in the CMHSPs' interpretation of the specifications for indicator #3, specifically regarding allowable visit types to be counted as ongoing covered services.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** continue to hold collaborative meetings with its CMHSPs to provide guidance on interpretation of the measure specifications. Additionally, HSAG recommends that **Northern Michigan Regional Entity** reach out to MDHHS for guidance on interpretation of the specifications whenever necessary to ensure consistency in reporting among the CMHSPs.

Weakness #2: During review of the member-level detail file, HSAG noted that multiple dates of birth did not match for indicators #4a, #4b, and #10. Additionally, the "Compliant" column was not properly formatted, which led to HSAG asking additional questions regarding data validation. [**Quality**]

Why the weakness exists: Northern Michigan Regional Entity indicated that it had used a Microsoft (MS) Excel VLOOKUP function to retrieve the DOB data for HSAG's audit and sorted the data by another field (other than Medicaid identification [ID]), which caused the function to return incorrect information.

Recommendation: HSAG recommends that **Northern Michigan Regional Entity** perform additional spot checks prior to submitting data to HSAG. Data validation is a crucial step in ensuring accurate submission. Incorporating additional spot checks can add value, especially when data are being integrated from multiple sources.

Weakness #3: During PSV, HSAG identified for indicator #1 that Northern Lakes Community Mental Health Authority was allowing providers to enter a reason for dispositions not being completed within three hours, even if the disposition was in fact completed within three hours for indicator #1. [**Timeliness**]

Why the weakness exists: Certain prompts should only exist if needed. Overdocumentation can lead to inaccurate data.

Recommendation: HSAG recommends that providers only be prompted to enter an explanation if a member is noncompliant. If the disposition is completed within the required time frame, then an explanation prompt should not be necessary.

Weakness #4: Northern Michigan Regional Entity's reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4a for the adult population decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

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

Weakness #5: Northern Michigan Regional Entity's reported rate for indicator #4b decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4b decreased by more than 5 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some members were not seen for timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit.

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

Compliance Review

Performance Results

Table 3-14 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Northern Michigan Regional Entity**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Northern Michigan Regional Entity** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-14—SFY 2021 and SFY 2022 Standard Compliance Scores for NMRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	7	0	0	**100%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
Standard V—Coordination and Continuity of Care	14	14	14	0	0	**100%**
Standard VI—Coverage and Authorization of Services	11	11	7	4	0	**64%**
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	**184**	**183**	**148**	**35**	**1**	**81%**

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

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

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

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

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

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Northern Michigan Regional Entity** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Northern Michigan Regional Entity** was responsible for implementing each action plan in a timely manner. Table 3-15 presents an overview of the results of the SFY 2023 compliance review for **Northern Michigan Regional Entity**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-15—SFY 2023 Summary of CAP Implementation for NMRE

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard IV—Assurances of Adequate Capacity and Services	2	2	**0**
Standard VI—Coverage and Authorization of Services	4	3	**1**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	6	5	**1**
Standard X—Subcontractual Relationships and Delegation	1	1	**0**
Standard XI—Practice Guidelines	3	1	**2**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	9	7	**2**
Total	**35**	**27**	**8**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: Northern Michigan Regional Entity demonstrated that it successfully remediated 27 of 35 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Northern Michigan Regional Entity** remediated all elements for five of the 10 standards reviewed: Member Rights and Member Information, Assurances of Adequate Capacity and Services, Provider Selection, Confidentiality, and Subcontractual Relationships and Delegation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Michigan Regional Entity did not remediate two of the three elements for the Practice Guidelines standard, indicating continued gaps in the PIHP's processes related to the adoption of clinical practice guidelines (CPGs). CPGs assist providers in applying up-to-date, evidence-based practice to clinical care. [**Quality**]

Why the weakness exists: Northern Michigan Regional Entity did not demonstrate that it adopted CPGs, adopted CPGs in consultation with its network providers, or had a schedule for updating/reviewing its CPGs periodically.

Recommendation: HSAG required **Northern Michigan Regional Entity** to submit an action plan to address these findings. Specifically, HSAG recommended **Northern Michigan Regional Entity** develop a procedure for obtaining input from network providers prior to adopting CPGs; formally adopting CPGs; and reviewing CPGs periodically, including how often CPGs will be reviewed. Additionally, HSAG recommended that the PIHP document the input from network providers in committee meeting minutes, a notes format, or other format that clearly indicates which network providers provided the input and their specialty, if applicable. Further, HSAG recommended that the PIHP formally document in committee meeting minutes what CPGs were adopted and the developer of the guidelines; who was present at the meeting adopting the CPGs, along with each person's title, organization, and/or provider specialty; and when CPGs were adopted. Lastly, **Northern Michigan Regional Entity** should continue to strengthen oversight and monitoring of the adoption of CPG processes to ensure continued remediation and compliance with the Practice Guidelines standard requirements.

Weakness #2: Northern Michigan Regional Entity did not remediate the two elements for the Health Information Systems standard. **Northern Michigan Regional Entity** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Northern Michigan Regional Entity** has not made its Provider Directory API publicly accessible. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: **Northern Michigan Regional Entity** did not submit documentation supporting the implementation of the Patient Access API. **Northern Michigan Regional Entity** claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, there was no requirement to audit the PIHP against. However, as a Medicaid MCE, **Northern Michigan Regional Entity** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Northern Michigan Regional Entity** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-3] Additionally, **Northern Michigan Regional Entity** has not linked its entire regionwide provider directory to the API or made the API accessible via a public-facing digital endpoint on the PIHP's website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

Recommendation: HSAG continues to recommend that **Northern Michigan Regional Entity** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Northern Michigan Regional Entity** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues recommend that **Northern Michigan Regional Entity** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Weakness #3: **Northern Michigan Regional Entity** did not remediate two of the nine elements for the Quality Assessment and Performance Improvement Program standard, indicating continued gaps in the PIHP's implementation of its quality assessment and performance improvement (QAPI) program. QAPI programs provide the foundation for Medicaid MCEs to continually monitor for and identify opportunities for performance improvement with the goal of improving quality of care and member outcomes. **[Quality]**

Why the weakness exists: HSAG was unable to determine if **Northern Michigan Regional Entity** met the time frame for determining if a critical incident was a sentinel event. **Northern Michigan Regional Entity** also confirmed it did not have a field to document the date the incident was determined to be sentinel. Additionally, documentation related to the assessment of member experience did not support that **Northern Michigan Regional Entity** took specific action on individual cases, when appropriate; identified and investigated sources of dissatisfaction; outlined systemic action steps to follow up on the findings; or evaluated the effects of activities implemented to improve satisfaction.

Recommendation: HSAG required **Northern Michigan Regional Entity** to submit an action plan to address these findings. Specifically, HSAG recommended that **Northern Michigan Regional Entity** designate or develop a field in its system to track when a critical incident is determined to be

[3-3] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

sentinel and create reports that allow it to track these time frames in real time. Additionally, related to the assessment of member experience, HSAG recommended that **Northern Michigan Regional Entity** develop a procedure to include the processes to take specific action on individual cases (when appropriate), identify and investigate sources of dissatisfaction, outline systemic action steps to follow up on the findings, and evaluate the effects of activities implemented to improve satisfaction. **Northern Michigan Regional Entity** could also develop a comprehensive member experience report (separate from its QAPI evaluation) that includes all activities to assess member experience with services and notify members when the results of member experience activities are available on the website. Lastly, **Northern Michigan Regional Entity** should continue to strengthen oversight and monitoring of its QAPI program to ensure continued remediation and compliance with the Quality Assessment and Performance Improvement Program standard requirements.

Weakness #4: Northern Michigan Regional Entity did not remediate one of the four elements for the Coverage and Authorization of Services standard, indicating continued gaps in the PIHP's processes related to providing members with appropriate notices of adverse benefit determination (NABDs). NABDs for the denial of payment are an important protection as they may be the only notification members receive alerting them that a claim has been submitted on their behalf. [**Quality**]

Why the weakness exists: Northern Michigan Regional Entity's policy did not fully align with the federal rule requiring the PIHP to provide members with an NABD for the denial of payment at the time of any action affecting a claim. This finding is particularly concerning given this requirement has been in federal rule since 2002.

Recommendation: HSAG required **Northern Michigan Regional Entity** to submit an action plan to address these findings. Specifically, HSAG recommended **Northern Michigan Regional Entity** update its denial of payment procedures to include the business rules that will trigger a denial of payment NABD and to specify the process for ensuring the denial of payment NABD will be sent to members at the time of the action affecting the claim; and update its annual audit tool to specifically review denial of payment procedures and NABDs. Additionally, **Northern Michigan Regional Entity** should continue to strengthen oversight and monitoring of the utilization management processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with the Coverage and Authorization of Services standard requirements.

Encounter Data Validation

Performance Results

Representatives from **Northern Michigan Regional Entity** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Northern Michigan Regional Entity**'s original questionnaire responses, and **Northern Michigan Regional Entity** responded to these specific questions. To support its questionnaire responses, **Northern Michigan Regional Entity** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Northern Michigan Regional Entity** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-16 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-16—EDV Results for NMRE

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Northern Michigan Regional Entity** uses PCE Systems as its primary software for claim adjudication and encounter preparation. • **Northern Michigan Regional Entity** has processes in place to detect and identify duplicate claims, and process and submit denied and adjusted claims. • **Northern Michigan Regional Entity** collects and processes its provider data, while its subcontractor manages the enrollment data.
Payment Structures	• For both inpatient and outpatient encounters, **Northern Michigan Regional Entity** utilizes capitation and fee-for-service methods as its claim payment strategies. • **Northern Michigan Regional Entity** adequately described its processes to collect and verify TPL information and submission of zero-paid claims.
Encounter Data Quality Monitoring	• **Northern Michigan Regional Entity** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, including claim volume by submission month, field-level completeness and validity, and timeliness on the encounter data collected by the subcontractors. • For encounters collected by **Northern Michigan Regional Entity**, it conducted the following data quality checks: claim volume by submission month, timeliness, and evaluating whether the payment fields in the claims align with the financial reports.

Analysis	Key Findings
Administrative Profile	
Encounter Data Completeness	• **Northern Michigan Regional Entity** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Northern Michigan Regional Entity** had a low volume of duplicate encounters, with 1.5 percent of professional encounters and less than 0.1 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Northern Michigan Regional Entity** demonstrated timely submission for professional encounters. Within 60 days, **Northern Michigan Regional Entity** submitted 99.6 percent of professional encounters to MDHHS after the payment date. • **Northern Michigan Regional Entity** did not demonstrate timely submission of institutional encounters, with 43.9 percent of institutional encounters submitted to MDHHS within 180 days of the payment date. Within 360 days, **Northern Michigan Regional Entity** submitted 65.1 percent of institutional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Northern Michigan Regional Entity**'s submitted data. For professional encounters, 96.0 percent of populated member IDs were valid, whereas 92.2 percent of populated institutional member IDs were valid. • All other data elements in **Northern Michigan Regional Entity**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Northern Michigan Regional Entity**'s submitted data, 95.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **Northern Michigan Regional Entity**'s submitted data, 99.6 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Northern Michigan Regional Entity**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Northern Michigan Regional Entity displayed timely submission of professional encounters after payment date, with 99.6 percent of encounters submitted within 60 days. [**Quality** and **Timeliness**]

Strength #3: Across all encounters, most key data elements for **Northern Michigan Regional Entity** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **Northern Michigan Regional Entity** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. [**Quality**]

Why the weakness exists: The absence of MRR in **Northern Michigan Regional Entity**'s data quality checks may stem from resource constraints, a lack of awareness about the benefits of MRR, or possibly a reliance on alternative methods for data quality assurance.

Recommendation: Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **Northern Michigan Regional Entity** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process.

Weakness #2: Northern Michigan Regional Entity did not submit institutional encounters timely, where 40.4 percent of institutional encounters were submitted within 60 days of payment, and 65.1 percent of encounters were submitted within 360 days. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Northern Michigan Regional Entity should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #3: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 96.0 percent and 92.2 percent, respectively. Additionally, 95.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Northern Michigan Regional Entity**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Northern Michigan Regional Entity should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

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 3-17 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 3-17—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality—Northern Michigan Regional Entity** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. However, through data analyses, **Northern Michigan Regional Entity** was unable to identify a statistically significant racial or ethnic disparity in healthcare. Therefore, **Northern Michigan Regional Entity**'s PIP topic was approved by MDHHS to focus on a non-disparity-related topic. Although no racial or ethnic disparities were determined for **Northern Michigan Regional Entity**'s service region during the initiation of the PIP, the PIHP should continually (e.g., monthly, quarterly, annually) evaluate for and subsequently reduce any disparities (e.g., race, age, gender) to address health inequity.
Timely Access to Care and Services	**Quality**, **Timeliness**, and **Access**—Through data analysis, **Northern Michigan Regional Entity** identified a need to implement initiatives targeting members diagnosed with an opioid use disorder and continued its PIP topic with the goal of increasing the percentage of members enrolled in Opioid Health Home services. Opioid Health Home services provide integrated, person-centered, and comprehensive care to eligible members to address the complexity of comorbid physical and behavioral health conditions. Therefore, successful implementation of **Northern Michigan Regional Entity**'s PIP should result in an increase in the number of members enrolled and retained in an Opioid Health Home and subsequently improve health outcomes for those members diagnosed with an opioid use disorder. The PMV activity also identified strengths of **Northern Michigan Regional Entity**'s managed care program, as some performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1).

Performance Area	Overall Performance Impact
	• Most child members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). These results suggest that **Northern Michigan Regional Entity** and/or its contracted CMHSPs implemented effective transitional care planning when a member experienced an inpatient psychiatric admission. In most cases, **Northern Michigan Regional Entity** and/or its contracted CMHSPs also rendered final pre-admission screening dispositions within three hours for members who were experiencing symptoms serious enough to warrant evaluation for inpatient care or were potentially at risk of danger to themselves or others. However, while the MPS was met for indicator #10, **Northern Michigan Regional Entity**'s performance declined by 9.63 percentage points for children; therefore, the PIHP should focus efforts to determine the root cause of this decline and subsequently implement performance improvement strategies. Further, while all rates for indicator #2 remain relatively low (45.71 percent to 66.67 percent), it should be noted that **Northern Michigan Regional Entity** demonstrated a substantial increase in performance for indicators #2a and #2c, indicating more new children diagnosed with MI or I/DD received a timely biopsychosocial assessment than in the previous year. Additionally, although many adult members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a) and many members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b), neither associated performance indicator rate met MDHHS' established MPSs and declined in performance from the prior year. Also, fewer new members started services timely, as all rates under indicator #3 demonstrated a decline of 0.89 percentage points to 31.82 percentage points from the prior year. While MDHHS has not established MPSs for indicators #2, #2e, and #3, the results of the PMV activity confirmed that **Northern Michigan Regional Entity** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Timeliness** and **Access**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Northern Michigan Regional Entity** demonstrated that it developed a network adequacy plan, but the plan did not include MDHHS' time/distance standards. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that

Performance Area	Overall Performance Impact
	Northern Michigan Regional Entity made efforts to align its analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Northern Michigan Regional Entity** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Northern Michigan Regional Entity**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Northern Michigan Regional Entity** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings and follow-up care following discharge from an inpatient psychiatric hospital, as **Northern Michigan Regional Entity** met the MPS for the children and adult populations under indicator #1, the children population under indicator #4a, and the children and adult populations under indicator #10. However, **Northern Michigan Regional Entity** demonstrated lower performance for all rates under indicator #2, the rate for indicator #2e, and all rates for indicator #3 as rates were below 72 percent (rates ranged from 45.71 percent to 71.67 percent). All rates under indicator #3 also demonstrated a decline in performance from the prior year, with four of the five rates demonstrating a substantial decline of 5 percentage points or more. It should be noted that while continued opportunity for performance exists for indicator #2, four of the five rates increased from the prior year, with indicators #2a and #2c demonstrating marked improvement of 6.09 percentage points and 10.93 percentage points, respectively. While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services. The presence of network adequacy gaps is also supported by the data gleaned through the PIP activity. The barriers reported by **Northern Michigan Regional Entity** included staff shortage and provider capacity, and the potential impact those may have on increasing the percentage of members enrolled in Opioid Health Home services. **Northern Michigan Regional Entity** implemented several interventions including, but not limited to, advocating for expanding qualifications of licensed practical nurses, providing funding for additional training, and providing support to ensure financial sustainability. **Northern Michigan Regional Entity** should continue its efforts and explore other options, as needed, for increasing provider capacity

Performance Area	Overall Performance Impact
	to ensure members diagnosed with an opioid use disorder have access to and retain services through an Opioid Health Home.
Health Information Systems and Technology	**Quality** and **Access—Northern Michigan Regional Entity** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Northern Michigan Regional Entity** received a *Reportable* indicator designation for all applicable indicators,[3-4] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. While some data inconsistencies were noted during the activity, they did not affect the *Reportable* designation. Additionally, while leveraging technology strategically across all CMHSPs, **Northern Michigan Regional Entity** continued to improve the streamlining of data submissions to the PIHP for the calculation of the performance indicators. Additionally, through the EDV activity, **Northern Michigan Regional Entity** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Northern Michigan Regional Entity** has not implemented the Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Northern Michigan Regional Entity** suggested that the requirements of the API were not applicable to the PIHP as MDHHS had not put forth a requirement related to the API, **Northern Michigan Regional Entity**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **Northern Michigan Regional Entity** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Northern Michigan Regional Entity** should begin preparing for the development and implementation of these new requirements.

[3-4] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-18 displays the overall validation rating 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 3-18—Overall Validation Rating for LRE

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-19 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goals and address the barriers.

Table 3-19—Barriers and Interventions for LRE

Barriers	Interventions
Lack of data integrity from CMHSPs/lack of standardization of data expectation.	Developed FUH reporting templates and trained CMHSPs. Developed error reports to identify CMHSP data errors for follow-up and retraining with CMHSPs. Ensured each CMHSP has trained backup staff to cover reporting of FUH data to the PIHP.
Lack of data integrity from [name of contracted vendor redacted].	Modified [name of contracted vendor redacted] programming logic to ensure measure data integrity.
Lack of CC360 (MDHHS data warehouse) data availability/CC360 data lag.	Developed predictive models that reduce the risk of CC360 data lag.
Lack of FUH collaboration at MHP level.	Developed FUH reporting templates and trained CMHSPs. Determined the best timing and frequency of uploading FUH data into CC360. Held quarterly meetings with MHPs to discuss FUH measure.
Lack of FUH collaboration at CMHSP level	Presented FUH data errors to the CMHSP. Held quarterly meetings with CMHSP staff.
Lack of FUH collaboration at provider level	Drafted value-based incentive program for providers to establish goals. Collaborated with providers to identify opportunities for CMHSP/MHP to meet with consumer/guardian prior to discharge. Developed educational materials for members prior to discharge.
Lack of trust of the behavioral health system among African Americans/Blacks.	Developed outreach efforts specifically geared toward African Americans/Blacks to trust the system. Met with local Black community leaders to determine if they are a possible pathway to improving trust of the system.

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 that met State and federal requirements. A methodologically sound design created the foundation for **Lakeshore Regional Entity** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Lakeshore Regional Entity used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Lakeshore Regional Entity** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of African-American/Black members attending follow-up appointments after hospitalization for mental illness, **Lakeshore Regional Entity** should identify the barriers of care that are specific to the African-American/Black population and implement interventions that are tailored to the needs of the African-American/Black community to mitigate those identified barriers.

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 2023 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 3-20 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-20—Performance Measure Results for LRE

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	97.56%	-2.15%	95.00%
Adults—Indicator #1b	98.82%	98.22%	-0.60%	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%	58.94%	-12.79%	NA
MI–Adults—Indicator #2b	78.94%	55.57%	-23.37%	NA
I/DD–Children—Indicator #2c	73.33%	60.64%	-12.69%	NA
I/DD–Adults—Indicator #2d	47.22%	66.20%	+18.98%	NA
Total—Indicator #2	73.41%	57.86%	-15.55%	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%	67.22%	-1.26%	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	75.59%	52.58%	-23.01%	NA
MI–Adults—Indicator #3b	70.29%	56.31%	-13.98%	NA
I/DD–Children—Indicator #3c	80.00%	64.13%	-15.87%	NA
I/DD–Adults—Indicator #3d	79.73%	59.46%	-20.27%	NA
Total—Indicator #3	74.35%	55.28%	-19.07%	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%	93.55%	-2.96%	95.00%
Adults	97.28%	96.20%	-1.08%	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%	98.06%	+0.40%	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%	5.18%	-0.15%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	95.29%	+18.07%	—
#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%	21.77%	+4.07%	—
I/DD–Adults—Indicator #8b	8.79%	10.82%	+2.03%	—
MI and I/DD–Adults—Indicator #8c	8.92%	10.87%	+1.95%	—
#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%	99.85%	+0.07%	—
I/DD–Adults—Indicator #9b	92.57%	95.41%	+2.84%	—
MI and I/DD–Adults—Indicator #9c	91.06%	93.75%	+2.69%	—
#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	6.03%	9.92%	+3.89%	15.00%
MI and I/DD–Adults—Indicator #10b	9.81%	8.90%	-0.91%	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%	15.02%	-0.29%	—
MI and I/DD–Adults	23.60%	22.39%	-1.21%	—
#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%	45.11%	-1.55%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 continued to demonstrate strength in its efforts toward data quality improvement and CMHSP oversight through real-time monitoring using its Power Business Intelligence (BI) technology dashboard. **Lakeshore Regional Entity** also integrated an Arc of Treatment Model and began monitoring CMHSP data on a larger scale by examining data by case numbers rather than specific indicators. By viewing data on a larger scale, **Lakeshore Regional Entity** was able to identify members who were present in more than one indicator and any trends within the Arc of Treatment Model, further ensuring ongoing monitoring of performance and data completeness and accuracy. [**Quality**]

Strength #2: In addition to reviewing the performance indicator submissions from the CMHSPs, **Lakeshore Regional Entity** implemented a new process that used reports to monitor quality and timeliness. Executive leadership at **Lakeshore Regional Entity** and CMHSP leads collaborated based on review of the reports and were able to address timeliness issues more efficiently. **Lakeshore Regional Entity** noted substantial improvements and consistency in obtaining timely data as a result of this new process. [**Quality** and **Timeliness**]

Strength #3: Lakeshore Regional Entity's reported rate for indicator #4b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upon review of HealthWest's member-level detail file, HSAG identified three cases with completed biopsychosocial assessment dates that occurred prior to the non-emergency request for service dates for indicator #2. [**Quality**]

Why the weakness exists: The biopsychosocial assessment dates for all three cases required correction. HSAG noted that HealthWest engaged in a manual entry process, which resulted in the incorrect dates being entered.

Recommendation: As a result of this finding, HealthWest has since added an extra layer of data validation as part of its data cleanup process prior to submission. This process is intended to ensure that all dates are in proper chronological order and that they match the records in the chart. HealthWest is also enhancing the logic for its performance indicator report and clinical documentation workflows so that fewer charts have to be reviewed manually. Additionally, **Lakeshore Regional Entity** instructed PCE to deploy programming logic for edits that will reject submitted CMHSP data if the request date is later than the assessment date and if the assessment date is later than the ongoing covered service date. While the incorrect dates did not impact the rate, HSAG recommends that **Lakeshore Regional Entity** continue to monitor the remediation plans and work with the CMHSP to expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data. This should include a reduction of manual entry processes, wherever possible.

Weakness #2: Upon review of OnPoint's member-level detail file, HSAG identified one case with a completed biopsychosocial assessment date that occurred prior to the non-emergency request for service date for indicator #2. [**Quality**]

Why the weakness exists: The biopsychosocial assessment date required correction as a result of human error.

Recommendation: As a result of this finding, **Lakeshore Regional Entity** instructed PCE to deploy programming logic for edits that will reject submitted CMHSP data if the request date is later than the assessment date and if the assessment date is later than the ongoing covered service date. While the incorrect dates did not impact the rate, HSAG recommends that **Lakeshore Regional Entity** continue to monitor the remediation plan and expand on or implement additional process enhancements, when necessary, to improve the accuracy of indicator #2 data.

Weakness #3: Upon review of West Michigan Community Mental Health's proof of service documentation provided, HSAG identified one case with an incorrect request date documented for indicator #2. West Michigan Community Mental Health noted that the correct request date reflected a greater-than-14-day difference between the non-emergency request date and completed biopsychosocial assessment date, which implies that this case should have received an out-of-compliance disposition instead of an in-compliance disposition. At HSAG's request, all reported cases were reviewed, and an additional five cases contained the same errors and should have been reported as out of compliance. [**Quality**]

Why the weakness exists: The documented request dates for five cases required correction as a result of human error.

Recommendation: West Michigan Community Mental Health indicated that new staff began processing the performance indicators as of Q2 SFY 2023. These staff have been trained on existing procedures, and every screening within the 60-day window is now being reviewed in detail to ensure the correct request date is reported. West Michigan Community Mental Health is also in the process of implementing a new module into its electronic health record (EHR) that will provide a simpler way of tracking multiple requests for services and attempts to screen members, thus reducing the potential for human error. HSAG recommends that **Lakeshore Regional Entity** monitor the remediation plan and work with the CMHSP to expand on or implement additional process

enhancements, when necessary, to improve the accuracy of indicator #2 data. This should include a reduction of manual entry processes, wherever possible.

Weakness #4: Lakeshore Regional Entity's reported rate for indicator #4a for the child population decreased by more than 2 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4a for the child population decreased by more than 2 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some children were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

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

Compliance Review

Performance Results

Table 3-21 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Lakeshore Regional Entity**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Lakeshore Regional Entity** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-21—SFY 2021 and SFY 2022 Standard Compliance Scores for LRE

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	17	2	0	**89%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	5	2	0	**71%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
Standard V—Coordination and Continuity of Care	14	14	11	3	0	**79%**
Standard VI—Coverage and Authorization of Services	11	11	8	3	0	**73%**
Standard VII—Provider Selection	16	16	13	3	0	**81%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
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 XIII—Quality Assessment and Performance Improvement Program	30	30	26	4	0	**87%**
Total	**184**	**183**	**152**	**31**	**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, 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] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Lakeshore Regional Entity** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Lakeshore Regional Entity** was responsible for implementing each action plan in a timely manner. Table 3-22 presents an overview of the results of the SFY 2023 compliance review for **Lakeshore Regional Entity**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-22—SFY 2023 Summary of CAP Implementation for LRE

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	2	2	**0**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	2	2	**0**
Standard V—Coordination and Continuity of Care	3	3	**0**
Standard VI—Coverage and Authorization of Services	3	3	**0**

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard VII—Provider Selection	3	3	**0**
Standard VIII—Confidentiality	2	2	**0**
Standard IX—Grievance and Appeal Systems	5	5	**0**
Standard X—Subcontractual Relationships and Delegation	2	2	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	4	4	**0**
Total	**31**	**29**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: Lakeshore Regional Entity demonstrated that it successfully remediated 29 of 31 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Lakeshore Regional Entity** remediated all elements for 11 of the 12 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Lakeshore Regional Entity did not remediate the two elements for the Health Information Systems standard. **Lakeshore Regional Entity** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Lakeshore Regional Entity** has not made its Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Lakeshore Regional Entity did not submit documentation supporting the implementation of the Patient Access API. **Lakeshore Regional Entity** claimed that MDHHS has not established standards for the Patient Access API; therefore, the PIHP could not develop technical specifications to build toward. However, as a Medicaid MCE, **Lakeshore Regional Entity** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Lakeshore Regional Entity** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-5] The final rule also outlines the technical specifications and implementation guidelines for the development of the APIs. Additionally, **Lakeshore Regional Entity** has not linked its entire regionwide provider directory to the API or made the API accessible via a PIHP-specific public-facing digital endpoint on the PIHP's website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

Recommendation: HSAG continues to recommend that **Lakeshore Regional Entity** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Lakeshore Regional Entity** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Lakeshore Regional Entity** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

[3-5] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Encounter Data Validation

Performance Results

Representatives from **Lakeshore Regional Entity** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Lakeshore Regional Entity**'s original questionnaire responses, and **Lakeshore Regional Entity** responded to these specific questions. To support its questionnaire responses, **Lakeshore Regional Entity** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Lakeshore Regional Entity** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-23 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-23—EDV Results for LRE

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Lakeshore Regional Entity** uses PCE Systems as its primary software for claim adjudication and encounter preparation. • **Lakeshore Regional Entity** has processes in place to detect and identify duplicate claims, and process and submit denied and adjusted claims. • **Lakeshore Regional Entity** collects provider data from the CMHSPs during contracting and credentialing. Both **Lakeshore Regional Entity** and its subcontractors manage the enrollment data.
Payment Structures	• **Lakeshore Regional Entity** relies on one payment methodology for inpatient encounters (capitation) and outpatient encounters (capitation). • **Lakeshore Regional Entity** noted that for TPL data, the CMHSPs submitted coordination of benefits (COB) information in their encounters, as required by MDHHS reporting rules effective FY 2023. **Lakeshore Regional Entity** indicated it submits zero-paid claims to MDHHS after validation.

Analysis	Key Findings
Encounter Data Quality Monitoring	• **Lakeshore Regional Entity** indicated it edited or made modifications to some of the subcontractor data. • **Lakeshore Regional Entity** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, including claim volume by submission month, field-level completeness and validity, and timeliness; evaluated whether the payment fields in the claims align with the financial reports; and MRR. • **Lakeshore Regional Entity** did not offer responses regarding data quality checks performed internally for encounters in its data warehouses, since its CMHSP subcontractors handle the submission of all encounters and conducted the data quality checks.
Administrative Profile	
Encounter Data Completeness	• **Lakeshore Regional Entity** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Lakeshore Regional Entity** had a low volume of duplicate encounters, with 2.6 percent of professional encounters and less than 0.1 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Lakeshore Regional Entity** did not demonstrate timely submission of professional encounters, with 72.3 percent of professional encounters submitted to MDHHS within 180 days of the payment date. Within 360 days, **Lakeshore Regional Entity** submitted 90.6 percent of professional encounters to MDHHS after the payment date. • **Lakeshore Regional Entity** demonstrated high levels of timely submission for institutional encounters. Within 60 days, **Lakeshore Regional Entity** submitted 95.0 percent of institutional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Lakeshore Regional Entity**'s submitted data. For professional encounters, 95.3 percent of populated member IDs were valid, whereas 93.5 percent of populated institutional member IDs were valid. • In **Lakeshore Regional Entity**'s submitted professional encounters, the billing provider NPI was populated 62.4 percent of the time, and the rendering provider NPI was populated 26.9 percent of the time. • All other data elements in **Lakeshore Regional Entity**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **Lakeshore Regional Entity**'s submitted data, 97.0 percent were identified in the enrollment data. • Of all identified provider NPIs in **Lakeshore Regional Entity**'s submitted data, 99.5 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Lakeshore Regional Entity**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Lakeshore Regional Entity has a robust system for monitoring encounter data submissions designed to oversee the accuracy, completeness, and timeliness of encounter data, which includes encounter data submissions from its own data warehouse and directly from its subcontractors. [**Quality**]

Strength #3: While MRR can be labor- and resource-intensive process for conducting data quality checks, **Lakeshore Regional Entity** indicated its usage as a method for assessing its subcontractors' data. The use of this method enhances the reliability, accuracy, and contextual understanding of its subcontractors' encounter data. This reflects **Lakeshore Regional Entity**'s commitment to delivering high-quality healthcare data. [**Quality**]

Strength #4: Lakeshore Regional Entity displayed timely submission of institutional encounters after payment date, with 95 percent of encounters submitted within 60 days. [**Quality** and **Timeliness**]

Strength #5: Across all encounters, most key data elements for **Lakeshore Regional Entity** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Lakeshore Regional Entity modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Lakeshore Regional Entity should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: Lakeshore Regional Entity did not submit professional encounters timely, where 60.9 percent of professional encounters were submitted within 60 days of payment, and not reaching greater than 90 percent of professional encounters submitted until within 360 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Lakeshore Regional Entity should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #3: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.3 percent and 93.5 percent, respectively. Additionally, 97 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Lakeshore Regional Entity**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Lakeshore Regional Entity should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #4: Although not required to be populated, 62.4 percent and 26.9 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Lakeshore Regional Entity should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

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 3-24 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 3-24—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Lakeshore Regional Entity** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Lakeshore Regional Entity** identified a race/ethnicity disparity between African-American/Black members compared to its White population who received a follow-up visit with a mental health provider within 30 days after discharge from an inpatient psychiatric hospital. 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). **Lakeshore Regional Entity** identified several barriers to care including a lack of data integrity from CMHSPs/lack of standardization of data expectation; lack of data availability from MDHHS' data warehouse; lack of collaboration at the MHP, CMHSP, and provider level; and a lack of trust of the behavioral health system among African-American/Black members. To address these barriers, **Lakeshore Regional Entity** implemented several interventions, including but not limited to: developed reporting templates and trained CMHSP staff; modified programming logic to ensure measure-related data integrity; drafted value-based incentive program for providers to establish goals; developed educational materials for members prior to discharge; developed outreach efforts specifically geared toward African-American/Black members to improve their trust of the behavioral health system; and met with local Black community leaders to determine if there is a possible pathway to improving trust of the system. Timely follow-up care after discharge can prevent readmissions and lead to better health outcomes. Therefore, successful implementation of **Lakeshore Regional Entity**'s PIP should improve the prevalence of its African-American/Black members receiving timely follow-up care after being discharged from psychiatric hospitalization.
Timely Access to Care and Services	The PMV activity identified strengths of **Lakeshore Regional Entity**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most adult members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a). • Most members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b).

Performance Area	Overall Performance Impact
	• Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). These results suggest that **Lakeshore Regional Entity** and/or its contracted CMHSPs implemented effective transitional care planning when a member experienced an inpatient psychiatric or substance use detox admission. In most cases, **Lakeshore Regional Entity** and/or its contracted CMHSPs also rendered final pre-admission screening dispositions within three hours for members who were experiencing symptoms serious enough to warrant evaluation for inpatient care or were potentially at risk of danger to themselves or others. **Lakeshore Regional Entity** also demonstrated marked improvement, with an increase of 18.98 percentage points, in adults diagnosed with an I/DD who received a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (indicator #2d). Additionally, within its Access Standards policy, MDHHS has outlined SUD admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Lakeshore Regional Entity** did not demonstrate a process to actively monitor adherence to all SUD access standards, including screening, referral, and admission standards for priority populations. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Lakeshore Regional Entity** implemented actions to monitor priority population admission standards for SUD treatment. However, **Lakeshore Regional Entity** demonstrated worsening performance for indicators #2 and #3, as all rates, except for #2d which improved in performance, experienced a substantial decline from the prior year (ranging from a decline of 12.69 percentage points to 23.37 percentage points). While MDHHS has not established MPSs for these indicators, the results of the PMV activity confirmed that fewer members than the prior year received a timely biopsychosocial assessment and fewer new members than the prior year started timely services, indicating **Lakeshore Regional Entity** has continued opportunities to improve timely access to non-emergency behavioral health care and services.
Network Adequacy	MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Lakeshore Regional Entity** demonstrated that it conducted an annual network adequacy evaluation that included a review of time/distance and

Performance Area	Overall Performance Impact
	member-to-provider ratios; therefore, a CAP for these standards were not required during the SFY 2023 CAP review. **Lakeshore Regional Entity** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Lakeshore Regional Entity**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Lakeshore Regional Entity** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity also demonstrated an adequate network of providers for rendering timely pre-admission screenings, timely follow-up care following discharge from an inpatient psychiatric hospital for adults, and timely follow-up care following discharge from an SUD detox unit, as **Lakeshore Regional Entity** met the MPS for the children and adult populations under indicator #1, the adult population under indicator #4a, and the consumers population under indicator #4b. However, **Lakeshore Regional Entity** demonstrated lower performance for most rates under indicator #2, the rate for indicator #2e, and all rates under indicator #3, as performance declined from the prior year, all rates were below 68 percent (rates ranged from 52.58–67.22 percent), and all but one rate declined. While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services.
Health Information Systems and Technology	**Lakeshore Regional Entity** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Lakeshore Regional Entity** received a *Reportable* indicator designation for all applicable indicators,[3-6] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. **Lakeshore Regional Entity** also continued to leverage BI technology to enhance data quality and oversight of its CMHSPs. Additionally, through the EDV activity, **Lakeshore Regional Entity** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting, and has robust processes to monitor the accuracy, completeness, and timeliness of

[3-6] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Area	Overall Performance Impact
	encounter data submissions, which helps ensure that MDHHS can use the data to effectively monitor the services provided under the Medicaid managed care program. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Lakeshore Regional Entity** has not implemented the Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Lakeshore Regional Entity** suggested that the requirements of the API were not applicable to the PIHP as MDHHS has not established standards for the API, **Lakeshore Regional Entity**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **Lakeshore Regional Entity** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Lakeshore Regional Entity** should begin preparing for the development and implementation of these new requirements.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-25 displays the overall validation rating 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 3-25—Overall Validation Rating for SWMBH

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.

* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-26 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goals and address the barriers.

Table 3-26—Barriers and Interventions for SWMBH

Barriers	Interventions
Inconsistent coordination between ED and PIHP/providers.	Provided feedback to Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment) programs and ED staff; collaborated to identify ways to increase the percentage of Blacks/African Americans who received follow-up care. Expanded Project ASSERT peer intervention to Van Buren County Community Mental Health.
Data sharing gaps between Project ASSERT programs and PIHP/MDHHS.	Project ASSERT programs reported encounters for ED follow-up services using H0002 code, beginning with Integrated Services of Kalamazoo County.

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 that met State and federal requirements. A methodologically sound design created the foundation for **Southwest Michigan Behavioral Health** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Southwest Michigan Behavioral Health used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Southwest Michigan Behavioral Health** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of African-American/Black members attending follow-up appointments after an ED visit for alcohol or other drug abuse or dependence, **Southwest Michigan Behavioral Health** should identify the barriers of care that are specific to the African-American/Black population and implement interventions that are tailored to the needs of the African-American/Black community to mitigate those identified barriers.

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 2023 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 3-27 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-27—Performance Measure Results for SWMBH

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	96.39%	-2.97%	95.00%
Adults—Indicator #1b	99.32%	97.85%	-1.47%	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%	50.23%	-21.74%	NA
MI–Adults—Indicator #2b	70.75%	67.47%	-3.28%	NA
I/DD–Children—Indicator #2c	83.50%	52.67%	-30.83%	NA
I/DD–Adults—Indicator #2d	82.35%	73.68%	-8.67%	NA
Total—Indicator #2	72.12%	61.15%	-10.97%	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%	62.34%	-1.92%	NA

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	56.24%	-8.75%	NA
MI–Adults—Indicator #3b	67.04%	56.68%	-10.36%	NA
I/DD–Children—Indicator #3c	52.94%	57.58%	+4.64%	NA
I/DD–Adults—Indicator #3d	80.00%	80.00%	+/-0.00%	NA
Total—Indicator #3	65.64%	57.12%	-8.52%	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%	94.74%	-3.37%	95.00%
Adults	96.21%	94.80%	-1.41%	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%	98.92%	+0.99%	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%	6.37%	+0.47%	—
#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%	89.41%	+1.28%	—
#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%	23.74%	+4.60%	—
I/DD–Adults—Indicator #8b	8.46%	8.78%	+0.32%	—
MI and I/DD–Adults—Indicator #8c	8.45%	10.00%	+1.55%	—
#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	99.74%	99.93%	+0.19%	—
I/DD–Adults—Indicator #9b	92.70%	93.41%	+0.71%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
MI and I/DD–Adults—Indicator #9c	88.75%	92.45%	+3.70%	—
#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%	2.94%	-4.75%	15.00%
MI and I/DD–Adults—Indicator #10b	12.27%	9.57%	-2.70%	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%	17.81%	-2.25%	—
MI and I/DD–Adults	21.99%	21.45%	-0.54%	—
#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%	48.25%	-3.43%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 continued to demonstrate strength in its collaboration and process improvements across all CMHSPs. Through committee meetings, process improvement trainings, and Power BI dashboard checks and balances, **Southwest Michigan Behavioral Health** ensured standardization of CMHSP data entry that supports performance indicator reporting while providing **Southwest Michigan Behavioral Health** with the ability to readily monitor CMHSP performance. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Southwest Michigan Behavioral Health continued to see an improvement in data quality as all delegated CMHSPs had switched to the same PCE-based EHR system, which includes extensive data controls and validation steps. The implementation of the PCE migration for Integrated Services of Kalamazoo County in 2022 is resulting in overall data quality improvement. [**Quality**]

Strength #3: Southwest Michigan Behavioral Health's reported rate for indicator #4b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Southwest Michigan Behavioral Health's reported rates for indicators #10a and #10b decreased from SFY 2022 to SFY 2023, demonstrating improvement, as a lower rate indicates better performance for these performance indicators. In addition, both performance indicators exceeded the established MPS for both SFY 2022 and SFY 2023, indicating that there were less readmissions for MI and I/DD children and adults to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During the PSV session of the virtual review, in an Integrated Services of Kalamazoo County case reviewed for indicator #1, the start time and disposition time were the same. [**Quality**]

Why the weakness exists: Integrated Services of Kalamazoo County researched the issue further, tested the fields used within the performance indicator event screen in the electronic medical record (EMR) for the indicator data, and reported back to HSAG that the fields required manual entry by clinical staff and allowed values that may conflict or be nonchronological because field controls were not configured for the times.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** ensure that Integrated Services of Kalamazoo County provide targeted training to clinical staff to ensure they understand that dates and times entered need to match clinical documentation for the pre-screening. Additionally, HSAG recommends that **Southwest Michigan Behavioral Health** ensure that Integrated Services of Kalamazoo County perform a visual validation of all dates and times entered for indicator #1 prior to submission to **Southwest Michigan Behavioral Health** to ensure the dates and times match clinical documentation for the pre-screening.

Weakness #2: During HSAG's initial review of the member-level file detail provided, it was noted that for indicator #4b, **Southwest Michigan Behavioral Health** reported one exception with the reason "Exclude - Other." **Southwest Michigan Behavioral Health** researched the case and found that the record was for short-term residential rehabilitation services, had been erroneously marked as a sub-acute detoxification discharge, and should not have been included in indicator #4b. [**Quality**]

Why the weakness exists: Southwest Michigan Behavioral Health indicated that categorizing a service that did not qualify for the indicator was primarily a staff error and would be addressed through staff training. **Southwest Michigan Behavioral Health** also planned to explore changes to

performance indicator logic to identify similar services that should not be treated as inpatient detoxification for the indicator.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** carry out its proposed CAP to provide targeted training to SUD providers regarding which services qualify for the indicator #4b denominator, as well as explore report logic as a fail-safe to prevent errors.

Weakness #3: During the PSV session of the virtual review, an SUD case reviewed for indicator #2e was determined to be for an existing client and not a new request for services. [**Quality**]

Why the weakness exists: **Southwest Michigan Behavioral Health** indicated that the client is a twin who shares the same last name, date of birth, and Social Security number with his sibling, and that the two client records were combined into one record in error during 2022. To prevent the reporting of cases that are not true requests for services, **Southwest Michigan Behavioral Health** reported that it will update the report logic to better match a request for services to BH-TEDS admission records.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** carry out its proposed CAP to update the report logic to require a match between requests for services and BH-TEDS admission records. HSAG further recommends that **Southwest Michigan Behavioral Health** notify MDHHS when duplicate Social Security numbers are identified within the enrollment data, as twin members should have unique Social Security numbers assigned to them.

Weakness #4: During the PSV session of the virtual review, in an SUD case reviewed for indicator #4b, the dates reported did not match the service dates in the EMR. [**Quality**]

Why the weakness exists: **Southwest Michigan Behavioral Health** indicated that the SUD provider did not complete the BH-TEDS discharge record for the inpatient stay, so the record was still showing as "in progress"; as a result, the report logic did not pull the correct date because it does not look for records that are still in progress. **Southwest Michigan Behavioral Health** further indicated that it planned to contact the provider to correct the record and to review its report logic to ensure accurate reporting of follow-up care when members transfer from inpatient care to residential treatment.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** carry out its proposed CAP and also consider providing targeted training to SUD providers on how to update BH-TEDS records for members who transfer directly from inpatient care to residential treatment.

Weakness #5: **Southwest Michigan Behavioral Health**'s reported rates for indicator #4a for the child and adult populations decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rates for indicator #4a for the child and adult populations decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some children and adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **Southwest Michigan Behavioral Health** focus its efforts on increasing timely follow-up care for children and adults following discharge from a psychiatric inpatient unit. **Southwest Michigan Behavioral Health** should also consider the root

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

Compliance Review

Performance Results

Table 3-28 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Southwest Michigan Behavioral Health**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Southwest Michigan Behavioral Health** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-28—SFY 2021 and SFY 2022 Standard Compliance Scores for SWMBH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	6	1	0	**86%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	12	2	0	**86%**
Standard VI—Coverage and Authorization of Services	11	11	11	0	0	**100%**
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	**184**	**183**	**150**	**33**	**1**	**82%**

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

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Southwest Michigan Behavioral Health** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Southwest Michigan Behavioral Health** was responsible for implementing each action plan in a timely manner. Table 3-29 presents an overview of the results of the SFY 2023 compliance review for **Southwest Michigan Behavioral Health**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-29—SFY 2023 Summary of CAP Implementation for SWMBH

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	1	1	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	2	2	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	5	5	**0**
Standard XI—Practice Guidelines	2	2	**0**
Standard XII—Health Information Systems[1]	2	1	**1**
Standard XIII—Quality Assessment and Performance Improvement Program	10	10	**0**
Total	**33**	**32**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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 demonstrated that it successfully remediated 32 of 33 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Southwest Michigan Behavioral Health** remediated all elements for nine of the 10 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Provider Selection, Confidentiality, Grievance and Appeal Systems, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Southwest Michigan Behavioral Health did not remediate the one of the two elements for the Health Information Systems standard. **Southwest Michigan Behavioral Health** has not implemented the Patient Access API in accordance with the requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. [**Quality** and **Access**]

Why the weakness exists: Southwest Michigan Behavioral Health has not implemented the Patient Access API and claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, there was no requirement to audit the PIHP against. However, as a Medicaid MCE, **Southwest Michigan Behavioral Health** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Southwest Michigan Behavioral Health** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-7]

Recommendation: HSAG continues to recommend that **Southwest Michigan Behavioral Health** thoroughly review the requirements of 42 CFR §431.60 and the CMS Interoperability and Patient

[3-7] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access API. **Southwest Michigan Behavioral Health** must ensure its API meets all federally required provisions and is prominently accessible on its website. Further, HSAG continues to recommend that **Southwest Michigan Behavioral Health** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **Southwest Michigan Behavioral Health** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Southwest Michigan Behavioral Health**'s original questionnaire responses, and **Southwest Michigan Behavioral Health** responded to these specific questions. To support its questionnaire responses, **Southwest Michigan Behavioral Health** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Southwest Michigan Behavioral Health** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-30 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-30—EDV Results for SWMBH

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Southwest Michigan Behavioral Health** uses a combination of Pyx12 and internal custom SQL logic for claim adjudication and encounter preparation. • **Southwest Michigan Behavioral Health** has processes in place to detect and identify duplicate claims, as well as manage both denied and adjusted claims during processing and submission. • **Southwest Michigan Behavioral Health** collects and processes provider data, as well as handles the enrollment data.

Analysis	Key Findings
Payment Structures	• For inpatient encounters, **Southwest Michigan Behavioral Health** utilizes a fee-for-service method for its claim payment strategies, while for outpatient, it uses capitation, fee-for-service, and case rate methods. • **Southwest Michigan Behavioral Health** collects and verify TPL information through manual lookup in the Community Health Automated Medicaid Processing System (CHAMPS), manual entry into its claims processing system, and presentation/scanning of insurance cards at intake.
Encounter Data Quality Monitoring	• **Southwest Michigan Behavioral Health** does not conduct any reviews of the encounters before submission to MDHHS. However, it performs quality checks on data stored in its data warehouse, including claim volume by submission month, electronic data interchange (EDI) compliance edits, field-level completeness and accuracy, alignment of payment fields in claims with financial reports, and MRRs.
Administrative Profile	
Encounter Data Completeness	• **Southwest Michigan Behavioral Health** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Southwest Michigan Behavioral Health** had a low volume of duplicate encounters, with 2.9 percent of professional encounters and 0.1 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Southwest Michigan Behavioral Health** did not demonstrate timely submission of professional or institutional encounters. For professional encounters, **Southwest Michigan Behavioral Health** submitted 80.1 percent of encounters to MDHHS within 60 days of payment and submitted 92.5 percent of encounters to MDHHS within 180 days of payment. • **Southwest Michigan Behavioral Health** submitted institutional encounters slightly more timely than professional encounters, with 88.7 percent of institutional encounters submitted to MDHHS within 60 days, and 91.8 percent submitted to MDHHS within 180 days.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Southwest Michigan Behavioral Health**'s submitted data. For professional encounters, 94.2 percent of populated member IDs were valid, whereas 93.0 percent of populated institutional member IDs were valid. • In **Southwest Michigan Behavioral Health**'s submitted professional encounters, the billing provider NPI was populated

Analysis	Key Findings
	43.8 percent of the time, and the rendering provider NPI was populated 17.4 percent of the time. • All other data elements in **Southwest Michigan Behavioral Health**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Southwest Michigan Behavioral Health**'s submitted data, 97.3 percent were identified in the enrollment data. • Of all identified provider NPIs in **Southwest Michigan Behavioral Health**'s submitted data, 99.4 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Southwest Michigan Behavioral Health**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Southwest Michigan Behavioral Health has a robust system for monitoring encounter data submissions designed to oversee the accuracy, completeness, and timeliness of encounter data, which includes encounter data submissions from its own data warehouse and directly from its subcontractors. [**Quality**]

Strength #3: While MRR can be labor- and resource-intensive process for conducting data quality checks, **Southwest Michigan Behavioral Health** indicated its usage as a method for assessing its subcontractors' data. The use of this method enhances the reliability, accuracy, and contextual understanding of its subcontractors' encounter data. This reflects **Southwest Michigan Behavioral Health**'s commitment to delivering high-quality healthcare data. [**Quality**]

Strength #4: Across all encounters, most key data elements for **Southwest Michigan Behavioral Health** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Southwest Michigan Behavioral Health did not submit professional or institutional encounters timely, where within 120 days of payment, 87.2 percent of professional encounters were submitted, and 90.6 percent of institutional encounters were submitted. **Southwest Michigan Behavioral Health** reached over a 99 percent professional encounter submission rate within 330 days and after 360 days for institutional encounters. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Southwest Michigan Behavioral Health should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 94.2 percent and 93 percent, respectively. Additionally, 97.3 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Southwest Michigan Behavioral Health**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Southwest Michigan Behavioral Health should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #3: Although not required to be populated, 43.8 percent and 17.4 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Southwest Michigan Behavioral Health should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

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 3-31 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 3-31—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Southwest Michigan Behavioral Health** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Southwest Michigan Behavioral Health** identified a race/ethnicity disparity that was also statistically significant between African-American/Black members compared to its White population who received a follow-up visit for alcohol or other drug abuse or dependence within 30 days from an ED visit. 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 members) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White members). **Southwest Michigan Behavioral Health** reported inconsistent coordination between the ED and the PIHP/providers as a barrier to care. In an effort to achieve the PIP goal and to address this barrier, **Southwest Michigan Behavioral Health** provided feedback to Project ASSERT programs and ED staff, collaborated to identify ways to increase the percentage of African-American/Black members who receive follow-up care, and had a planned expansion of Project ASSERT peer intervention to another county within its service region. According to NCQA, timely follow-up care for individuals with alcohol or other drug abuse or dependence who were seen in the ED is associated with a reduction in substance use, future ED use, hospital admissions, and bed days. Successful implementation of **Southwest Michigan Behavioral Health**'s PIP should therefore support improved outcomes for its African-American/Black population who seek treatment at an ED for alcohol or other drug abuse or dependence. **Southwest Michigan Behavioral Health** should conduct a study to determine whether any barriers to obtaining timely appointments are unique to African-American/Black members. If significant differences in barriers are noted between the African-American/Black and White populations, **Southwest Michigan Behavioral Health** should target interventions specifically to the African-American/Black population to address those barriers.
Timely Access to Care and Services	**Quality**, **Timeliness**, and **Access**—The PMV activity identified strengths of **Southwest Michigan Behavioral Health**'s managed care program, as some performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b).

Performance Area	Overall Performance Impact
	• Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). Additionally, MDHHS' Access Standards policy outlines admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Southwest Michigan Behavioral Health** did not demonstrate a process to actively monitor adherence to all time frame standards, including admission standards for priority populations. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Southwest Michigan Behavioral Health** implemented actions to monitor priority population admission standards for SUD treatment. **Southwest Michigan Behavioral Health** also demonstrated varying results for new members starting timely services. For indicator #3c, the rate of new children with I/DD starting services timely increased by a rate of 4.64 percentage points from the previous year. In contrast, for indicator #3a, the rate of new MI children, and indicator #3b, the rate of new MI adults, fell by 8.75 percentage points and 10.36 percentage points, respectively. Additionally, fewer new members received a timely biopsychosocial assessment and fewer new members received a timely face-to-face service for treatment or supports from the prior year, as all rates for indicator #2 and indicator #2e demonstrated a decline over time ranging from 1.92 percentage points to 30.83 percentage points. While MDHHS has not established MPSs for indicator #2, indicator #2e, or indicator #3, the results of the PMV activity confirmed that **Southwest Michigan Behavioral Health** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Timeliness** and **Access**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. The PMV activity demonstrated varying results related to the PIHP's network adequacy. **Southwest Michigan Behavioral Health** appeared to have an adequate network of providers for rendering timely pre-admission screenings, timely follow-up care following discharge from an SUD detox unit, and lower percentages for readmissions of MI and I/DD children and adults to an inpatient psychiatric unit within 30 days of discharge, as **Southwest Michigan Behavioral Health** met the MPS for both rates under indicator #1, the one rate under indicator #4b, and both rates under indicator #10. However, **Southwest Michigan Behavioral Health** demonstrated lower performance for all rates

Performance Area	Overall Performance Impact
	under indicator #2, #2e, and #3, as all rates were at or below 80 percent. Except for indicators #3c and #3d, all rates demonstrated a decline from the prior year, with all but one of those rates declining substantially as indicated by a decline of more than 5 percentage points. Additionally, **Southwest Michigan Behavioral Health** did not meet the MDHHS-established MPS for follow-up care following discharge from a psychiatric inpatient unit (indicator #4a.) While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Southwest Michigan Behavioral Health** demonstrated that it had not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS. The member/provider ratio standards had also not been reviewed since 2018. However, through the current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, HSAG confirmed remediation of all deficiencies for the Assurances of Adequate Capacity and Services program area, indicating **Southwest Michigan Behavioral Health** has taken steps to monitor its network adequacy. **Southwest Michigan Behavioral Health** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Southwest Michigan Behavioral Health**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Southwest Michigan Behavioral Health** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP.
Health Information Systems and Technology	**Quality** and **Access—Southwest Michigan Behavioral Health** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Southwest Michigan Behavioral Health** received a *Reportable* indicator designation for all applicable indicators,[3-8] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Southwest Michigan**

[3-8] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Area	Overall Performance Impact
	Behavioral Health demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting, and has robust processes to monitor the accuracy, completeness, and timeliness of encounter data submissions, which helps ensure that MDHHS can use the data to effectively monitor the services provided under the Medicaid managed care program. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Southwest Michigan Behavioral Health** had not implemented the Patient Access API that met all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Southwest Michigan Behavioral Health** suggested that the requirements of the Patient Access API were not applicable to the PIHP as MDHHS has not established standards for the API, **Southwest Michigan Behavioral Health**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **Southwest Michigan Behavioral Health** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Southwest Michigan Behavioral Health** should begin preparing for the development and implementation of these new requirements.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-32 displays the overall validation rating 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 3-32—Overall Validation Rating for MSHN

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-33 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goals and address the barriers.

Table 3-33—Barriers and Interventions for MSHN

Barriers	Interventions
Workforce shortage; lack of qualified, culturally competent clinicians resulting in inadequate, limited available appointments within 14 days.	Conducted a feasibility study to collect information from CMHSPs and SUD providers regarding specific cultural competency requests.
	Recruited student interns and recent graduates from colleges and universities with diverse student populations. Used external contractors to provide services.
Members do not show up for appointments.	Implemented an appointment reminder system and modified the process for coordination between providers.
Minority groups are unaware of services offered.	Identified and engaged with partner organizations that predominantly serve communities of color. Distributed CMHSP informational materials to individuals through identified partner organizations within communities of color.
Lack of insight into what resources and community partners are available to address disparities.	Identified survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community. Conducted an assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity.
Insufficient data to identify social determinants of health (SDOH) such as inadequate housing, food insecurity, transportation needs, and employment/income challenges.	Developed a system to effectively collect SDOH data for individuals served, also to regionally analyze SDOH data and develop action steps.

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 that met State and federal requirements. A methodologically sound design created the foundation for **Mid-State Health Network** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Mid-State Health Network used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Mid-State Health Network** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of Black/African-American members receiving a medically necessary service within 14 days of completing a biopsychosocial assessment, **Mid-State Health Network** should continue to focus its efforts on identifying the barriers of care that are specific to the Black/African-American population and implement interventions that are tailored to the needs of the Black/African-American community to mitigate those identified barriers.

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 2023 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 3-34 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-34—Performance Measure Results for MSHN

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	99.32%	+2.59%	95.00%
Adults—Indicator #1b	99.19%	99.42%	+0.23%	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%	59.14%	-6.63%	NA
MI–Adults—Indicator #2b	62.59%	62.95%	+0.36%	NA
I/DD–Children—Indicator #2c	62.21%	49.21%	-13.00%	NA
I/DD–Adults—Indicator #2d	64.56%	57.29%	-7.27%	NA
Total—Indicator #2	63.73%	60.81%	-2.92%	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%	72.68%	-2.24%	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%	56.86%	-0.74%	NA
MI–Adults—Indicator #3b	63.07%	59.47%	-3.60%	NA
I/DD–Children—Indicator #3c	68.00%	77.16%	+9.16%	NA
I/DD–Adults—Indicator #3d	56.58%	61.90%	+5.32%	NA
Total—Indicator #3	61.27%	59.53%	-1.74%	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	96.81%	97.25%	+0.44%	95.00%
Adults	94.93%	95.60%	+0.67%	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%	97.83%	+2.35%	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%	7.11%	-0.36%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	96.76%	+9.81%	—
#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	19.46%	21.67%	+2.21%	—
I/DD–Adults—Indicator #8b	7.52%	8.77%	+1.25%	—
MI and I/DD–Adults—Indicator #8c	9.38%	10.12%	+0.74%	—
#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%	99.85%	+0.13%	—
I/DD–Adults—Indicator #9b	89.20%	92.53%	+3.33%	—
MI and I/DD–Adults—Indicator #9c	92.76%	93.75%	+0.99%	—
#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%	8.75%	+4.90%	15.00%
MI and I/DD–Adults—Indicator #10b	11.44%	13.01%	+1.57%	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%	19.69%	+1.14%	—
MI and I/DD–Adults	26.64%	25.91%	-0.73%	—
#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%	48.77%	-1.01%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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's affiliated CMHSPs participated in discussions at the Quality Improvement Committee meetings to help identify causal factors, barriers, and effective interventions. Best practices were identified and shared with other CMHSPs and PIHPs, including processes, policies, procedures, and protocols used. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Mid-State Health Network continued to increase its leverage of CAPs with delegated CMHSPs to closely work with these CMHSPs and monitor performance improvement efforts. These efforts have assisted in identifying and addressing systemic issues through process improvement and further supporting oversight of **Mid-State Health Network**'s affiliated CMHSPs. [**Quality**]

Strength #3: Mid-State Health Network's reported rates for indicators #1a and #1b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Mid-State Health Network's reported rates for indicator #4a for the child and adult populations increased from SFY 2022 to SFY 2023 and exceeded the established MPS for SFY 2023, with the adult population exceeding the MPS for SFY 2022 as well, demonstrating continuous improvement and suggesting that children and adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days) most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #5: Mid-State Health Network's reported rate for indicator #4b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit most of the time. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During Community Mental Health Authority of Clinton, Eaton, & Ingham Counties' PSV, while reviewing cases for indicator #1, HSAG found a data entry error for one case which led to documenting an incorrect wait time. **Mid-State Health Network** further researched the issue and reported an additional seven cases with similar documentation errors that needed correction. [**Quality**]

Why the weakness exists: Review of the crisis screening showed a data entry error which resulted in an incorrect wait time being documented. During the review, **Mid-State Health Network** discussed a data entry error involving the date for pre-admission screening start time.

Recommendation: While this finding did not significantly impact the rate, HSAG recommends that **Mid-State Health Network** complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check. HSAG also recommends and supports **Mid-State Health Network**'s efforts in continuing to meet with staff members to provide further training when errors occur, in addition to the **Mid-State Health Network**'s proposed corrective action to have the quality improvement team review all indicator #1 "out-of-compliance" items and check with the CMHSP for accuracy before submission.

Weakness #2: During Lifeways' PSV, HSAG identified one case for indicator #1 that should have been reported as in compliance instead of out of compliance. [**Quality**]

Why the weakness exists: After further review of this case, **Mid-State Health Network** noted that two inpatient screenings were completed for this member. The second document that was completed and counted as out of compliance was completed in error and found to be a duplicate document. Rather than starting a new document, the CMHSP should have updated the initial inpatient screening to include the correct placement of the member.

Recommendation: HSAG recommends that **Mid-State Health Network** continue its efforts to meet with CMHSP staff members to provide further training when these and similar errors occur, in addition to having the quality improvement team review all indicator #1 out-of-compliance items to check CMHSP reporting accuracy before submission.

Weakness #3: During Saginaw County Community Mental Health Authority's PSV, HSAG found zero elapsed minutes documented and reported for one indicator #1 case. [**Quality**]

Why the weakness exists: **Mid-State Health Network** indicated that the staff member who entered this case was no longer available to follow up on the reason this particular case was incorrectly documented.

Recommendation: While **Mid-State Health Network** has since worked with PCE to develop a system update to help capture cases with zero elapsed minutes, HSAG recommends and supports **Mid-State Health Network**'s efforts in monitoring for this particular issue until the PCE system update is in place. Additionally, HSAG recommends that **Mid-State Health Network** continue to monitor for cases with unusual elapsed times after implementing the system update to further ensure the system edits are working as expected.

Weakness #4: After reviewing Bay-Arenac Behavioral Health's proof-of-service documentation, HSAG found that one indicator #3 case was reported as in compliance when no valid follow-up service was documented. [**Quality**]

Why the weakness exists: The logic captured this date in error because there was a "cost reconsideration" for the assessment on the date that was pulled for the follow-up date. This resulted in the logic capturing a single Current Procedural Terminology (CPT) code twice for both the assessment and the follow-up service on the same day.

Recommendation: While PCE completed a logic update in June 2023 to prevent the specific CPT code from being billed twice in the same day, HSAG recommends that **Mid-State Health Network** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV on a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly identifying valid ongoing services.

Weakness #5: After reviewing Huron Behavioral Health's proof-of-service documentation, HSAG found that one case should have been counted as an exception rather than as compliant for indicator #4a. [**Quality**]

Why the weakness exists: Huron Behavioral Health confirmed that the member should have been counted as an exception originally, as the member had discharged to a residential care facility outside of the county.

Recommendation: While this finding did not significantly impact the rate, HSAG recommends that **Mid-State Health Network** and the CMHSP employ additional enhancements to **Mid-State Health Network**'s validation process to ensure appropriate categorization of compliant cases and capture of exceptions.

Weakness #6: After reviewing Shiawassee Health & Wellness' proof-of-service documentation, HSAG found that one member for indicator #3 had an incorrect medically necessary ongoing service date documented and pulled for reporting. [**Quality**]

Why the weakness exists: After further review of this case, HSAG noted that staff submitted documentation for the incorrect day due to overlooking notes that were scanned into the chart. HSAG requested that the CMHSP further research this issue, and the CMHSP noted that no other cases fell into the scenario, which was due to human error in extracting the wrong document from the EMR.

Recommendation: While **Mid-State Health Network** provided evidence reflecting the correct date of the ongoing service that matched the reported date, HSAG recommends that **Mid-State Health Network** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV on a statistically significant sample of cases for indicator #3 each quarter to ensure that only correct services are reported as ongoing services.

Compliance Review

Performance Results

Table 3-35 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Mid-State Health Network**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Mid-State Health Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-35—SFY 2021 and SFY 2022 Standard Compliance Scores for MSHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	5	2	0	**71%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	13	1	0	**93%**
Standard VI—Coverage and Authorization of Services	11	11	10	1	0	**91%**
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	**184**	**184**	**160**	**24**	**0**	**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, 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] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Mid-State Health Network** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Mid-State Health Network** was responsible for implementing each action plan in a timely manner. Table 3-36 presents an overview of the results of the SFY 2023 compliance review for **Mid-State Health Network**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-36—SFY 2023 Summary of CAP Implementation for MSHN

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	1	1	**0**
Standard VI—Coverage and Authorization of Services	1	1	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	6	6	**0**
Standard XII—Health Information Systems[1]	1	0	**1**
Standard XIII—Quality Assessment and Performance Improvement Program	2	2	**0**
Total	**24**	**23**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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 demonstrated that it successfully remediated 23 of 24 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Mid-State Health Network** remediated all elements for nine of the 10 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Mid-State Health Network did not remediate the one element for the Health Information Systems standard. **Mid-State Health Network** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Mid-State Health Network** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Mid-State Health Network did not submit documentation supporting the implementation of the Patient Access API. **Mid-State Health Network** claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, there was no requirement to audit the PIHP against. However, as a Medicaid MCE, **Mid-State Health Network** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Mid-State Health Network** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-9] Additionally, **Mid-State Health Network** has not linked its entire regionwide provider directory to the API or posted a PIHP-specific public-facing digital endpoint on the PIHP's website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

Recommendation: HSAG continues to recommend that **Mid-State Health Network** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and

[3-9] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Mid-State Health Network** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Mid-State Health Network** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **Mid-State Health Network** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Mid-State Health Network**'s original questionnaire responses, and **Mid-State Health Network** responded to these specific questions. To support its questionnaire responses, **Mid-State Health Network** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Mid-State Health Network** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-37 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-37—EDV Results for MSHN

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Mid-State Health Network** uses PCE Systems and REMI as its primary software for claim adjudication and encounter preparation. • Its claims processing system automatically rejects duplicate or overlapping fee-for-service claims, except in cases outlined in its substance abuse disorder overlapping rules document. **Mid-State Health Network** follows specific procedures in submitting denied and adjusted claims. • **Mid-State Health Network** collects provider data through its subcontractors, and shared responsibility with its subcontractor for collecting and maintaining its enrollment data.

Analysis	Key Findings
Payment Structures	• For inpatient encounters, **Mid-State Health Network** utilizes a capitation method for its claim payment strategies, while for outpatient, it uses line-by-line, per diem, and capitation methods. • All **Mid-State Health Network**'s subcontractors were required to collect TPL and bill those prior to sending claims or encounters. **Mid-State Health Network** indicated that it submits zero-paid claims to MDHHS after validation.
Encounter Data Quality Monitoring	• **Mid-State Health Network** indicated it edited or made modifications to some of the subcontractor data. • **Mid-State Health Network** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, including claim volume by submission month, field-level completeness and validity, and timeliness. • **Mid-State Health Network** did not offer responses regarding data quality checks performed internally for encounters in their data warehouses, since its CMHSP subcontractors handle the submission of all encounters and conducted the data quality checks.
Administrative Profile	
Encounter Data Completeness	• **Mid-State Health Network** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Mid-State Health Network** had a moderate volume of duplicate encounters, with 3.5 percent of professional encounters and 0.4 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Mid-State Health Network** demonstrated timely submission for professional encounters. Within 60 days, **Mid-State Health Network** submitted 85.1 percent of professional encounters to MDHHS after the payment date, and within 180 days, **Mid-State Health Network** submitted 93.7 percent of encounters to MDHHS after the payment date. • **Mid-State Health Network** did not demonstrate timely submission of institutional encounters, with 53.1 percent of institutional encounters submitted to MDHHS within 60 days of the payment date. Within 180 days and 360 days, **Mid-State Health Network** submitted 60.5 percent and 87.7 percent of institutional encounters to MDHHS after the payment date, respectively.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Mid-State Health Network**'s submitted data. For professional encounters, 97.1 percent of populated member IDs were valid, whereas 92.4 percent of populated institutional member IDs were valid.

Analysis	Key Findings
	• In **Mid-State Health Network**'s submitted professional encounters, the billing provider NPI was populated 55.8 percent of the time, and the rendering provider NPI was populated 27.9 percent of the time. • All other data elements in **Mid-State Health Network**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Mid-State Health Network**'s submitted data, 95.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Mid-State Health Network**'s submitted data, 98.5 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Mid-State Health Network**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Mid-State Health Network displayed timely submission of professional encounters after payment date, with 90.5 percent of encounters submitted within 120 days. [**Quality** and **Timeliness**]

Strength #3: Across all encounters, most key data elements for **Mid-State Health Network** were populated at high rates, and most elements were over 98 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Mid-State Health Network modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Mid-State Health Network should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **Mid-State Health Network** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. [**Quality**]

Why the weakness exists: The absence of MRR in **Mid-State Health Network**'s data quality checks may stem from resource constraints, a lack of awareness about the benefits of MRR, or possibly a reliance on alternative methods for data quality assurance.

Recommendation: Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **Mid-State Health Network** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process.

Weakness #3: Mid-State Health Network did not submit institutional encounters timely, where 55.6 percent of institutional encounters were submitted within 120 days of payment, and did not reach greater than 90 percent of professional encounters submitted until after 360 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Mid-State Health Network should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97.1 percent and 92.4 percent, respectively. Additionally, 95.9 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Mid-State Health Network**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Mid-State Health Network should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #5: Although not required to be populated, 55.8 percent and 27.9 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Mid-State Health Network should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

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 3-38 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 3-38—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Mid-State Health Network** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Mid-State Health Network** identified a race/ethnicity disparity that was also statistically significant between the Black/African-American population compared to its White population of members new to services who received a medically necessary service within 14 days of completing a biopsychosocial assessment. 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 of 65.04 percent without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). **Mid-State Health Network** identified, among several other barriers, that minority groups are often unaware of services offered. To address this barrier, **Mid-State Health Network** implemented several interventions, including recruiting student interns and recent graduates from colleges and universities with diverse student populations, identifying and engaging with partner organizations that predominantly serve communities of color, and distributing CMHSP informational materials to individuals within communities of color through partner organizations. Providing members with timely and medically necessary services after a biopsychosocial assessment can lead to better mental and physical health outcomes. Therefore, successful implementation of **Mid-State Health Network**'s PIP should result in improved outcomes for Black/African-American members new to PIHP services. **Mid-State Health Network** could conduct a study to identify the reasons that Black/African-American members are less likely to obtain a timely appointment after a biopsychosocial assessment to determine if barriers are different for Black/African-American members than for other racial groups. If significant

Performance Area	Overall Performance Impact
	differences are noted, **Mid-State Health Network** should implement specific interventions that target the barriers for the Black/African-American population.
Timely Access to Care and Services	**Quality**, **Timeliness**, and **Access**—The PMV activity identified strengths of **Mid-State Health Network**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most adult members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a) • Most members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). These results suggest that **Mid-State Health Network** and/or its contracted CMHSPs implemented effective transitional care planning when a member experienced an inpatient psychiatric or substance use detox admission, and had processes in place that limited readmissions to an inpatient psychiatric unit within 30 days of discharge. **Mid-State Health Network** and/or its contracted CMHSPs also rendered final pre-admission screening dispositions within three hours for members who were experiencing symptoms serious enough to warrant an evaluation for inpatient care or were potentially at risk of danger to themselves or others. Of note, rates for indicators #3c (I/DD children) and #3d (I/DD adults) increased by 5 percentage points or more from SFY 2022, indicating that children and adults started medically necessary, ongoing covered services within 14 days of having a non-emergent biopsychosocial assessment more often in SFY 2023. Additionally, MDHHS' Access Standards policy outlines SUD admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Mid-State Health Network** did not demonstrate a process to actively monitor adherence to all time frame standards, including admission time frames for pregnant women receiving SUD services. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Mid-State Health Network** implemented actions to report on and monitor priority population admission standards for pregnant women receiving SUD treatment.

Performance Area	Overall Performance Impact
	However, **Mid-State Health Network** demonstrated worsening performance for indicators #2 and #3, as all rates, with the exception of #2b, #3c, and #3d which improved in performance, experienced a decline from the prior year (ranging from a decline of 0.74 percentage points to 13 percentage points). While MDHHS has not established MPSs for these indicators, the results of the PMV activity confirmed that fewer MI children, I/DD children, and I/DD adult members received a timely biopsychosocial assessment, fewer new members received a timely service for face-to-face treatment of SUD, and fewer MI children and MI adults started timely services after a biopsychosocial assessment, indicating **Mid-State Health Network** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Timeliness** and **Access**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Mid-State Health Network** demonstrated that it had not implemented processes to evaluate its provider network using time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. Further, although the compliance review activity indicated that **Mid-State Health Network** had conducted an annual network adequacy evaluation, the evaluation was a draft version and did not address the time/distance standards specific to provider types within MDHHS' defined time/distance standards (inpatient psychiatric and other select providers by adults and pediatric). The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated **Mid-State Health Network** had made efforts to align its network adequacy analyses with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Mid-State Health Network** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Mid-State Health Network**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Mid-State Health Network** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings, timely follow-up care following discharge from an inpatient psychiatric hospital, timely follow-up care following discharge from an SUD detox unit, and a lower percentage of readmissions for MI and I/DD members to an inpatient psychiatric unit within

Performance Area	Overall Performance Impact
	30 days of discharge, as **Mid-State Health Network** met the MPS for all rates under indicators #1, #4a, #4b, and #10. However, **Mid-State Health Network** demonstrated lower performance for most rates under indicator #2, with three rates (#2a, #2c, and #2d) having a decrease of 5 percentage points or more from the SFY 2022 rates. Indicator #3 performance varied, as performance declined from the prior year for three of the five rates; however, two rates (#3c and #3d) demonstrated an increase in the rate by 5 percentage points or more. While various factors could influence lower rates for the noted indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services. The presence of network adequacy gaps is also supported by the data gleaned through the PIP activity. The primary barrier reported by **Mid-State Health Network** for members receiving treatment was the lack of qualified, trained, and culturally competent staff. **Mid-State Health Network**'s interventions are focused on building its network with well-trained staff. **Mid-State Health Network** should continue these efforts and explore other options for increasing provider capacity to provide culturally competent and integrated treatment services.
Health Information Systems and Technology	**Quality** and **Access—Mid-State Health Network** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Mid-State Health Network** received a *Reportable* indicator designation for all applicable indicators,[3-10] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Mid-State Health Network** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Mid-State Health Network** had not implemented the Patient Access API that met all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Mid-State Health Network** indicated that the requirements of the API were not applicable to the PIHP as MDHHS had not put forth a requirement related to the API, **Mid-State Health Network**, being a Medicaid MCE, is required to abide by federal Medicaid managed care

[3-10] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Area	Overall Performance Impact
	regulations and all guidance issued by CMS. **Mid-State Health Network** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Mid-State Health Network** should begin preparing for the development and implementation of these new requirements.

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 rating (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-39 displays the overall validation rating 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 3-39—Overall Validation Rating for CMHPSM

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-40 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated to support achievement of the PIP goals and address the barriers.

Table 3-40—Barriers and Interventions for CMHPSM

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

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 that met State and federal requirements. A methodologically sound design created the foundation for **Community Mental Health Partnership of Southeast Michigan** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Community Mental Health Partnership of Southeast Michigan used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

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** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and decrease the prevalence of no-show appointments for the African-American population, **Community Mental Health Partnership of Southeast Michigan** should identify the barriers of care that are specific to the African-American population and implement interventions that are tailored to the needs of the African-American community to mitigate those identified barriers.

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 2023 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 3-41 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-41—Performance Measure Results for CMHPSM

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	100%	+1.20%	95.00%

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
Adults—Indicator #1b	99.30%	99.55%	+0.25%	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%	62.13%	-6.02%	NA
MI–Adults—Indicator #2b	63.95%	58.41%	-5.54%	NA
I/DD–Children—Indicator #2c	72.06%	66.34%	-5.72%	NA
I/DD–Adults—Indicator #2d	59.38%	59.38%	+/-0.00%	NA
Total—Indicator #2	66.17%	60.34%	-5.83%	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%	60.32%	-1.66%	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%	72.57%	-0.51%	NA
MI–Adults—Indicator #3b	81.28%	72.31%	-8.97%	NA
I/DD–Children—Indicator #3c	85.29%	85.11%	-0.18%	NA
I/DD–Adults—Indicator #3d	57.14%	89.29%	+32.15%	NA
Total—Indicator #3	77.25%	74.63%	-2.62%	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%	94.44%	+4.70%	95.00%
Adults	95.95%	94.86%	-1.09%	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%	95.73%	-3.04%	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%	6.21%	+0.10%	—
#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%	90.75%	+5.42%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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	16.40%	18.26%	+1.86%	—
I/DD–Adults—Indicator #8b	9.63%	10.66%	+1.03%	—
MI and I/DD–Adults—Indicator #8c	8.97%	9.18%	+0.21%	—
#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%	99.72%	+0.20%	—
I/DD–Adults—Indicator #9b	88.95%	93.68%	+4.73%	—
MI and I/DD–Adults—Indicator #9c	91.43%	93.33%	+1.90%	—
#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%	6.35%	+1.22%	15.00%
MI and I/DD–Adults—Indicator #10b	12.39%	14.23%	+1.84%	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%	25.34%	-0.27%	—
MI and I/DD–Adults	34.35%	29.24%	-5.11%	—
#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%	35.86%	-0.45%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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: Community Mental Health Partnership of Southeast Michigan continued to focus its efforts on increasing regional outcome measures and key metric data visibility for the region. Dashboards were reviewed and discussed collectively at regional committee meetings; were available for individual use; and allowed **Community Mental Health Partnership of Southeast Michigan** to easily review all key data pieces in one place, easily identify areas of concern, and address these areas in a timely manner. **Community Mental Health Partnership of Southeast Michigan** used monitoring and facilitated discussions around data using dashboards across teams to increase awareness and promote performance improvement project development and regional buy-in to improvement activities. [**Quality**, **Timeliness**, and **Access**]

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

Strength #3: Community Mental Health Partnership of Southeast Michigan's reported rates for indicators #1a and #1b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed most of the time. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: The rates for indicator #2 decreased from SFY 2022 to SFY 2023 for MI children, MI adults, and I/DD children (indicators #2a, #2b, and #2c). [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for indicators #2a, #2b, and #2c decreased from SFY 2022 to SFY 2023, suggesting that some adults and children may not have been able to receive a timely biopsychosocial assessment following a non-emergency request for service. **Community Mental Health Partnership of Southeast Michigan** identified that CAPs were put in place for some of its CMHSPs and that it had identified trends related to indicators #2a and #2b of appointments being cancelled, rescheduled, or a "no show" by the person served. Additionally, in some instances, there was a lack of staff documentation.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** continue its improvement efforts and oversight of the CMHSPs, including providing education, expanding appointment options, and ensuring staff coverage to improve performance related to indicator #2 and to further ensure timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #2: Community Mental Health Partnership of Southeast Michigan's reported rate for indicator #4a for the adult population decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4a for the adult population decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some adults were not seen for timely follow-up care (i.e., within seven days) following discharge from a psychiatric inpatient unit.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** focus its efforts on increasing timely follow-up care for adults following discharge from a psychiatric inpatient unit. **Community Mental Health Partnership of Southeast Michigan** should also consider the root cause of the decrease in performance and should implement appropriate interventions to improve performance related to the performance indicator, such as providing patient and provider education or improving upon coordination of care following discharge.

Compliance Review

Performance Results

Table 3-42 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Community Mental Health Partnership of Southeast Michigan**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Community Mental Health Partnership of Southeast Michigan** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-42—SFY 2021 and SFY 2022 Standard Compliance Scores for CMHPSM

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	5	2	0	**71%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	11	3	0	**79%**
Standard VI—Coverage and Authorization of Services	11	11	9	2	0	**82%**
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	**184**	**183**	**144**	**39**	**1**	**79%**

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

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Community Mental Health Partnership of Southeast Michigan** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Community Mental Health Partnership of Southeast Michigan** was responsible for implementing each action plan in a timely manner. Table 3-43 presents an overview of the results of the SFY 2023 compliance review for **Community Mental Health Partnership of Southeast Michigan**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-43—SFY 2023 Summary of CAP Implementation for CMHPSM

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	3	3	**0**
Standard VI—Coverage and Authorization of Services	2	2	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	9	9	**0**
Standard X—Subcontractual Relationships and Delegation	1	1	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	8	8	**0**
Total	**39**	**37**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: Community Mental Health Partnership of Southeast Michigan demonstrated that it successfully remediated 37 of 39 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Community Mental Health Partnership of Southeast Michigan** remediated all elements for 11 of the 12 standards reviewed: Member Rights and Member Information, Availability of Services,

Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Community Mental Health Partnership of Southeast Michigan did not remediate the two elements for the Health Information Systems standard. **Community Mental Health Partnership of Southeast Michigan** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Community Mental Health Partnership of Southeast Michigan** has not made its entire provider directory publicly accessible via the Provider Directory API in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Community Mental Health Partnership of Southeast Michigan has not implemented all requirements of the Patient Access API, such as developing a member-facing website with educational resources in nontechnical, simple, and easy-to-understand language explaining how members can access their health information via the API, including information on how members can protect the privacy and security of their health information. Additionally, the Provider Directory API digital endpoint was not available on **Community Mental Health Partnership of Southeast Michigan**'s website. **Community Mental Health Partnership of Southeast Michigan** also claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, there was no requirement to audit the PIHP against. However, as a Medicaid MCE, **Community Mental Health Partnership of Southeast Michigan** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Community Mental Health Partnership of Southeast Michigan** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 and 42 CFR §431.70 beginning January 1, 2021.[3-11] Additionally, **Community Mental Health Partnership of Southeast Michigan** has not linked its entire regionwide provider directory to the Provider Directory API and there was no PIHP-specific digital endpoint posted on the PIHP's website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

[3-11] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Recommendation: HSAG continues to recommend that **Community Mental Health Partnership of Southeast Michigan** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Community Mental Health Partnership of Southeast Michigan** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Community Mental Health Partnership of Southeast Michigan** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **Community Mental Health Partnership of Southeast Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Community Mental Health Partnership of Southeast Michigan**'s original questionnaire responses, and **Community Mental Health Partnership of Southeast Michigan** responded to these specific questions. To support its questionnaire responses, **Community Mental Health Partnership of Southeast Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Community Mental Health Partnership of Southeast Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-44 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-44—EDV Results for CMHPSM

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• Due to data entry process, no primary software was noted in **Community Mental Health Partnership of Southeast Michigan**'s response. • **Community Mental Health Partnership of Southeast Michigan** noted that it employs multiple checks for duplicate claims. **Community Mental Health Partnership of Southeast**

Analysis	Key Findings
	Michigan follows specific procedures in submitting denied and adjusted claims. Additionally, it indicated that providers play an active role in identifying and correcting encounter issues. • **Community Mental Health Partnership of Southeast Michigan** manages the collection and processing of provider data and handles the enrollment data.
Payment Structures	• **Community Mental Health Partnership of Southeast Michigan** utilizes line-by-line method for its claim payment strategies for both its inpatient and outpatient encounters. • **Community Mental Health Partnership of Southeast Michigan** collects and documents all relevant TPL information on the member chart. **Community Mental Health Partnership of Southeast Michigan** indicated it submits zero-paid claims to MDHHS after validation.
Encounter Data Quality Monitoring	• **Community Mental Health Partnership of Southeast Michigan** and/or its subcontractors perform field-level completeness and validity as well as timeliness quality checks on encounter data collected by subcontractors. • **Community Mental Health Partnership of Southeast Michigan** did not offer responses regarding data quality checks performed internally for encounters in their data warehouses, since its CMHSP subcontractors handle the submission of all encounters and conducted the data quality checks.
Administrative Profile	
Encounter Data Completeness	• **Community Mental Health Partnership of Southeast Michigan** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Community Mental Health Partnership of Southeast Michigan** had a moderate volume of duplicate encounters, with 4.1 percent of professional encounters and less than 0.1 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Community Mental Health Partnership of Southeast Michigan** demonstrated timely submission of professional and institutional encounters. Within 60 days, **Community Mental Health Partnership of Southeast Michigan** submitted 99.7 percent of professional and institutional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for professional and institutional encounters in **Community Mental Health Partnership of Southeast Michigan**'s submitted data. For professional encounters, 95.2 percent of populated member IDs were valid, whereas 90.7 percent of populated institutional member IDs were valid.

Analysis	Key Findings
	• All other data elements in **Community Mental Health Partnership of Southeast Michigan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Community Mental Health Partnership of Southeast Michigan**'s submitted data, 95.3 percent were identified in the enrollment data. • Of all identified provider NPIs in **Community Mental Health Partnership of Southeast Michigan**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Community Mental Health Partnership of Southeast Michigan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Community Mental Health Partnership of Southeast Michigan displayed timely submission of professional and institutional encounters after payment date, with 99.7 percent of encounters submitted within 60 days for both categories of service. [**Quality** and **Timeliness**]

Strength #3: Across all encounters, most key data elements for **Community Mental Health Partnership of Southeast Michigan** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Community Mental Health Partnership of Southeast Michigan did not indicate claim volume quality checks performed for claims/encounters from its subcontractors' data. [**Quality**]

Why the weakness exists: Claim volume checks are crucial to validating that the submitted data align with the expected volume, helping identify any discrepancies or missing information. The lack

of this check increases the risk of errors and omissions in data submission, which can impact the reliability and effectiveness of the overall encounter data system.

Recommendation: Community Mental Health Partnership of Southeast Michigan should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness of encounter data. By implementing such measures, **Community Mental Health Partnership of Southeast Michigan** can enhance the overall quality and reliability of the encounter data it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.

Weakness #2: While several PIHPs recognized the labor- and resource-intensive nature of MRR as a method for conducting data quality checks and reported its usage, **Community Mental Health Partnership of Southeast Michigan** did not indicate the incorporation of MRR as part of its data quality assessment for its subcontractors' data. [**Quality**]

Why the weakness exists: The absence of MRR in **Community Mental Health Partnership of Southeast Michigan**'s data quality checks may stem from resource constraints, a lack of awareness about the benefits of MRR, or possibly a reliance on alternative methods for data quality assurance.

Recommendation: Acknowledging the efficacy of MRR in ensuring accuracy and completeness in encounter data, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** evaluates the feasibility and potential benefits of integrating MRR into its data quality checks. This could enhance the reliability and thoroughness of its data assessment process.

Weakness #3: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.2 percent and 90.7 percent, respectively. Additionally, 95.3 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Community Mental Health Partnership of Southeast Michigan**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Community Mental Health Partnership of Southeast Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #4: Community Mental Health Partnership of Southeast Michigan had a relatively high percentage of duplicates for professional encounters (4.1 percent). [**Quality**]

Why the weakness exists: Duplicates could be a result of error within the internal process of encounter submission. If duplicates are not properly identified and handled, duplicate encounters can falsely indicate higher utilization of services.

Recommendation: HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** examine its internal process of identifying duplicates.

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 3-45 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 **Community Mental Health Partnership of Southeast Michigan**'s Medicaid members.

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

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Community Mental Health Partnership of Southeast Michigan** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Community Mental Health Partnership of Southeast Michigan** identified a race/ethnicity disparity that was also statistically significant between the Black/African-American population and the White population for members new to services who did not show up for their initial biopsychosocial assessment. The goals for **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 (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). **Community Mental Health Partnership of Southeast Michigan** identified, among other barriers, unintended biases in staff assumptions or communications that could affect the response of members seeking services and/or their willingness to attend services. To address this barrier, **Community Mental Health Partnership of Southeast Michigan** implemented interventions, such as, staff asking and documenting if members have any barriers to attending their initial biopsychosocial appointment and staff being trained on using script/discussion guidelines when speaking to members to reduce communication barriers related to diversity, equity, and inclusion, and to reduce potential stigmatizing communication. Ensuring members attend their initial biopsychosocial assessment is the first step to obtaining timely health care services, and providing members with timely and medically necessary services after a biopsychosocial assessment can lead to better mental and physical health outcomes. Therefore, successful implementation of **Community Mental Health Partnership of Southeast**

Performance Area	Overall Performance Impact
	Michigan's PIP should support a reduction in Black/African-American members not attending their initial biopsychosocial assessment. **Community Mental Health Partnership of Southeast Michigan** could conduct a study to identify the reasons that Black/African-American members are less likely to obtain a timely appointment after a biopsychosocial assessment to determine if barriers are different for Black/African-American members than for other racial groups. If significant differences are noted, **Community Mental Health Partnership of Southeast Michigan** should implement specific interventions to address those barriers for the Black/African-American population.
Timely Access to Care and Services	The PMV activity identified strengths of **Community Mental Health Partnership of Southeast Michigan**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • All children and most adults received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). These results suggest that **Community Mental Health Partnership of Southeast Michigan** and/or its contracted CMHSPs implemented effective transitional care planning when a member had a substance use detox admission and had processes in place that limited readmissions to an inpatient psychiatric unit within 30 days of discharge. **Community Mental Health Partnership of Southeast Michigan** and/or its contracted CMHSPs also rendered final pre-admission screening dispositions within three hours for members who were experiencing symptoms serious enough to warrant an evaluation for inpatient care or were potentially at risk of danger to themselves or others. Additionally, through its Access Standards policy, MDHHS has outlined admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Community Mental Health Partnership of Southeast Michigan** did not demonstrate a process to actively monitor adherence to all MDHHS timely access standards, specifically the screening and admission time frames for pregnant women receiving SUD services. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area,

Performance Area	Overall Performance Impact
	indicating **Community Mental Health Partnership of Southeast Michigan** implemented actions to monitor priority population admission standards according to MDHHS' Access Standards policy. However, **Community Mental Health Partnership of Southeast Michigan** demonstrated worsening performance for indicators #2, #2e, and #3, as all rates, except for #2d which had no change in the rate and #3d which significantly improved in performance (an increase of 32.15 percent), experienced a decline from SFY 2022 (ranging from a decline of 0.18 percentage points to 8.97 percentage points). Of note, rates for indicators #2a, #2b, #2c, and #3b decreased by 5 percentage points or more from the SFY 2022 rates. While MDHHS has not established MPSs for these indicators, the results of the PMV activity confirmed that fewer MI children, MI adults, and I/DD children members received a timely biopsychosocial assessment; fewer new members received a timely face-to-face service for SUD treatment; and fewer MI children, MI adults, and I/DD children started timely services after a biopsychosocial assessment, indicating **Community Mental Health Partnership of Southeast Michigan** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Timeliness** and **Access**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Community Mental Health Partnership of Southeast Michigan** did not demonstrate that it had implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document, or that member/provider ratio standards were reviewed consistently, as the PIHP had not reviewed member/ratio standards since 2018. Additionally, the PIHP had not submitted annual assurances and supporting documentation demonstrating that **Community Mental Health Partnership of Southeast Michigan** had the capacity to serve the expected enrollment in its service area in accordance with MDHHS' PIHP Network Adequacy Standard Procedural Document. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that **Community Mental Health Partnership of Southeast Michigan** made efforts to align its network adequacy analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Community Mental Health Partnership of Southeast Michigan** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Community Mental Health Partnership of Southeast Michigan**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum

Performance Area	Overall Performance Impact
	of services for which the PIHP is responsible. **Community Mental Health Partnership of Southeast Michigan** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings and follow-up care following discharge from an SUD detox unit, and a lower percentage of readmissions for MI and I/DD members to an inpatient psychiatric unit within 30 days of discharge as **Community Mental Health Partnership of Southeast Michigan** met the MPS for all rates under indicators #1, #4b, and #10. However, **Community Mental Health Partnership of Southeast Michigan** demonstrated lower performance for all but one rate under indicator #2, the rate for indicator #2e, and the rates for indicators #3a, #3b, and #3c, as performance declined from the prior year. Further, four rates under indicators #2 and #3 had a rate decrease of 5 percentage points or more from SFY 2022. While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services.
Health Information Systems and Technology	**Quality** and **Access—Community Mental Health Partnership of Southeast Michigan** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Community Mental Health Partnership of Southeast Michigan** received a *Reportable* indicator designation for all applicable indicators,[3-12] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Community Mental Health Partnership of Southeast Michigan** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Community Mental Health Partnership of Southeast Michigan** had not implemented the Patient Access or Provider Directory APIs that met all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). **Community Mental Health Partnership of Southeast Michigan** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further,

[3-12] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Area	Overall Performance Impact
	CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Community Mental Health Partnership of Southeast Michigan** should begin preparing for the development and implementation of these new requirements. Also, as indicated through the EDV activity, **Community Mental Health Partnership of Southeast Michigan** has opportunities to further ensure the quality and reliability of its encounter data submissions to MDHHS by conducting more robust quality data checks of its encounter data prior to submitting to MDHHS. Enhancing its current encounter data quality checks will help ensure that the encounter data continues to be reliable for MDHHS to use to effectively monitor the services provided under the Medicaid managed care program.

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 rating (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-46 displays the overall validation rating 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 DWIHN

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-47 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated to support achievement of the PIP goals and address the barriers.

Table 3-47—Barriers and Interventions for DWIHN

Barriers	Interventions
Member's difficulty getting an appointment within the required time frames.	Individual data shared with providers. Meetings with 19 clinically responsible service providers (CRSPs) have taken place every 45 days. The PIHP's Access Department will develop an Availability Access Report indicating available 7-day follow-up appointments, including new members, in an effort to reach out to providers when they are approaching exhaustion.
Member's failure to engage: no-shows, cancellations, rescheduling, and refusal of appointments.	Annual reviews began examining CRSPs' notes in January 2023 and has been ongoing throughout this year. This tool is used for chart auditing by the DWIHN Quality Department, and results are discussed with the providers. The PIHP's utilization management department attempted to reach members prior to discharge to identify any barriers to keeping follow-up appointments.
Lack of coordination and continuity of care between inpatient and outpatient follow-up services.	The PIHP's complex case management (CCM) [staff] attempted to assist with care coordination with Black/African-American members prior to discharge and enroll [them] in CCM.
Lack of transportation for members.	Transportation payment was provided to outpatient providers to assist in providing transportation for members in need.
Member's view on the importance of the appointment.	Anti-Stigma brochures indicating the importance of members seeking mental health services were developed and placed on the PIHP's website and provided to members during the hospital discharge process.

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 that met State and federal requirements. A methodologically sound design created the foundation for **Detroit Wayne Integrated Health Network** to progress to subsequent PIP stages—collecting data

and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Detroit Wayne Integrated Health Network used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

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** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the prevalence of Black or African-American members accessing follow-up care after discharge from psychiatric hospitalization, **Detroit Wayne Integrated Health Network** should identify the barriers of care that are specific to the Black or African-American population and implement interventions that are tailored to the needs of the Black or African-American community to mitigate those identified barriers.

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 2023 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 3-48 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-48—Performance Measure Results for DWIHN

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	99.24%	+1.46%	95.00%
Adults—Indicator #1b	97.14%	98.12%	+0.98%	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%	28.81%	-15.59%	NA
MI–Adults—Indicator #2b	57.14%	54.33%	-2.81%	NA
I/DD–Children—Indicator #2c	47.90%	28.71%	-19.19%	NA
I/DD–Adults—Indicator #2d	53.45%	43.55%	-9.90%	NA
Total—Indicator #2	52.85%	45.15%	-7.70%	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%	61.45%	-1.51%	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%	85.36%	+4.75%	NA
MI–Adults—Indicator #3b	81.15%	88.80%	+7.65%	NA
I/DD–Children—Indicator #3c	90.54%	84.78%	-5.76%	NA
I/DD–Adults—Indicator #3d	88.00%	77.05%	-10.95%	NA
Total—Indicator #3	82.36%	87.24%	+4.88%	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%	100%	+1.85%	95.00%
Adults	94.80%	98.14%	+3.34%	95.00%

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	100%	+/-0.00%	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%	5.86%	-0.04%	—
#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%	93.54%	+2.52%	—
#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%	17.44%	+3.44%	—
I/DD–Adults—Indicator #8b	8.23%	8.79%	+0.56%	—
MI and I/DD–Adults—Indicator #8c	6.02%	7.52%	+1.50%	—
#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%	99.84%	+0.07%	—
I/DD–Adults—Indicator #9b	93.69%	94.35%	+0.66%	—
MI and I/DD–Adults—Indicator #9c	96.69%	98.70%	+2.01%	—
#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%	7.51%	+2.45%	15.00%
MI and I/DD–Adults—Indicator #10b	14.93%	14.69%	-0.24%	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%	21.08%	-0.61%	—
MI and I/DD–Adults	27.84%	29.11%	+1.27%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	39.44%	+1.29%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 demonstrated improvement efforts as related to the performance indicators. **Detroit Wayne Integrated Health Network** continued to meet with its CRSPs every 30 to 45 days to review topics such as rates for indicators #2, #3, and #4a. Previous and current quarter individual rates were shared and discussed at every meeting. Data, barriers, interventions, and opportunities were also discussed at each meeting. Beginning May 2023, CRSPs were able to review their individual rates in **Detroit Wayne Integrated Health Network**'s risk matrix module, which allowed the CRSPs to view real-time data. In addition, financial incentives from **Detroit Wayne Integrated Health Network**'s finance department have been offered for high performance for the performance indicators. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Detroit Wayne Integrated Health Network's reported rates for indicators #1a and #1b increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that members receiving a pre-admission screening for psychiatric inpatient care had a timely disposition completed most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Detroit Wayne Integrated Health Network's reported rates for Indicator #4a for the child and adult populations increased from SFY 2022 to SFY 2023 and exceeded the established

MPS for SFY 2023, with the child population exceeding the MPS for SFY 2022 as well, demonstrating continuous improvement and suggesting that children and adults discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days) most of the time. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Detroit Wayne Integrated Health Network's reported rate for indicator #4b was 100 percent for both SFY 2022 and SFY 2023, and exceeded the established MPS for both SFY 2022 and SFY 2023, suggesting that all members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Although improvement efforts were discussed related to indicator #2, the rates for MI and I/DD children (i.e., indicators #2a and #2c) and I/DD adults (i.e., indicator #2d) significantly decreased from SFY 2022 to SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for indicators #2a, #2c, and #2d decreased from SFY 2022 to SFY 2023, suggesting that some children and adults may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **Detroit Wayne Integrated Health Network** continue with its improvement efforts (i.e., provider outreach, monitoring, and financial incentives) related to indicator #2 to further ensure timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Compliance Review

Performance Results

Table 3-49 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Detroit Wayne Integrated Health Network**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Detroit Wayne Integrated Health Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

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

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	6	1	0	**86%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard IV—Assurances of Adequate Capacity and Services	4	4	0	4	0	**0%**
Standard V—Coordination and Continuity of Care	14	14	11	3	0	**79%**
Standard VI—Coverage and Authorization of Services	11	11	7	4	0	**64%**
184Standard 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	**184**	**183**	**148**	**35**	**1**	**81%**

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

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

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

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

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

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Detroit Wayne Integrated Health Network** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Detroit Wayne Integrated Health Network** was responsible for implementing each action plan in a timely manner. Table 3-50 presents an overview of the results of the SFY 2023 compliance review for **Detroit Wayne Integrated Health Network**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-50—SFY 2023 Summary of CAP Implementation for DWIHN

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	1	1	**0**
Standard IV—Assurances of Adequate Capacity and Services	4	4	**0**
Standard V—Coordination and Continuity of Care	3	3	**0**
Standard VI—Coverage and Authorization of Services	4	4	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	6	6	**0**
Standard X—Subcontractual Relationships and Delegation	1	1	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	5	5	**0**
Total	**35**	**33**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: Detroit Wayne Integrated Health Network demonstrated that it successfully remediated 33 of 35 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Detroit Wayne Integrated Health Network** remediated all elements for 11 of the 12 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate

Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Detroit Wayne Integrated Health Network did not remediate the two elements for the Health Information Systems standard. **Detroit Wayne Integrated Health Network** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Detroit Wayne Integrated Health Network** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Detroit Wayne Integrated Health Network has not implemented all requirements of the Patient Access API, such as developing a member-facing website with educational resources in nontechnical, simple, and easy-to-understand language explaining how members can access their health information via the API, including information on how members can protect the privacy and security of their health information. Additionally, **Detroit Wayne Integrated Health Network** has not posted a PIHP-specific digital endpoint on its website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

Recommendation: HSAG continues to recommend that **Detroit Wayne Integrated Health Network** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Detroit Wayne Integrated Health Network** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Detroit Wayne Integrated Health Network** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **Detroit Wayne Integrated Health Network** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Detroit Wayne Integrated Health Network**'s original questionnaire responses, and **Detroit Wayne Integrated Health Network** responded to these specific questions. To support its questionnaire responses, **Detroit Wayne Integrated Health Network** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Detroit Wayne Integrated Health Network** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-51 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-51—EDV Results for DWIHN

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Detroit Wayne Integrated Health Network** uses MH-Win as its primary software for claim adjudication and encounter preparations. • **Detroit Wayne Integrated Health Network** identifies duplicate claims based on a list of specific fields. **Detroit Wayne Integrated Health Network** indicated that it follows specific procedures in submitting denied and adjusted claims. It utilizes a voiding process to nullify erroneous encounters, followed by resubmission of corrected data. • **Detroit Wayne Integrated Health Network** manages both provider data collection and processing, along with enrollment data handling.
Payment Structures	• **Detroit Wayne Integrated Health Network** utilizes a fee-for-service method for claim payment strategies in inpatient encounters. For outpatient encounters, it utilizes both fee-for-service and per member per month (PMPM) methods.

Analysis	Key Findings
	• **Detroit Wayne Integrated Health Network** indicated that its providers are responsible for billing and collecting payments from other payers.
Encounter Data Quality Monitoring	• **Detroit Wayne Integrated Health Network** indicated it edited or made modifications to some of the subcontractor data. • **Detroit Wayne Integrated Health Network** and/or its subcontractors perform MRR data quality checks on encounter data collected by subcontractors. • **Detroit Wayne Integrated Health Network** did not offer responses regarding data quality checks performed internally for encounters in their data warehouses, since its CMHSP subcontractors handle the submission of all encounters and conducted the data quality checks.
Administrative Profile	
Encounter Data Completeness	• **Detroit Wayne Integrated Health Network** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Detroit Wayne Integrated Health Network** had a high volume of duplicate encounters, with 7.9 percent of professional encounters and 0.3 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Detroit Wayne Integrated Health Network** demonstrated timely submission of professional and institutional encounters. Within 60 days, **Detroit Wayne Integrated Health Network** submitted 98.9 percent of professional encounters and 97.6 percent of institutional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Detroit Wayne Integrated Health Network**'s submitted data. For professional encounters, 97.0 percent of populated member IDs were valid, whereas 94.0 percent of populated institutional member IDs were valid. • All other data elements in **Detroit Wayne Integrated Health Network**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Detroit Wayne Integrated Health Network**'s submitted data, 97.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **Detroit Wayne Integrated Health Network**'s submitted data, 99.7 percent were identified in the provider data.

Analysis	Key Findings
Encounter Data Logic	• No major concerns were noted for **Detroit Wayne Integrated Health Network**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Detroit Wayne Integrated Health Network displayed timely submission of professional and institutional encounters after payment date, and within 120 days, had 99.9 percent of professional encounters submitted and 99.8 percent of institutional encounters submitted. [**Quality** and **Timeliness**]

Strength #3: Across all encounters, most key data elements for **Detroit Wayne Integrated Health Network** were populated at high rates, and most data elements were over 99 percent valid.

Weaknesses and Recommendations

Weakness #1: Detroit Wayne Integrated Health Network modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Detroit Wayne Integrated Health Network should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: Detroit Wayne Integrated Health Network did not indicate claim volume, accuracy, or timeliness quality checks performed for claims/encounters from its subcontractors' data. [**Quality**]

Why the weakness exists: Claim volume and accuracy checks are crucial to validating that the submitted data align with the expected volume and values, helping identify any discrepancies or missing information. Timeliness quality checks ensure that the claims/encounters are submitted within the specified time frames, meeting MDHHS' minimum monthly requirements. The lack of

these checks increases the risk of errors, omissions, or delays in data submission, which can impact the reliability and effectiveness of the overall encounter data system.

Recommendation: **Detroit Wayne Integrated Health Network** should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness, accuracy, and timeliness of encounter data. By implementing such measures, **Detroit Wayne Integrated Health Network** can enhance the overall quality and reliability of the encounter data that it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.

Weakness #3: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97 percent and 94 percent, respectively. Additionally, 97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Detroit Wayne Integrated Health Network**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: **Detroit Wayne Integrated Health Network** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #4: **Detroit Wayne Integrated Health Network** had a relatively high percentage of duplicates for professional encounters (7.9 percent). [**Quality**]

Why the weakness exists: Duplicates could be a result of error within the internal process of encounter submission. If duplicates are not properly identified and handled, duplicate encounters can falsely indicate higher utilization of services.

Recommendation: HSAG recommends that **Detroit Wayne Integrated Health Network** examine its internal process of identifying duplicates.

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 3-52 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 3-52—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality, Access, and Timeliness—Detroit Wayne Integrated Health Network** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Detroit Wayne Integrated Health Network** identified that Black or African-American members were not seen for follow-up care within seven days of discharge from a psychiatric inpatient unit as frequently as White members. **Detroit Wayne Integrated Health Network** determined that the goal of its PIP is 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). **Detroit Wayne Integrated Health Network** reported that, among several other barriers, members have difficulty in obtaining an appointment within the time frame. In an effort to achieve the PIP goal and address this barrier, **Detroit Wayne Integrated Health Network** is developing an Availability Access Report that will include available seven-day follow-up appointments to assist providers with scheduling appointments. According to a study funded by the National Institute of Mental Health, timely follow-up after hospitalization for mental illness can reduce the duration of acute mental health episodes and the likelihood that the member will be hospitalized. Therefore, the time between inpatient discharge and outpatient follow-up is considered an important indicator of healthcare quality. Successful implementation of **Detroit Wayne Integrated Health Network**'s PIP should support an increase in Black/African-American members obtaining timely follow-up care after discharge after psychiatric hospitalization. **Detroit Wayne Integrated Health Network** could conduct a study to identify the reasons that Black or African-American members are unable to obtain a timely appointment to determine if barriers are different for Black or African-American members than for other racial groups. If significant differences are noted, **Detroit Wayne Integrated Health Network** could implement specific interventions to address those barriers for the Black or African-American population.
Timely Access to Care and Services	**Quality, Access, and Timeliness—**The PMV activity identified strengths of **Detroit Wayne Integrated Health Network**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • All children and most adults received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a).

Performance Area	Overall Performance Impact
	• All members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). Additionally, through the Access Standards policy, MDHHS has outlined admission priority standards for each population along with the current interim service requirements. For example, members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Detroit Wayne Integrated Health Network** did not demonstrate a process to actively monitor time frame standards, including admission standards for priority populations. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Detroit Wayne Integrated Health Network** implemented actions to monitor priority population admission standards in accordance with MDHHS' Access Standards policy. However, **Detroit Wayne Integrated Health Network** demonstrated varying results for new members starting timely services. For indicators #3a and #3b, the rates for new children and adults with MI increased by 4.75 percentage points and 7.65 percentage points, respectively. In contrast, for indicators #3c and #3d, the rates for new children and adults with I/DD fell by 5.76 percentage points and 10.95 percentage points, respectively. Additionally, fewer new members received a timely biopsychosocial assessment and fewer new members received a timely face-to-face service for treatment or supports, as all rates for indicator #2 and indicator #2e demonstrated a decline ranging between 1.51 percentage points to 19.19 percentage points. While MDHHS has not established MPSs for indicators #2, #2e, and #3, the results of the PMV activity confirmed that **Detroit Wayne Integrated Health Network** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.
Network Adequacy	**Access, and Timeliness—**MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Detroit Wayne Integrated Health Network** demonstrated that it conducted an annual network adequacy evaluation. However, the evaluation did not include member-to-provider ratios and time/distance standards that aligned with MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, the annual assessment did not consider timely appointments or physical accessibility. The current SFY 2023 compliance review activity, which consisted of a CAP review of the

Performance Area	Overall Performance Impact
	deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that **Detroit Wayne Integrated Health Network** made efforts to align its network adequacy analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Detroit Wayne Integrated Health Network** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Detroit Wayne Integrated Health Network**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Detroit Wayne Integrated Health Network** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings and follow-up care following discharge from an inpatient psychiatric hospital or SUD detox unit, as **Detroit Wayne Integrated Health Network** met MPSs for all rates under indicators #1, #4a, #4b, and #10. However, **Detroit Wayne Integrated Health Network** demonstrated lower performance for all rates under indicator #2, the rate for indicator #2e, and the rates for indicators #3c and #3d, as performance declined from the prior year and all rates were below 89 percent (rates ranged from 28.71 percent to 88.80 percent). Additionally, although indicators #3a and #3b improved from SFY 2022, they were still below 89 percent. While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely services for new members, timely biopsychosocial assessments, and timely face-to-face services. The presence of network adequacy gaps is also supported by the data gleaned through the PIP activity. One of the primary barriers reported by **Detroit Wayne Integrated Health Network** for members receiving timely follow-up care after an inpatient stay for mental illness was a lack of available appointments within the seven-day time frame. **Detroit Wayne Integrated Health Network**'s interventions are focused on working closely with the CRSPs to ensure appointments are available. **Detroit Wayne Integrated Health Network** should continue these efforts and explore other options for increasing provider capacity to provide follow-up care after hospitalizations and getting all members assessed and into care timely after requests for services.
Health Information Systems and Technology	**Quality and Access—Detroit Wayne Integrated Health Network** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Detroit Wayne**

Performance Area	Overall Performance Impact
	Integrated Health Network received a *Reportable* indicator designation for all applicable indicators,[3-13] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Detroit Wayne Integrated Health Network** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Detroit Wayne Integrated Health Network** has not published its Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). **Detroit Wayne Integrated Health Network** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Detroit Wayne Integrated Health Network** should begin preparing for the development and implementation of these new requirements. Also, as indicated through the EDV activity, **Detroit Wayne Integrated Health Network** has opportunities to further ensure the quality and reliability of its encounter data submissions to MDHHS by conducting more robust quality data checks of its encounter data prior to submitting to MDHHS. Enhancing its current encounter data quality checks will help ensure that the encounter data continues to be reliable for MDHHS to use to effectively monitor the services provided under the Medicaid managed care program.

[3-13] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-53 displays the overall validation rating 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 3-53—Overall Validation Rating for OCHN

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-54 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated to support achievement of the PIP goals and address the barriers.

Table 3-54—Barriers and Interventions for OCHN

Barriers	Interventions
Improving medication safety between care transitions for dispensing, administering, and monitoring, as well as improving prescriber and member communication.	Educated providers on the World Health Organization's technical report on medication safety in polypharmacy which highlights guidelines and best practices.

Barriers	Interventions
Lack of mental health literacy of provider staff and members.	Improved health literacy knowledge of members and network staff through education on depression, screening, evidence-based practices, adherence strategies, and supportive intervention.
Individuals discharged from acute care settings are at-risk for medication nonadherence and require medication psychoeducation and support.	Improved medication adherence by updating the Acute Care Discharge (ACD) protocol and audit tool. Provider staff are educated on the updated protocol annually by assigned supervisors/managers at the provider level.
Improving the complexity of the medication regimen and encouraging prescribers to utilize shared decision making.	Educated and encouraged providers to use shared decision-making skills to support adherence.
Addressing transportation barriers for prescription pick-up/refills.	The PIHP and providers encouraged medication delivery enrollment, with participating pharmacies and services, to improve antidepressant medication adherence.
Lack of psychotropic and antidepressant medication adherence.	The PIHP's pharmacology partner, Genoa Pharmacy, provided system education on integrated pharmacy services, adherence strategies, and pharmacy collaboration to support psychotropic medication adherence.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the 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 that met State and federal requirements. A methodologically sound design created the foundation for **Oakland Community Health Network** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Oakland Community Health Network used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

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 annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and improve antidepressant medication management for its African-American members, **Oakland Community Health Network** should identify the barriers of care that are specific to the African-American population and implement interventions that are tailored to the needs of the African-American community to mitigate those identified barriers.

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 2023 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 3-55 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-55—Performance Measure Results for OCHN

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	94.56%	-3.36%	95.00%
Adults—Indicator #1b	93.04%	91.61%	-1.43%	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%	30.89%	-14.65%	NA

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
MI–Adults—Indicator #2b	50.43%	53.53%	3.10%	NA
I/DD–Children—Indicator #2c	53.33%	21.74%	-31.59%	NA
I/DD–Adults—Indicator #2d	42.86%	24.24%	-18.62%	NA
Total—Indicator #2	48.61%	44.97%	-3.64%	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	92.21%	81.71%	-10.50%	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%	99.62%	-0.01%	NA
MI–Adults—Indicator #3b	99.77%	98.91%	-0.86%	NA
I/DD–Children—Indicator #3c	100%	100%	+/-0.00%	NA
I/DD–Adults—Indicator #3d	100%	97.22%	-2.78%	NA
Total—Indicator #3	99.74%	99.09%	-0.65%	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%	96.15%	-3.85%	95.00%
Adults	95.56%	95.73%	0.17%	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%	100%	+/-0.00%	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%	7.31%	+0.31%	—
#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%	93.46%	+2.06%	—
#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%	24.21%	+5.07%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
I/DD–Adults—Indicator #8b	12.57%	14.19%	+1.62%	—
MI and I/DD–Adults—Indicator #8c	8.62%	11.01%	+2.39%	—
#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%	100%	+0.40%	—
I/DD–Adults—Indicator #9b	77.84%	83.51%	+5.67%	—
MI and I/DD–Adults—Indicator #9c	62.42%	80.00%	+17.58%	—
#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%	0.00%	+/-0.00%	15.00%
MI and I/DD–Adults—Indicator #10b	5.96%	9.83%	+3.87%	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%	19.53%	+0.54%	—
MI and I/DD–Adults	27.18%	26.88%	-0.30%	—
#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%	33.64%	+0.51%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 demonstrated increased efforts in improving indicator performance through code optimization. A data logic change was implemented for indicator #2 for members receiving CCBHC services. An emergent questionnaire second date field was added to capture the first request date for individuals who went directly to a CCBHC to request services. The second date field allowed logic within ODIN (EHR) to correctly capture the request date for the CCBHC population and for individuals who did not request services directly through the CCBHC. [**Quality**]

Strength #2: Oakland Community Health Network's reported rate for indicator #4b was 100 percent for both SFY 2022 and SFY 2023, and exceeded the established MPS for both SFY 2022 and SFY 2023, suggesting that all members received timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, the disposition time of one case for indicator #1 was marked as "a.m." when it should have been documented as "p.m." [**Quality**]

Why the weakness exists: An isolated employee error at the provider group led to a staff member incorrectly documenting the pre-admissions screening disposition time using a manual data entry process.

Recommendation: HSAG recommends that **Oakland Community Health Network** require the provider group to deploy additional quality assurance steps to more readily detect and correct employees' manual documentation errors. These mechanisms may include additional audit review of noncompliant cases wherein the disposition time has a different a.m./p.m. designation than the start time.

Weakness #2: During PSV, for indicator #4a, a partial hospitalization service was incorrectly reported in the indicator report module of ODIN as the discharge date for one case. Additionally, the same service was missed as an appropriate follow-up service. [**Quality**]

Why the weakness exists: Oakland Community Health Network identified the error during its review process, resulting in a manual override edit.

Recommendation: While **Oakland Community Health Network** had a review process in place, frequent manual edits may result in discrepancies and a reduction in time efficiency. Therefore, HSAG recommends that **Oakland Community Health Network** ensure that programming code is identifying the correct services for the performance indicator. Additionally, HSAG recommends that **Oakland Community Health Network** continue its review process prior to submitting data to the State.

Weakness #3: During member-level detail file review, HSAG identified blank fields across the performance indicators for the numerator and denominator data. [**Quality**]

Why the weakness exists: Upon reviewing the quality of data for the performance indicators, manually overridden fields for correction led to blank fields when data were extracted for the member-level detail file.

Recommendation: HSAG recommends that **Oakland Community Health Network** employ additional validation steps to the performance indicator review process to ensure all corrected data are captured in the member-level detail file, and that no fields are blank.

Weakness #4: Oakland Community Health Network's reported rates for indicators #1a and #1b decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023.

Why the weakness exists: The reported rates for indicators #1a and #1b decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some children and adults receiving a pre-admission screening for psychiatric inpatient care did not have a timely disposition completed. **Oakland Community Health Network** acknowledged having barriers related to retaining and hiring staff, which has impacted its ability to meet the standard for this indicator.

Recommendation: Although **Oakland Community Health Network** has demonstrated efforts toward improving its indicator #1 rates by offering signing bonuses, employee referral plans, and incentives for late shift applicants, and has been working with PCE to address issues noted with the logic to ensure cases are accurately assessed as compliant, there is still opportunity for improvement. Therefore, HSAG recommends that **Oakland Community Health Network** continue to focus its efforts on increasing timely dispositions and expand upon interventions currently in place.

Compliance Review

Performance Results

Table 3-56 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Oakland Community Health Network**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Oakland Community Health Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-56—SFY 2021 and SFY 2022 Standard Compliance Scores for OCHN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	17	2	0	**89%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	5	2	0	**71%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard IV—Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
Standard V—Coordination and Continuity of Care	14	14	13	1	0	**93%**
Standard VI—Coverage and Authorization of Services	11	11	9	2	0	**82%**
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 XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**184**	**183**	**156**	**27**	**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, 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] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Oakland Community Health Network** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Oakland Community Health Network** was responsible for implementing each action plan in a timely manner. Table 3-57 presents an overview of the results of the SFY 2023 compliance review for **Oakland Community Health Network**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-57—SFY 2023 Summary of CAP Implementation for OCHN

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	2	1	**1**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	2	2	**0**
Standard V—Coordination and Continuity of Care	1	1	**0**
Standard VI—Coverage and Authorization of Services	2	2	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	6	6	**0**
Standard X—Subcontractual Relationships and Delegation	3	3	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	2	2	**0**
Total	**27**	**24**	**3**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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 demonstrated that it successfully remediated 24 of 27 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Oakland Community Health Network** remediated all elements for nine of the 11 standards reviewed: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality,

Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Oakland Community Health Network did not remediate one of the two elements for the Member Rights and Member Information standard. **Oakland Community Health Network** has not included specific accessibility accommodations offered by provider locations in its provider directory. Providing accessibility information is critical, particularly as the number of managed LTSS programs increase. MCEs must present information in the directory with sufficient specificity to be useful to the readers. [**Quality** and **Access**]

Why the weakness exists: While **Oakland Community Health Network** has implemented processes to obtain accessibility accommodations, **Oakland Community Health Network** awaits a cost quote from its website vendor to revise the PIHP's website layout to incorporate the accessibility accommodations data into its online provider directory. However, this requirement was published in May 2016. It is concerning that **Oakland Community Health Network** has yet to make accessibility accommodations available to members through the provider directory seven years after the requirement has been final.

Recommendation: HSAG required **Oakland Community Health Network** to submit an action plan to address these findings. Specifically, HSAG recommended that **Oakland Community Health Network** update its online provider directory functionality to include specific accessibility accommodations for its provider network. Additionally, **Oakland Community Health Network** should continue to strengthen oversight and monitoring of its provider directory to ensure continued remediation and compliance with the Member Rights and Member Information standard requirements.

Weakness #2: Oakland Community Health Network did not remediate the two elements for the Health Information Systems standard. **Oakland Community Health Network** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Oakland Community Health Network** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having provider directory information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Oakland Community Health Network has not implemented all requirements of the Patient Access API, such as developing a member-facing website with educational resources in nontechnical, simple, and easy-to-understand language explaining how members can access their health information via the Patient Access API, including information on how members can protect the privacy and security of their health information. Additionally, **Oakland Community Health Network** has not posted a PIHP-specific digital endpoint on its

website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application.

Recommendation: HSAG continues to recommend that **Oakland Community Health Network** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Oakland Community Health Network** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Oakland Community Health Network** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Encounter Data Validation

Performance Results

Representatives from **Oakland Community Health Network** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Oakland Community Health Network**'s original questionnaire responses, and **Oakland Community Health Network** responded to these specific questions. To support its questionnaire responses, **Oakland Community Health Network** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Oakland Community Health Network** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-58 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-58—EDV Results for OCHN

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Oakland Community Health Network** uses PCE-ODIN as its primary software for claim adjudication and encounter preparations. • **Oakland Community Health Network** identifies duplicate claims based on a list of specific fields. **Oakland Community Health Network** indicated that it follows specific procedures in

Analysis	Key Findings
	submitting denied and adjusted claims. It has established procedures for claim reconsiderations, involving voiding original encounters and submitting corrected data. • **Oakland Community Health Network** manages both provider data collection and processing, along with enrollment data handling.
Payment Structures	• For inpatient encounters, **Oakland Community Health Network** utilizes per diem method for its claim payment strategies, while for outpatient, it uses per diem, capitation, and case rate methods. • **Oakland Community Health Network** indicated that its providers are required to collect ability to pay and other payer information for COB information on claims.
Encounter Data Quality Monitoring	• **Oakland Community Health Network** indicated it edited or made modifications to some of the subcontractor data. • **Oakland Community Health Network** and/or its subcontractors perform a few data quality checks on encounter data collected by subcontractors, including field-level completeness and validity, alignment of payment fields in claims with financial reports, and MRR. • **Oakland Community Health Network** did not offer responses regarding data quality checks performed internally for encounters in their data warehouses, since its CMHSP subcontractors handle the submission of all encounters and conducted the data quality checks.
Administrative Profile	
Encounter Data Completeness	• **Oakland Community Health Network** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Oakland Community Health Network** had a moderate volume of duplicate encounters, with 4.2 percent of professional encounters and 0.1 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Oakland Community Health Network** did not demonstrate timely submission of professional or institutional encounters. For professional encounters, **Oakland Community Health Network** submitted 54.8 percent of encounters to MDHHS within 60 days of payment and submitted 59.0 percent of encounters to MDHHS within 180 days of payment. Within 360 days of payment, **Oakland Community Health Network** submitted 81.3 percent of professional encounters to MDHHS. • For institutional encounters, **Oakland Community Health Network** submitted 1.8 percent of encounters to MDHHS after 60 days of payment. Within 180 days payment, **Oakland**

Analysis	Key Findings
	Community Health Network submitted 14.9 percent of encounters to MDHHS, and within 360 days, **Oakland Community Health Network** submitted 68.6 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Oakland Community Health Network**'s submitted data. For professional encounters, 95.3 percent of populated member IDs were valid, whereas 84.2 percent of populated institutional member IDs were valid. • In **Oakland Community Health Network**'s submitted professional encounters, the billing provider NPI was populated 44.0 percent of the time, and the rendering provider NPI was populated 23.6 percent of the time. • All other data elements in **Oakland Community Health Network**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Oakland Community Health Network**'s submitted data, 90.8 percent were identified in the enrollment data. • Of all identified provider NPIs in **Oakland Community Health Network**'s submitted data, 99.8 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Oakland Community Health Network**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: While MRR can be labor- and resource-intensive process for conducting data quality checks, **Oakland Community Health Network** indicated its usage as a method for assessing its subcontractors' data. The use of this method enhances the reliability, accuracy, and contextual

understanding of its subcontractors' encounter data. This reflects **Oakland Community Health Network**'s commitment to delivering high-quality healthcare data. [**Quality**]

Strength #3: Across all encounters, most key data elements for **Oakland Community Health Network** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Oakland Community Health Network modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Oakland Community Health Network should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: Oakland Community Health Network did not indicate claim volume or timeliness quality checks performed for claims/encounters from its subcontractors' data. [**Quality**]

Why the weakness exists: Claim volume checks are crucial to validating that the submitted data align with the expected volume, helping identify any discrepancies or missing information. Timeliness quality checks ensure that the claims/encounters are submitted within the specified time frames, meeting MDHHS' minimum monthly requirements. The lack of these checks increases the risk of errors, omissions, or delays in data submission, which can impact the reliability and effectiveness of the overall encounter data system.

Recommendation: Oakland Community Health Network should establish or refine either its subcontractors' or its data monitoring reports aimed at assessing the completeness, accuracy, and timeliness of encounter data. By implementing such measures, **Oakland Community Health Network** can enhance the overall quality and reliability of the encounter data that it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.

Weakness #3: Oakland Community Health Network did not submit professional or institutional encounters timely. For professional encounters, **Oakland Community Health Network** submitted 57.1 percent of encounters within 120 days, and within 360 days, submitted 81.3 percent of encounters. For institutional encounters, **Oakland Community Health Network** submitted 5.5 percent of encounters within 120 days, and within 360 days, submitted 68.6 percent of encounters. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Oakland Community Health Network should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.3 percent and 84.2 percent, respectively. Additionally, 90.8 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Oakland Community Health Network**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: Oakland Community Health Network should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

Weakness #5: Although not required to be populated, 44.0 percent and 23.6 percent of professional encounters contained a billing provider NPI and a rendering provider NPI, respectively. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Oakland Community Health Network should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Weakness #6: Oakland Community Health Network had a relatively high percentage of duplicates for professional encounters (4.2 percent). [**Quality**]

Why the weakness exists: Duplicates could be a result of error within the internal process of encounter submission. If duplicates are not properly identified and handled, duplicate encounters can falsely indicate higher utilization of services.

Recommendation: HSAG recommends that **Oakland Community Health Network** examine its internal process of identifying duplicates.

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 3-59 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 3-59—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality, Access, and Timeliness—Oakland Community Health Network** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Oakland Community Health Network** identified that African-American members had a lower percentage of adherence to antidepressant medication for at least 84 days than its White population. **Oakland Community Health Network** determined that the goal of its PIP was 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 of 46.2 percent 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). **Oakland Community Health Network** reported a lack of shared decision-making, among several other barriers, as a barrier to medication adherence. In an effort to achieve the PIP goal and address this barrier, **Oakland Community Health Network** is educating and encouraging providers to use shared decision-making skills to support antidepressant medication adherence. According to an article published by the Cambridge University Press and included in the National Institutes of Health's National Library of Medicine, in instances where multiple options are present and there is no clear best option, such as with antidepressant medications and treatment, shared decision-making is proven to improve adherence, satisfaction, and well-being. Therefore, successful implementation of **Oakland Community Health Network**'s PIP should result in improved outcomes for its members prescribed antidepressant medications. **Oakland Community Health Network** could study the reasons that African-American members do not adhere to their antidepressant medications to determine if barriers are different for African-American members than for other racial groups. If significant differences are noted, **Oakland Community Health Network** could implement specific interventions to address those barriers for the African-American population.
Timely Access to Care and Services	**Quality, Access, and Timeliness—**The PMV activity identified strengths of **Oakland Community Health Network**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a) • All members received timely follow-up care after discharge from a substance abuse detox unit (indicator #4b).

Performance Area	Overall Performance Impact
	• All MI and I/DD children and most MI and I/DD adult members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). Additionally, although there are no MPSs for indicator #3, all rates demonstrated high performance, with results between 97.22 percent and 100 percent, indicating most newly enrolled child and adult PIHP members were able to start medically necessary ongoing covered services within 14 days of completing non-emergency biopsychosocial assessments. Further, through the Access Standards policy, MDHHS has outlined admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Oakland Community Health Network** did not demonstrate a process to actively monitor adherence to all SUD access standards, including admission standards for priority populations. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Oakland Community Health Network** implemented actions to monitor priority population admission standards for SUD treatment. However, while MDHHS has not established MPSs for indicator #2 and indicator #2e, the results of the PMV activity confirmed that **Oakland Community Health Network** has continued opportunities to improve timely completion of biopsychosocial assessments for children and adults with MI and I/DD to ensure they can start medically necessary services more quickly, and continued opportunities to improve the time it takes for members with SUD to receive face-to-face care after requests are made for services.
Network Adequacy	**Access and Timeliness—**MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Oakland Community Health Network** demonstrated that it submitted a network adequacy plan to MDHHS, the plan did not demonstrate that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, **Oakland Community Health Network**'s network adequacy plan did not address MDHHS' required time/distance and member/provider ratio standards, and did not include a procedure to assess timely appointment standards, or language, cultural competency, or physical accessibility. The

Performance Area	Overall Performance Impact
	current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that **Oakland Community Health Network** made efforts to align its analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Oakland Community Health Network** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Oakland Community Health Network**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Oakland Community Health Network** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering follow-up care following discharge from an inpatient psychiatric hospital or SUD detox unit, as **Oakland Community Health Network** met MPSs for all rates under indicators #4a, #4b, and #10. However, **Oakland Community Health Network** demonstrated lower performance for both rates under indicator #1, as they did not meet the MDHHS-established MPSs; most rates under indicator #2, as four of the five rates declined between 3.64 percentage points and 31.59 percentage points from SFY 2022; and the rate for Indicator #2e, as the rate declined more than 10 percentage points from SFY 2022. All rates under indicators #2 and #2e were also below 82 percent (rates ranged from 21.74 percent to 81.71 percent). While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely pre-admission screenings and biopsychosocial assessments, and timely face-to-face SUD services.
Health Information Systems and Technology	**Quality and Access—Oakland Community Health Network** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Oakland Community Health Network** received a *Reportable* indicator designation for all applicable indicators,[3-14] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Oakland Community Health Network** demonstrated it can effectively collect, process, and transmit

[3-14] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

Performance Area	Overall Performance Impact
	encounter data to MDHHS in accordance with MDHHS' expectations for reporting. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Oakland Community Health Network** has not implemented the Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Oakland Community Health Network** suggested that the requirements of the API were not applicable to the PIHP as MDHHS had not put forth a requirement related to the API, **Oakland Community Health Network**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **Oakland Community Health Network** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Oakland Community Health Network** should begin preparing for the development and implementation of these new requirements. Also, as indicated through the EDV activity, **Oakland Community Health Network** has opportunities to further ensure the quality and reliability of its encounter data submissions to MDHHS by conducting more robust quality data checks of its encounter data prior to submitting to MDHHS. Enhancing its current encounter data quality checks will help ensure that the encounter data continues to be reliable for MDHHS to use to effectively monitor the services provided under the Medicaid managed care program.

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 rating (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-60 displays the overall validation rating 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 3-60—Overall Validation Rating for MCCMH

PIP Topic	Validation Rating*	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	*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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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-American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). Table 3-61 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and to address the barriers.

Table 3-61—Barriers and Interventions for MCCMH

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

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 designed a methodologically sound PIP that met State and federal requirements. A methodologically sound design created the foundation for **Macomb County Community Mental Health** to progress to subsequent PIP

stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Macomb County Community Mental Health used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Macomb County Community Mental Health** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and increase the number of African-American members discharged from a psychiatric inpatient unit who are seen for timely follow-up care, **Macomb County Community Mental Health** should identify the barriers of care that are specific to the African-American population and implement interventions that are tailored to the needs of the African-American community to mitigate those identified barriers.

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 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 2023 data were presented to allow identification of opportunities to improve rate accuracy for future reporting only. A *Reportable* designation signifies that **Macomb County Community Mental Health** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Performance Results

Table 3-62 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-62—Performance Measure Results for MCCMH

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	99.01%	-0.99%	95.00%
Adults—Indicator #1b	99.41%	99.01%	-0.40%	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%	15.08%	-17.65%	NA
MI–Adults—Indicator #2b	45.09%	17.09%	-28.00%	NA
I/DD–Children—Indicator #2c	57.78%	17.95%	-39.83%	NA
I/DD–Adults—Indicator #2d	45.16%	23.81%	-21.35%	NA
Total—Indicator #2	42.22%	16.86%	-25.36%	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%	82.52%	-5.04%	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	66.20%	—	NA
MI–Adults—Indicator #3b	DNR	72.40%	—	NA
I/DD–Children—Indicator #3c	DNR	80.68%	—	NA
I/DD–Adults—Indicator #3d	DNR	55.56%	—	NA
Total—Indicator #3	DNR	71.45%	—	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%	51.47%	-1.16%	95.00%
Adults	55.44%	38.93%	-16.51%	95.00%

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	92.88%	-7.12%	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%	4.56%	+0.08%	—
#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%	94.92%	+2.11%	—
#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%	21.71%	+4.50%	—
I/DD–Adults—Indicator #8b	5.03%	5.94%	+0.91%	—
MI and I/DD–Adults—Indicator #8c	6.42%	6.81%	+0.39%	—
#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%	100%	+/-0.00%	—
I/DD–Adults—Indicator #9b	94.17%	94.35%	+0.18%	—
MI and I/DD–Adults—Indicator #9c	93.94%	92.96%	-0.98%	—
#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%	4.23%	-5.77%	15.00%
MI and I/DD–Adults—Indicator #10b	14.83%	15.36%	+0.53%	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%	15.50%	-1.24%	—
MI and I/DD–Adults	22.14%	20.22%	-1.92%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	46.59%	+0.39%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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: While performing its standard monitoring and validation processes throughout 2023, **Macomb County Community Mental Health** identified several data issues and worked proactively with PCE to correct its report logic prior to the 2023 PMV activity. [**Quality**]

Strength #2: Macomb County Community Mental Health acted on all HSAG recommendations from the prior year's PMV activity, which resulted in an improvement in data quality and no evidence during the 2023 PMV activity of the same types of data errors. [**Quality**]

Strength #3: Macomb County Community Mental Health's reported rate for indicator #10a decreased by more than 5 percentage points from SFY 2022 to SFY 2023, demonstrating improvement, as a lower rate indicates better performance for this performance indicator. In addition, indicator #10a exceeded the established MPS for both SFY 2022 and SFY 2023, indicating that there were less readmissions for MI and I/DD children to an inpatient psychiatric unit within 30 days of discharge. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, in four of the five cases reviewed, the member presented for pre-screening at a date and/or time that was considerably different than the date/time reported for the indicator. **Macomb County Community Mental Health** further researched the issue and reported an additional 28 cases in which the member presented for pre-screening at a date and/or time that differed from the date/time reported for indicator #1. Of those 28 cases, three additional cases were found that should have been marked as out of compliance. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** reported that its report logic for indicator #1 was only looking for dates and times of one Certificate of Need (CON) per member per request for pre-screening. However, this logic does not account for scenarios in which a CON is sent back and forth between a hospital and **Macomb County Community Mental Health** prior to disposition. **Macomb County Community Mental Health** indicated that it is updating the report logic to pull from the first date and time a CON is received and the date and time of disposition.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** complete its proposed corrective action for updating the report logic. Additionally, HSAG recommends that **Macomb County Community Mental Health** perform PSV for a statistically significant sample of cases for indicator #1 each quarter to ensure that the corrected report logic prevents the issue from reoccurring.

Weakness #2: During PSV, HSAG noted that one case reported in indicator #3 was for a member in the Omnibus Budget Reconciliation Act (OBRA) program, which should have been excluded from reporting. **Macomb County Community Mental Health** further researched the issue and reported one additional OBRA member categorized as "in-compliance" for indicator #3 that should have been excluded. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** reported that while its report logic for indicator #3 was correctly omitting OBRA members, the logic did not account for the change in provider names made in FOCUS (EHR) for standard cost allocation. **Macomb County Community Mental Health** indicated that it followed up with PCE to update the report logic and that the fix was completed in June 2023.

Recommendation: While **Macomb County Community Mental Health** completed its proposed corrective action by updating the report logic in June 2023, HSAG recommends that **Macomb County Community Mental Health** perform PSV for a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly excluding/omitting OBRA members from the appropriate performance indicators.

Weakness #3: During PSV, HSAG found that report logic for indicator #3 incorrectly identified the first ongoing service for one case. **Macomb County Community Mental Health** further researched the issue and reported an additional 36 members who had incorrect ongoing services identified for indicator #3. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** reported that its report logic for indicator #3 did not exclude services with the "secondary staff type," which resulted in

incorrectly identifying the first ongoing service in one event. **Macomb County Community Mental Health** indicated that it plans to follow up with PCE to update the performance indicator report logic to exclude secondary staff types from all performance indicator events.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** complete its proposed corrective action for updating the report logic. Additionally, HSAG recommends that **Macomb County Community Mental Health** perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting. The validation checks could include performing PSV for a statistically significant sample of cases for indicator #3 each quarter to ensure that report logic is correctly identifying valid ongoing services according to the MDHHS Codebook specifications.

Weakness #4: During PSV, HSAG found that one case reported in indicator #3 was incorrectly excluded from reporting for indicator #3. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** reported that for indicator #3, the report logic incorrectly omitted/excluded a member from reporting due to the member not being recognized as a new member for indicator #2a. This error was due to the report logic looking for both a "triage" and a "screening" instead of having one or the other completed. **Macomb County Community Mental Health** reported that the report logic was updated in May 2023 to correctly recognize a new member as having completed either a triage or a screening.

Recommendation: While **Macomb County Community Mental Health** completed its proposed corrective action by updating the report logic in May 2023 to correctly look for either a "triage call" and/or "assessment/screening" for this indicator, HSAG recommends that **Macomb County Community Mental Health** perform validation checks on a statistically significant sample of omitted records to ensure appropriate members are being included in the performance indicators.

Weakness #5: During PSV, HSAG found that one case reported in indicator #4b was incorrectly reported as "in-compliance" and should have been reported as "out-of-compliance" due to the member not being seen for an appropriate follow-up service within the seven-day time frame. [**Quality**]

Why the weakness exists: **Macomb County Community Mental Health** reported that for indicator #4b, the report logic incorrectly identified an inpatient detox claim that was billed in conjunction with a service code of "S9976" (lodging, per diem) for residential treatment as a compliant follow-up service. **Macomb County Community Mental Health** reported that it plans to follow up with PCE to exclude this service code combination as a compliant follow-up service.

Recommendation: HSAG recommends that **Macomb County Community Mental Health** complete its proposed corrective action for updating the report logic. HSAG also recommends that **Macomb County Community Mental Health** implement additional validation checks to further ensure data accuracy for future reporting periods. This additional level of validation could involve reviewing a statistically significant sample of compliant records listed in the member-level data to ensure appropriate follow-up services are being reported that align with MDHHS Codebook specifications of a valid follow-up service.

Weakness #6: Macomb County Community Mental Health's reported rate for indicator #4b decreased by more than 7 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The reported rate for indicator #4b decreased by more than 7 percentage points from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023, suggesting that some members were not seen for timely follow-up care (i.e., within seven days) following discharge from a substance abuse detox unit.

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

Compliance Review

Performance Results

Table 3-63 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Macomb County Community Mental Health**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Macomb County Community Mental Health** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-63—SFY 2021 and SFY 2022 Standard Compliance Scores for MCCMH

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	7	0	0	**100%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	11	3	0	**79%**
Standard VI—Coverage and Authorization of Services	11	11	8	3	0	**73%**
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	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
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	**184**	**183**	**141**	**42**	**1**	**77%**

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

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Macomb County Community Mental Health** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Macomb County Community Mental Health** was responsible for implementing each action plan in a timely manner. Table 3-64 presents an overview of the results of the SFY 2023 compliance review for **Macomb County Community Mental Health**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-64—SFY 2023 Summary of CAP Implementation for MCCMH

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	3	2	**1**
Standard VI—Coverage and Authorization of Services	3	3	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	2	2	**0**
Standard IX—Grievance and Appeal Systems	4	4	**0**

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard X—Subcontractual Relationships and Delegation	4	4	**0**
Standard XI—Practice Guidelines	3	3	**0**
Standard XII—Health Information Systems[1]	3	1	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	10	8	**2**
Total	**42**	**37**	**5**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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: Macomb County Community Mental Health demonstrated that it successfully remediated 37 of 42 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Macomb County Community Mental Health** remediated all elements for eight of the 11 standards reviewed: Member Rights and Member Information, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Practice Guidelines. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Macomb County Community Mental Health did not remediate two of the three elements for the Health Information Systems standard. **Macomb County Community Mental Health** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and

inform providers to support better health outcomes. Additionally, **Macomb County Community Mental Health** has not made the Provider Directory API publicly accessible in accordance with 42 CFR §431.70. Having this information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: **Macomb County Community Mental Health** did not submit documentation supporting the implementation of the Patient Access and Provider Directory APIs. **Macomb County Community Mental Health** claimed that MDHHS has not put forth a requirement related to the Patient Access API; therefore, there was no requirement to audit the PIHP against. **Macomb County Community Mental Health** also reported that that there is nothing in its contract with MDHHS explicitly related to the Provider Directory API. However, as a Medicaid MCE, **Macomb County Community Mental Health** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Macomb County Community Mental Health** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 and 42 CFR §431.70 beginning January 1, 2021.[3-15]

Recommendation: HSAG continues to recommend that **Macomb County Community Mental Health** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Macomb County Community Mental Health** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Macomb County Community Mental Health** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

Weakness #2: **Macomb County Community Mental Health** did not remediate two of the eight elements for the Quality Assessment and Performance Improvement Program standard, indicating continued gaps in the PIHP's implementation of its QAPI program. QAPI programs provide the foundation for Medicaid MCEs to continually monitor for and identify opportunities for performance improvement with the goal of improving quality of care and member outcomes. [**Quality]**

Why the weakness exists: **Macomb County Community Mental Health** did not demonstrate that its Clinical Risk Management Committee (CRMC) completed a quarterly review and analysis of critical incidents, sentinel events, and risk events data. Additionally, **Macomb County Community Mental Health** did not produce evidence that it notified its provider network of the availability of the PIHP's QAPI program evaluation on its website.

Recommendation: HSAG required **Macomb County Community Mental Health** to submit an action plan to address these findings. Specifically, HSAG recommended that **Macomb County Community**

[3-15] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Mental Health develop quarterly analyses of critical incidents, sentinel events, and risk events that includes both quantitative and qualitative analyses, and document the review of the analyses in its CRMC minutes during which the review was completed. HSAG also recommended that **Macomb County Community Mental Health** update its policy with the process to disseminate information on the effectiveness of the PIHP's QAPI program annually to network providers and to members upon request, and develop plan to disseminate the QAPI program evaluation to network providers.

Encounter Data Validation

Performance Results

Representatives from **Macomb County Community Mental Health** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Macomb County Community Mental Health**'s original questionnaire responses, and **Macomb County Community Mental Health** responded to these specific questions. To support its questionnaire responses, **Macomb County Community Mental Health** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Macomb County Community Mental Health** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-65 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-65—EDV Results for MCCMH

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Macomb County Community Mental Health** uses PCE Systems as its primary software for claim adjudication and encounter preparations. • **Macomb County Community Mental Health**'s EMR system checks for duplicate claims based on a list of fields. **Macomb County Community Mental Health** indicated that it follows specific procedures in submitting denied and adjusted claims. It utilizes a voiding process to nullify erroneous encounters, followed by resubmission of corrected data.

Analysis	Key Findings
	• **Macomb County Community Mental Health** collects and processes its provider data; however, it shares responsibility with its subcontractor in handling the enrollment data.
Payment Structures	• **Macomb County Community Mental Health** utilizes negotiated (flat) rate method for its claim payment strategies for both its inpatient and outpatient encounters. • **Macomb County Community Mental Health** collects TPL information by including COB data on the claims and utilizes a system to track commercial insurance.
Encounter Data Quality Monitoring	• **Macomb County Community Mental Health** does not conduct any reviews of the encounters before submission to MDHHS; however, the PIHP indicated that for data stored its data warehouse or that it collects, these quality checks are performed: EDI compliance edits, field-level completeness and accuracy, timeliness, alignment of payment fields in claims with financial reports, and MRR.
Administrative Profile	
Encounter Data Completeness	• **Macomb County Community Mental Health** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Macomb County Community Mental Health** had a low volume of duplicate encounters, with 1.1 percent of professional encounters and 0.7 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Macomb County Community Mental Health** demonstrated timely submission of professional and institutional encounters. Within 60 days, **Macomb County Community Mental Health** submitted 94.5 percent of professional encounters and 94.2 percent of institutional encounters to MDHHS after the payment date. Within 180 days of payment, **Macomb County Community Mental Health** submitted 98.3 percent of professional encounters and 96.5 percent of institutional encounters to MDHHS.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Macomb County Community Mental Health**'s submitted data. For professional encounters, 95.5 percent of populated member IDs were valid, whereas 91.2 percent of populated institutional member IDs were valid. • All other data elements in **Macomb County Community Mental Health**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **Macomb County Community Mental Health**'s submitted data, 94.6 percent were identified in the enrollment data. • Of all identified provider NPIs in **Macomb County Community Mental Health**'s submitted data, 99.4 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Macomb County Community Mental Health**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Macomb County Community Mental Health has a robust system for monitoring encounter data submissions designed to oversee the accuracy, completeness, and timeliness of encounter data, which includes encounter data submissions from its own data warehouse and directly from its subcontractors. [**Quality**]

Strength #3: While MRR can be labor- and resource-intensive process for conducting data quality checks, **Macomb County Community Mental Health** indicated its usage as a method for assessing its subcontractors' data. The use of this method enhances the reliability, accuracy, and contextual understanding of its subcontractors' encounter data. This reflects **Macomb County Community Mental Health**'s commitment to delivering high-quality healthcare data. [**Quality**]

Strength #4: Macomb County Community Mental Health displayed timely submission of professional and institutional encounters after payment date, and within 60 days, submitted 94.5 percent and 94.2 percent of encounters, respectively. [**Quality** and **Timeliness**]

Strength #5: Across all encounters, most key data elements for **Macomb County Community Mental Health** were populated at high rates, and most data elements were over 98 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 95.5 percent and 91.2 percent, respectively. Additionally, 94.6 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Macomb County Community Mental Health**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: **Macomb County Community Mental Health** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

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 3-66 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 3-66—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality, Access, and Timeliness—Macomb County Community Mental Health** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Macomb County Community Mental Health** identified that African-American members were not seen for follow-up care within seven days of discharge from a psychiatric inpatient unit as frequently as White members. **Macomb County Community Mental Health** determined that the goal of its PIP is there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian), or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). **Macomb County Community Mental Health** reported that, among several other barriers, there is limited appointment availability with directly operated and contract service providers within the time frame. In an effort to achieve the PIP goal and address this barrier, **Macomb County Community Mental**

Performance Area	Overall Performance Impact
	Health is increasing the number of available appointments at **Macomb County Community Mental Health** locations for members discharging from inpatient hospital settings as well as updating EMR calendars to accurately represent available appointments within the network. According to a study funded by the National Institute of Mental Health, timely follow-up after hospitalization for mental illness can reduce the duration of acute mental health episodes and the likelihood that the member will be hospitalized. Therefore, the time between inpatient discharge and outpatient follow-up is considered an important indicator of healthcare quality. Successful implementation of **Macomb County Community Mental Health**'s PIP should demonstrate an improvement in the number of its African-American members receiving timely follow-up care after psychiatric hospitalization. **Macomb County Community Mental Health** should consider studying the potential reasons that African-American/Black members are unable to obtain a timely appointment to determine if barriers are different for African-American/Black members than for other racial groups. If significant differences are noted, **Macomb County Community Mental Health** should implement specific interventions to address those barriers for the African-American/Black population.
Timely Access to Care and Services	**Quality, Access, and Timeliness—**The PMV activity identified strengths of **Macomb County Community Mental Health**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • Most members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most child members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). However, **Macomb County Community Mental Health** demonstrated lower performance for new members starting timely services. For indicator #3, all rates were at or below 80.68 percent. Additionally, fewer new members received a timely biopsychosocial assessment and fewer new members with SUD received a timely face-to-face service for treatment or supports, as all rates for indicator #2 and indicator #2e demonstrated a substantial decline in rates ranging from a decline of 5.04 percentage points to 39.83 percentage points. Further, the rates indicating the percentage of discharges from a psychiatric inpatient unit that resulted in a follow-up care visit within seven days (indicator #4a) did not meet the MDHHS-established MPSs and both rates declined from the prior year, with the rate for adults declining substantially (16.51 percentage points.) While MDHHS has not established MPSs for indicators #2, #2e, and #3, the results of the PMV activity confirmed that **Macomb County Community Mental Health** has continued opportunities to improve timely access to non-emergency behavioral health and SUD care and services.

Performance Area	Overall Performance Impact
Network Adequacy	**Access and Timeliness**—MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Macomb County Community Mental Health** demonstrated that it did not conduct regular, comprehensive annual network adequacy evaluations that included an assessment of the network against MDHHS established time/distance and member/provider ratio standards. Additionally, its network adequacy plan did not include procedures for assessing adequacy against timely appointment standards, or consider the language, cultural competency, or physical accessibility needs of its membership. However, the current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, indicated that **Macomb County Community Mental Health** made efforts to conduct an analysis and align its analysis with MDHHS' standards as all deficiencies for the Assurances of Adequate Capacity and Services program area were remediated. **Macomb County Community Mental Health** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Macomb County Community Mental Health**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Macomb County Community Mental Health** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity demonstrated an adequate network of providers for rendering timely pre-admission screenings for psychiatric inpatient care, as **Macomb County Community Mental Health** met MPSs for all rates under indicator #1. Additionally, a lower percentage of MI and I/DD child members were readmitted to the hospital within 30 days of discharge from an inpatient psychiatric unit as the rate for indicator #10a met the MDHHS-established MPS, suggesting most child members received appropriate and timely follow-up care after discharge. However, **Macomb County Community Mental Health** demonstrated lower performance for rates under indicators #4a, #4b, and #10b, as these rates did not meet the MPSs and demonstrated worsening performance from the prior year, indicating that child and adult members were not being seen timely for follow-up care after a psychiatric inpatient discharge and a high percentage of adult members were having readmissions to the hospital within 30 days after a psychiatric inpatient stay. Additionally, **Macomb County Community Mental Health** demonstrated lower performance for all rates under indicator #2, the rate for indicator #2e, and all rates under indicator #3, as all rates were at or below 82.52 percent (rates ranged from 15.08 percent to 82.52 percent). While various factors could

Performance Area	Overall Performance Impact
	influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely biopsychosocial assessments and MI, I/DD, and SUD services for new members. The presence of network adequacy gaps is also supported by the data gleaned through the PIP activity. One of the primary barriers reported by **Macomb County Community Mental Health** for members receiving timely follow-up care after an inpatient stay for mental illness was limited appointment availability with directly operated and contract service providers. **Macomb County Community Mental Health**'s interventions are focused on increasing the number of available appointments and ensuring EMR systems reflect accurate available appointments. **Macomb County Community Mental Health** should continue these efforts and explore other options for increasing provider capacity to provide timely and medically necessary care to its members.
Health Information Systems and Technology	**Quality and Access—Macomb County Community Mental Health** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Macomb County Community Mental Health** received a *Reportable* indicator designation for all applicable indicators,[3-16] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Macomb County Community Mental Health** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting, and has robust processes to monitor the accuracy, completeness, and timeliness of encounter data submissions, which helps ensure that MDHHS can use the encounter data to effectively monitor the services provided under the Medicaid managed care program. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Macomb County Community Mental Health** has not published its Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). **Macomb County Community Mental Health** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Macomb County Community Mental Health** should begin preparing for the development and implementation of these new requirements.

[3-16] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

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 rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-67 displays the overall validation rating 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 3-67—Overall Validation Rating for Region 10

PIP Topic	Validation Rating*	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 PIP had not progressed to including remeasurement (R1, R2) results during SFY 2023.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PIHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement).

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 3-68 displays the barriers identified through quality improvement and causal/barrier analysis processes, and the interventions initiated by the PIHP to support achievement of the PIP goal and address the barriers.

Table 3-68—Barriers and Interventions for Region 10

Barriers	Interventions
Members are not sufficiently engaged in or committed to the Access screening and referral process.	Created/strengthened caller engagement and commitment during the Access screening.
Members experience lack of transportation	Expanded transportation resources.
Members experience a delay or extended duration between the point of Access screening and the program first contact.	Improved SUD program appointments' scheduling capacity and processes.
Members feel discouraged by the number and range of tasks to complete the program intake.	Supported SUD program intake and service provision innovations.

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 that met State and federal requirements. A methodologically sound design created the foundation for **Region 10 PIHP** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. [**Quality**]

Strength #2: Region 10 PIHP used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritized the identified barriers to improve member outcomes. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Region 10 PIHP** revisit its causal/barrier analysis annually and continue to evaluate interventions to determine the effectiveness of each effort. To reduce the existing disparity and improve the timeliness of Black/African-American members receiving a face-to-face SUD service after request, **Region 10 PIHP** should identify the barriers of care that are specific to the Black/African-American population and implement interventions that are tailored to the needs of the Black/African-American community to mitigate those identified barriers.

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 2023 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 3-69 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. Comparison percentages shaded in green indicate a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023, and percentages shaded in red indicate a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

Table 3-69—Performance Measure Results for Region 10

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	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%	100%	+/-0.00%	95.00%
Adults—Indicator #1b	100%	99.77%	-0.23%	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%	58.48%	-8.32%	NA
MI–Adults—Indicator #2b	51.83%	53.64%	+1.81%	NA
I/DD–Children—Indicator #2c	67.68%	50.00%	-17.68%	NA
I/DD–Adults—Indicator #2d	57.41%	61.64%	+4.23%	NA
Total—Indicator #2	58.64%	54.99%	-3.65%	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%	72.21%	+5.69%	NA

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
#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%	78.59%	-16.60%	NA
MI–Adults—Indicator #3b	88.60%	80.16%	-8.44%	NA
I/DD–Children—Indicator #3c	92.73%	85.82%	-6.91%	NA
I/DD–Adults—Indicator #3d	84.31%	81.97%	-2.34%	NA
Total—Indicator #3	91.25%	80.30%	-10.95%	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%	97.30%	+1.53%	95.00%
Adults	92.65%	94.64%	+1.99%	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%	94.95%	+3.46%	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%	6.82%	+0.16%	—
#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%	96.55%	+5.99%	—
#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%	17.52%	+3.74%	—
I/DD–Adults—Indicator #8b	6.33%	6.63%	+0.30%	—
MI and I/DD–Adults—Indicator #8c	7.58%	8.56%	+0.98%	—
#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%	99.94%	+0.10%	—
I/DD–Adults—Indicator #9b	93.57%	94.07%	+0.50%	—

Performance Indicator	SFY 2022 Rate	SFY 2023 Rate	SFY 2022–SFY 2023 Comparison	Minimum Performance Standard
MI and I/DD–Adults—Indicator #9c	92.59%	94.40%	+1.81%	—
#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%	8.57%	-1.96%	15.00%
MI and I/DD–Adults—Indicator #10b	9.86%	10.62%	+0.76%	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%	16.74%	-0.15%	—
MI and I/DD–Adults	24.40%	24.49%	0.09%	—
#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%	46.36%	-1.02%	—

Indicates that the reported rate met or exceeded the MPS.
Indicates a rate increase of 5 percentage points or more from SFY 2022 to SFY 2023.
Indicates a rate decrease of 5 percentage points or more from SFY 2022 to SFY 2023.

— Indicates that an MPS was not established for this measure indicator.
NA indicates that an MPS was not currently established.
* 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 demonstrated strength in its oversight of its affiliated CMHSPs by continuing to require root cause analyses and CAPs from any CMHSPs for which the performance indicators did not meet the MDHHS MPS. During the monthly Quality Management Committee (QMC) meetings and through the contract monitoring process, **Region 10 PIHP** continued to evaluate any barriers that the CMHSPs have identified as being noncompliant with performance indicator standards and helped build strategies for CMHSPs to meet performance indicator

thresholds. Additionally, data quality reports were distributed to the CMHSPs on an ongoing basis to assist in timely identification of potential data quality issues. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Region 10 PIHP demonstrated efforts in improving timeliness and access to follow-up care after SUD detox discharges (indicator #4b). **Region 10 PIHP**'s performance indicator team, PIHP SUD team, and clinical team consulted with each other with an overall goal of achieving improved SUD follow-up care rates. **Region 10 PIHP** also hired a peer recovery coach as of January 2023 to conduct follow-up calls for individuals who have been referred for SUD treatment and missed their first appointment. In addition, SUD providers are asked to submit appointment detail information to support efforts in identifying and addressing barriers to accessing SUD services. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Region 10 PIHP's reported rate for indicator #4a for the child population increased from SFY 2022 to SFY 2023 and exceeded the established MPS for both SFY 2022 and SFY 2023, demonstrating continuous improvement and suggesting that children discharged from a psychiatric inpatient unit were being seen for timely follow-up care (i.e., within seven days) most of the time. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV with St. Clair County Community Mental Health, it was identified for one indicator #3 case that the medically necessary ongoing covered service date did not match what was reported in the member-level detail file submitted to HSAG. [**Quality**]

Why the weakness exists: It was confirmed by St. Clair County Community Mental Health that this discrepancy was due to an override of the case from "out-of-compliance" to "in-compliance" and manually entering the wrong date.

Recommendation: While St. Clair County Community Mental Health reviewed all remaining cases and confirmed there were no other cases with manual overrides that had incorrect dates entered and no impact on reporting, as the service date was still within the required time frame for indicator #3, HSAG recommends that **Region 10 PIHP** and the CMHSP expand upon their performance indicator validation checks to ensure any manually entered dates as a result of system overrides are reviewed for accuracy.

Compliance Review

Performance Results

Table 3-70 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Region 10 PIHP**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Region 10 PIHP** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 13 standards.

Table 3-70—SFY 2021 and SFY 2022 Standard Compliance Scores for Region 10

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	15	4	0	**79%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	6	1	0	**86%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
Standard V—Coordination and Continuity of Care	14	14	12	2	0	**86%**
Standard VI—Coverage and Authorization of Services	11	11	8	3	0	**73%**
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 XIII—Quality Assessment and Performance Improvement Program	30	30	27	3	0	**90%**
Total	**184**	**183**	**155**	**28**	**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, 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] This standard includes a comprehensive assessment of the PIHP's IS capabilities.

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Region 10 PIHP** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Region 10 PIHP** was responsible for implementing each action plan in a timely manner. Table 3-71 presents an overview of the results of the SFY 2023 compliance review for **Region 10 PIHP**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-71—SFY 2023 Summary of CAP Implementation for Region 10

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	4	4	**0**
Standard III—Availability of Services	1	1	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	2	2	**0**
Standard VI—Coverage and Authorization of Services	3	3	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	5	5	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	3	3	**0**
Total	**28**	**26**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive 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 demonstrated that it successfully remediated 26 of 28 elements, indicating the necessary policies, procedures, and/or interventions were implemented to assure compliance with the requirements under review. Further, **Region 10 PIHP** remediated all elements for nine of the 10 standards reviewed: Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 10 PIHP did not remediate the two elements for the Health Information Systems standard. **Region 10 PIHP** has not implemented the Patient Access API in accordance with all requirements of 42 CFR §431.60; therefore, the PIHP's members are not able to access their health data via the API on their internet-enabled devices (e.g., smartphones). Ensuring that members have simple and easy access, without special effort, to their health information can empower patients to make better decisions and inform providers to support better health outcomes. Additionally, **Region 10 PIHP** has not implemented the Provider Directory API in accordance with all requirements of 42 CFR §431.70. Having this information available through an API facilitates public access to accurate information about which managed care providers are in network and accepting new patients, as well as current contact information for providers. [**Quality** and **Access**]

Why the weakness exists: Region 10 PIHP did not submit documentation supporting the implementation of the Patient Access or Provider Directory APIs. **Region 10 PIHP** also claimed that MDHHS has not put forth a requirement related to the APIs; therefore, there was no requirement to audit the PIHP against. However, as a Medicaid MCE, **Region 10 PIHP** is required to comply with all federal Medicaid managed care requirements. This is further supported by MDHHS' contract with **Region 10 PIHP** that requires the PIHP to comply with all federal rules and regulations. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 beginning January 1, 2021.[3-17]

Recommendation: HSAG continues to recommend that **Region 10 PIHP** thoroughly review the requirements of 42 CFR §431.60, 42 CFR §431.70, and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) requiring Medicaid MCEs to implement the Patient Access and Provider Directory APIs. **Region 10 PIHP** must ensure its APIs meet all federally required provisions and are prominently accessible on its website. Further, HSAG continues to recommend that **Region 10 PIHP** consider proactive ways to solicit developers to register their third-party applications with the PIHP, as the Patient Access API is only functional and useful for members with an available application.

[3-17] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

Encounter Data Validation

Performance Results

Representatives from **Region 10 PIHP** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Region 10 PIHP**'s original questionnaire responses, and **Region 10 PIHP** responded to these specific questions. To support its questionnaire responses, **Region 10 PIHP** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Region 10 PIHP** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-72 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-72—EDV Results for Region 10

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Region 10 PIHP** uses PCE Systems as its primary software for claim adjudication and encounter preparations. • **Region 10 PIHP** identifies duplicate claims based on a list of specific fields. **Region 10 PIHP** indicated that it follows specific procedures in submitting denied and adjusted claims. It utilizes a voiding process to nullify erroneous encounters, followed by resubmission of corrected data. • **Region 10 PIHP** collects providers' demographic data annually and updates it as needed, and shares responsibility with its subcontractor for collecting and maintaining its enrollment data.
Payment Structures	• For inpatient encounters, **Region 10 PIHP** utilizes line-by-line, per diem, and capitation methods for its claim payment strategies, while for outpatient, it uses line-by-line, capitation, and negotiated (flat) rate methods. • **Region 10 PIHP** collects primary insurance information during intake through disclosure, CHAMPS, or TriZetto. Subcontractors are mandated to collect and report primary insurance data.

Analysis	Key Findings
Encounter Data Quality Monitoring	• **Region 10 PIHP** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, including claim volume by submission month; EDI compliance edits; field-level completeness and validity, timeliness, alignment of payment fields in claims with financial reports; and MRR. • For encounter data collected by **Region 10 PIHP**, it conducts similar data quality checks on encounter data collected by subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Region 10 PIHP** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Region 10 PIHP** had a low volume of duplicate encounters, with 2.1 percent of professional encounters and 0.3 percent of institutional encounters identified as duplicative.
Encounter Data Timeliness	• **Region 10 PIHP** demonstrated timely submission for professional encounters. Within 60 days, **Region 10 PIHP** submitted 99.1 percent of professional encounters to MDHHS after the payment date. • **Region 10 PIHP** did not demonstrate timely submission of institutional encounters, with 4.8 percent of institutional encounters submitted to MDHHS within 60 days of the payment date. Within 180 days, **Region 10 PIHP** submitted 12.9 percent of institutional encounters to MDHHS after the payment date, and within 360 days of payment, **Region 10 PIHP** submitted 54.5 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• The member ID field had lower than expected validity rates for both professional and institutional encounters in **Region 10 PIHP**'s submitted data. For professional encounters, 97.9 percent of populated member IDs were valid, whereas 92.9 percent of populated institutional member IDs were valid. • All other data elements in **Region 10 PIHP**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Region 10 PIHP**'s submitted data, 97.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **Region 10 PIHP**'s submitted data, 99.8 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Region 10 PIHP**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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 demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The PIHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Region 10 PIHP has a robust system for monitoring encounter data submissions designed to oversee the accuracy, completeness, and timeliness of encounter data, which includes encounter data submissions from its own data warehouse and directly from its subcontractors. [**Quality**]

Strength #3: While MRR can be labor- and resource-intensive process for conducting data quality checks, **Region 10 PIHP** indicated its usage as a method for assessing its subcontractors' data. The use of this method enhances the reliability, accuracy, and contextual understanding of its subcontractors' encounter data. This reflects **Region 10 PIHP**'s commitment to delivering high-quality healthcare data. [**Quality**]

Strength #4: Region 10 PIHP displayed timely submission of professional encounters after payment date, with 99.1 percent of encounters submitted within 60 days. [**Quality** and **Timeliness**]

Strength #5: Across all encounters, most key data elements for **Region 10 PIHP** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 10 PIHP did not submit institutional encounters timely, where 7.1 percent of institutional encounters were submitted within 120 days of payment, and 54.5 percent of encounters were submitted within 360 days. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Region 10 PIHP should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: The member ID field had lower than expected validity rates in both professional and institutional data, with validity rates of 97.9 percent and 92.9 percent, respectively. Additionally,

97.5 percent of members with a medical encounter were identified in the enrollment file. Combined, these findings suggest that **Region 10 PIHP**'s enrollment data may not be complete. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., enrollment start date or enrollment end date) may be important in subsequent analyses. Additionally, members identified in the encounter file should be enrolled on the date the service occurred.

Recommendation: **Region 10 PIHP** should collaborate with MDHHS to ensure both entities have an accurate and complete database of enrolled members.

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 3-73 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 3-73—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality, Access, and Timeliness—Region 10 PIHP** continued its PIP topic required by MDHHS to focus on disparities within the PIHP's population and address health inequity. **Region 10 PIHP** identified a race/ethnicity disparity between Black/African-American members compared to its White population who received a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs. **Region 10 PIHP** determined the goals of the PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate of 68.1 percent without a decline in performance to the comparison subgroup (White), or achieve clinically or programmatically significant improvement as a result of implemented intervention(s). **Region 10 PIHP** identified several barriers to care including insufficient member engagement in the screening and referral process, lack of transportation, delay in starting initial services, and the complexities of completing program intake. To address these barriers, **Region 10 PIHP** implemented several interventions, including but not limited to, strengthened caller engagement, expanded transportation resources, improved appointment scheduling processes, and supported intake and service provision innovations. According to the Office of Disease Prevention and Health Promotion within its Healthy People 2030 goals, SUD is linked to many health problems and can

Performance Area	Overall Performance Impact
	lead to overdose and death. Interventions to help people with SUD get treatment can reduce related health problems and deaths. Therefore, successful implementation of **Region 10 PIHP**'s PIP should support more timely access to SUD services and improve the health outcomes for its African-American/Black members diagnosed with SUD. **Region 10 PIHP** could conduct a study to identify the reasons that Black/African-American members are unable to obtain a timely face-to-face SUD service and determine if those barriers are different than the barriers experienced by other racial groups. If significant differences are noted, **Region 10 PIHP** should implement interventions tailored to the Black/African-American population to address the specific racial barriers.
Timely Access to Care and Services	**Access, and Timeliness—**The PMV activity identified strengths of **Region 10 PIHP**'s managed care program, as several performance measure indicators met MDHHS' MPS. Notably, during the reporting period: • All child and most adult members received timely pre-admission screenings for inpatient psychiatric care (indicator #1). • Most child members received timely follow-up care after discharge from a psychiatric inpatient unit (indicator #4a). • Most members were not readmitted to an inpatient psychiatric unit within 30 days of discharge (indicator #10). These results suggest that **Region 10 PIHP** and/or its contracted CMHSPs implemented effective transitional care planning for many members who had an inpatient psychiatric or substance use detox admission. **Region 10 PIHP** also rendered pre-admission screening dispositions within three hours for most members who were experiencing symptoms serious enough to warrant evaluation for inpatient care, or were potentially at risk of danger to themselves or others. Additionally, through its Access Standards policy, MDHHS has outlined SUD admission priority standards for each population along with the current interim service requirements. Members who are pregnant or injecting drug users have admission preference over any other member accessing the system and are identified as a priority population. During the SFY 2021 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Region 10 PIHP** did not demonstrate a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for an SUD, which are more stringent than the appointment standards tracked and reported via the MMBPIS. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Availability of Services program area, indicating **Region 10 PIHP**

Performance Area	Overall Performance Impact
	implemented actions to monitor priority population admission standards for SUD treatment. However, through the PMV activity, **Region 10 PIHP** demonstrated worsening performance for indicator #3, as all rates experienced a decline from the prior year (ranging from a decline of 2.34 percentage points to 16.60 percentage points). While MDHHS has not established MPSs for this indicator, the results of the PMV activity confirmed that fewer members are starting timely services, indicating **Region 10 PIHP** has continued opportunities to improve timely access to non-emergency behavioral health care and services.
Network Adequacy	**Access, and Timeliness—**MDHHS established network adequacy standards that reflect services that it deemed most in need of access to increase the health and wellness of Medicaid members served by the PIHPs. During the SFY 2023 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), **Region 10 PIHP** did not demonstrate it had implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document or that it evaluated member-to-provider ratios annually. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies for the Assurances of Adequate Capacity and Services program area, indicating **Region 10 PIHP** implemented actions to evaluate its provider network using the required time/distance standards. **Region 10 PIHP** will be required to participate in a new NAV activity in SFY 2024. The purpose of the activity is to assess and validate the adequacy of **Region 10 PIHP**'s network in accordance with MDHHS' established network adequacy standards. The findings from this activity will provide insight into whether the PIHP maintains a provider network that is sufficient to provide timely and accessible care to Medicaid members across the continuum of services for which the PIHP is responsible. **Region 10 PIHP** must work in collaboration with MDHHS and HSAG throughout the NAV activity and follow all reporting standards and specifications communicated to the PIHP. The PMV activity also demonstrated an adequate network of providers for rendering timely pre-admission screenings for psychiatric inpatient care and timely follow-up care following discharge from an inpatient psychiatric hospital for children, as **Region 10 PIHP** met the MPS for the two rates under indicator #1 and the child population under indicator #4a. Additionally, MI and I/DD children and adults had few readmissions to an inpatient psychiatric unit within 30 days of discharge as indicated by the two rates under indicator #10 meeting MPS, suggesting members discharged from inpatient care were prioritized for follow-up services.

Performance Area	Overall Performance Impact
	However, **Region 10 PIHP** demonstrated lower performance for indicator #2 as rates, which were between 50.00 percent and 61.64 percent, and three of the five rates within indicator #2 (#2a, #2c, and Total) demonstrated a decline from the prior year. Additionally, all rates under indicator #3 declined from the prior year. While various factors could influence lower rates for these indicators, a potential factor could be an inadequate provider network to provide timely biopsychosocial assessments and medically necessary ongoing services for new members.
Health Information Systems and Technology	**Quality and Access—Region 10 PIHP** is required to report on performance indicators in the areas of Access, Adequacy/Appropriateness, Outcomes: Employment, Outcomes: Inpatient Recidivism, and Residence. Through the PMV activity, **Region 10 PIHP** received a *Reportable* indicator designation for all applicable indicators,[3-18] indicating the PIHP maintained an adequate health information system that allowed it to calculate performance measure rates that were accurate based on measure specifications and MDHHS' reporting requirements. Additionally, through the EDV activity, **Region 10 PIHP** demonstrated it can effectively collect, process, and transmit encounter data to MDHHS in accordance with MDHHS' expectations for reporting, and has robust processes to monitor the accuracy, completeness, and timeliness of encounter data submissions, which helps ensure that MDHHS can use the data to effectively monitor the services provided under the Medicaid managed care program. However, the compliance review identified noncompliance within the federal managed care Health Information System program area. **Region 10 PIHP** has not implemented the Patient Access and Provider Directory APIs that meet all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). While **Region 10 PIHP** suggested that the requirements of the API were not applicable to the PIHP as MDHHS has not established standards for the API, **Region 10 PIHP**, being a Medicaid MCE, is required to abide by federal Medicaid managed care regulations and all guidance issued by CMS. **Region 10 PIHP** must ensure it implements all requirements of the APIs described in CMS-9115-F. Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Region 10 PIHP** should begin preparing for the development and implementation of these new requirements.

[3-18] Indicator #2e received an indicator designation of *Not Applicable*, as the PIHPs were not required to report a rate to MDHHS for this indicator. The SFY 2023 data presented in this is report are included to allow identification of opportunities to improve rate accuracy for future reporting only.

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 2022 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 2022 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: • 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.
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 recommended increased causal/barrier analysis to identify barriers to integrated care as well as reassessment post intervention. Potential barriers were identified during a committee meeting. Barriers included incorrect selection of the radio button within the EMR. While this information is available in the BH-TEDS document, the NorthCare BPS Help Guide was updated to better reflect how to complete this section. Information will be brought back to the committee. It was also identified that there may have been an increased amount of coordinated care rather than integrated care. To determine if there has been an increase in coordinated treatment rather than integrated treatment, data was reviewed regarding the number of people in Mental Health treatment, Substance Use Disorder treatment, and those getting both Mental Health and Substance Use Disorder treatment from separate providers. Reviewing data this way shows a decrease in individuals getting only Mental Health or only Substance Use Disorder treatment and an increase in individuals getting treatment at both Mental Health and Substance Use Disorder providers. This implies there has been an increase in coordinated care, although not integrated care.

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): • PIP is in the first year of intervention, and thus far has not shown improvement. Data and updates about the PIP implementation provided in June and "part met" results received in August. Resubmission provided August 22, 2023 (due 9.1.23).
c. Identify any barriers to implementing initiatives: • Staff comfort addressing SUD, staff turnover, ease of use of EMR for SA [substance abuse] assessments.
HSAG Assessment: HSAG has determined that **NorthCare Network** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • Indicator 2/4a: The Performance Indicator (PI) reporting processes document was updated to indicate looking for missing dates for PI [performance indicator] 2 and 4a. • Indicator 1: A request for a change to the electronic medical record (EMR) to not allow 0 time for PI 1 was uploaded. PI data was manually reviewed for any 0-minute preadmission screenings (PAS) along with any under 10 minutes. There were 2 at 0 minutes in FY [fiscal year] 23 Q [quarter] 3. The EMR change request was submitted for implementation as of 8.28.23. • Employment TEDS are being compared to ensure they make sense. BH TEDS has EMR front end edits added where possible to limit nonsense information. Manual reviews were completed in the past when BH-TEDS employment status and salary didn't match. • NorthCare QI [quality improvement] staff are reviewing PI to see if appointments occurred within 7 days post hospitalization when there are multiple admissions, checking to see if there is correlation between 7-day follow up and recidivism. Additionally, NorthCare Data Analyst is comparing average length of stay (ALOS), 7-day follow up, and recidivism to determine trends and correlations. NorthCare is also creating a report to determine if the Individual Plan of Service (IPOS) was reviewed and/or changed within reasonable time following discharge from inpatient psychiatric care. NorthCare has a monthly ES [emergency services] meeting with CMH [Community Mental Health] ES staff and discharge planning is frequently discussed. NorthCare also built a clinical dashboard to show if a progress note was entered within 2 days of inpatient psychiatric admission to monitor discharge planning at a macro level.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA [not applicable]
c. Identify any barriers to implementing initiatives: • At this time the report is not yet created.
HSAG Assessment: HSAG has determined that NorthCare Network fully addressed the prior year's recommendations. NorthCare Network fully addressed the prior year's recommendation for indicator #2 to 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. During the SFY 2023 audit, NorthCare Network indicated that identified quality issues were discussed during its quarterly meetings as well as reviewed quarterly during its review process with the CMHSPs. Additionally, NorthCare Network

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
enhanced its validation process by updating its process document to look for missing dates. No blank biopsychosocial assessment dates or dates outside of 14 days were identified during the SFY 2023 PMV audit. **NorthCare Network** fully addressed the prior year's recommendation for indicator #4a to 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. During the SFY 2023 audit, **NorthCare Network** indicated that identified quality issues were discussed during its quarterly quality meetings, monthly emergency services meetings, as well as reviewed quarterly during its review process with the CMHSPs. Additionally, **NorthCare Network** discussed that seven-day follow-up was a topic of focus during its quarterly meetings and that a lot of its CMHSPs continued to take necessary steps and were diligent in scheduling seven-day follow-up appointments for members, even if the member already had a case management appointment scheduled within seven days. No blank follow-up care dates or compliant cases were identified with follow-up care dates outside of the seven-day criteria during the SFY 2023 PMV audit. **NorthCare Network** fully addressed the prior year's recommendation for indicator #1 to conduct an additional final review of the detailed data for members with zero minutes reported as the elapsed time and explore potential system changes that PCE could implement to assist in preventing inaccurate time of decision data entry in reporting. While this issue was not apparent during the SFY 2023 audit, **NorthCare Network** worked with PCE to make logic changes to implement a warning screen any time the elapsed time is zero minutes. **NorthCare Network** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit. **NorthCare Network** fully addressed the prior year's recommendation to focus its efforts on reducing the number of inpatient psychiatric unit readmissions for MI and I/DD children for indicator #10a. While **NorthCare Network** incorporated several reporting enhancements for monitoring discharges more closely and worked with providers on adequate discharge planning, patient education, coordination of services post-discharge, while also conducting monthly meetings with CMHSP staff where discharge planning was frequently discussed. **NorthCare Network** also demonstrated a significant improvement in indicator #10a performance since the prior year, as the indicator #10a rate decreased by over 15 percentage points from SFY 2022 and exceeded the established MPS for SFY 2023.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
performance of the entity responsible for credentialing (e.g., continued monthly file reviews until full compliance is achieved). • **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. 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).
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):** • Materials were recently submitted in the HSAG Corrective Action Plan Compliance Review. NorthCare met with the region, reviewed credentialing processes, and audited at time of site review.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CMH's are in the middle of their plan of correction. CMH plan of correction are due 9.8.23.
c. Identify any barriers to implementing initiatives: • Timing of site reviews and timelines of plans of correction vs. HSAG reviews.
HSAG Assessment: HSAG has determined that **NorthCare Network** partially addressed the prior year's recommendations. While the responses provided by **NorthCare Network** lacked details, the SFY 2023 compliance review activity confirmed that the PIHP implemented its action plans to address all deficiencies related to the Grievance and Appeal Systems program area. However, the SFY 2023 compliance review activity also confirmed that two elements in the Provider Selection program area did not demonstrate compliance, and **NorthCare Network** was required to submit an updated action plan. As such, HSAG recommends that **NorthCare Network** prioritize efforts to ensure its updated action plan is fully implemented. Additionally, **NorthCare Network** should continue to strengthen oversight and monitoring of the credentialing processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with the Provider Selection requirements.

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: • 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.
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) Quality Improvement team utilizes PDCA (Plan, Do, Check, Act) to discover, analyze, and solve barriers, and manage change. This team meets monthly to review current trends, barriers, actions, and outcomes. The NMRE Opioid Health Home (OHH) team meets with Health Home Partners (HHP) monthly to review progress and challenges. Barriers were reported and/or documented by HHPs and/or reports generated by NMRE team via Health Home Dashboard for claim and enrollment monitoring.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NMRE provided advocacy to MDHHS requesting expansion of positions allowed to provide care coordination, and the expansion was granted. NMRE supported this by providing funding for CHW (Community Health Worker) training allowing providers to have more qualified staff as part of their team. Active efforts are in place to maintain and increase capacity by ensuring financial sustainability. HHPs are not reporting losses and are satisfied with the revenue. Complexity and lack of understanding of the enrollment process are being addressed via scheduled Waiver Support Application (WSA) trainings, NMRE one on one TA [technical assistance] calls, scheduled one on one HHP check-ins, and meetings with MDHHS. NMRE took a lead role in aiding MDHHS in WSA redesign to be more efficient for streamlined enrollment. As of FY [fiscal year] 21 NMRE was able to add 3 new OHH partners.
c. Identify any barriers to implementing initiatives: • Provider Capacity Initiative: Tribal entities have an exceptionally long and complex paneling process. • Post Public Health Emergency Medicaid Redetermination outcomes may affect enrollment numbers.
HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- 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. 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.
- 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. 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.
- 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. 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.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):**

- NMRE has updated processes to note all manual changes/overrides. The NMRE Grant and Treatment Manager has a process to verify all notes and overrides for SUD. The NMRE has also implemented a procedure requiring each CMH review all overrides for Performance Measures and include a note to indicate the reason.
- *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. 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.* This item should not have been included in our review this year as it was previously discussed and settled on between MDHHS, HSAG, and NMRE in 2021. [NMRE staff name redacted] provided all the relevant information from our prior communications on this item to [HSAG auditor name redacted] as part of the PMV follow up which resulted in someone reaching out to MDHHS yet again to verify the information from the previous communication. This resulted in our PMV response including the language in item 7 which reads:

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

8/28/2023-HSAG followed up with MDHSS and the expectation for Region 2 is to report expired counts from providers and not expected to provide the details.

- *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. 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.* MDHHS has implemented validation for these situations and subsequently our systems have been updated to reflect the new error logic provided by MDHHS.

A035	Minimum Wage	ESA1650	Invalid Minimum Wage - Blank not allowed.
		ESA1660	Invalid Minimum Wage - If Service Start Date < 10/01/2017 - Should be 01, 02, 03, 97, or 98.
		ESA1670	Invalid Minimum Wage - IF Service Start Date > 09/30/2017 - Should be 01, 02, or 03.
		ESA1672	Invalid Minimum Wage - If Service Start Date > 09/30/2018 and A033 (Employment Status) is 01 or 02, minimum wage must be 01
		ESA1674	Invalid Minimum Wage - If Service Start Date > 09/30/2018 and < 10/01/2023 and A033 (Employment Status) is 04 and A034 (Detailed not in Competitive, Integrated Workforce) = 62, minimum wage must be 02
		ESA1675	Invalid Minimum Wage - If Service Start Date > 09/30/2023 and A033 (Employment Status) is 04 and A034 (Detailed not in the competitive, integrated labor force) is 62, value must be 01 or 02
		ESA1676	Invalid Minimum Wage - If Service Start Date > 09/30/2018 and A033 (Employment Status) is 03, minimum wage must be 03.
		ESA1678	Invalid Minimum Wage - If Service Start Date > 09/30/2018 and A033 (Employment Status) is 04 with A034 (Detailed not in Competitive, Integrated Workforce) = 01, 02, 03, 04, 60, 61, or 65, minimum wage must be 03.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Improved accuracy.

c. Identify any barriers to implementing initiatives:

- None.

HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** fully addressed the prior year's recommendations.

Northern Michigan Regional Entity fully addressed the prior year's recommendation for indicator #4a to include an extra step in the calculation process to highlight manual changes to assist in determining compliance. During the SFY 2023 audit, **Northern Michigan Regional Entity** noted that it reviewed discharge dates more closely for indicator #4a and that the CMHSPs provided training to their data entry staff. **Northern Michigan Regional Entity** also confirmed that it has since updated its processes to note all manual changes/overrides and is now requiring that each CMHSP review all overrides and include a note to indicate the reason. No further issues were noted related to manually reviewed cases for indicator #4a during the SFY 2023 audit.

Northern Michigan Regional Entity fully addressed the prior year's recommendation for indicator #2e. While the other PIHPs were able to receive and have oversight of the expired request data, MDHHS confirmed during the SFY 2023 audit that **Northern Michigan Regional Entity** was not required to collect and provide member-level information for expired requests since the requests do not come through its system. Since **Northern Michigan Regional Entity**'s systems were set up to allow members to enter through any provider within its network, the requests are routed directly through the provider systems, which is why **Northern Michigan Regional Entity** is unable to provide the member-level detail. Therefore, HSAG considers this recommendation as addressed by the PIHP.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
Northern Michigan Regional Entity fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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). • **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. 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. • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
crosswalk, the PIHP could submit it with the annual QAPI submission to MDHHS to solicit additional collaboration between the PIHP and 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):** • Regarding provider selection, the NMRE implemented a series of educational sessions for both Individual and Organizational credentialing functions (regionally referred to as Credentialing Roundtables), in which all staff in the credentialing functional areas were educated in the MDHHS standard, their contracted requirements, auditing tools and the sharing of best practices. This was received well enough that it was suggested by attendees to be conducted annually. NMRE has also implemented a new organizational annual monitoring tool and improved our practitioner monitoring tool to ensure all measures of the contracted standards are met, and to what degree. The NMRE takes the recommendation of sampling and follow up oversight seriously and will initiate internal discussion regarding this process. • The PIHP's Practice Guideline policy has been updated to reflect a periodic review, update, and adoption of practice guidelines at least annually and/or as the need arises, as well as dissemination of the practice guidelines to all affected members, potential members, and providers are well informed. The PIHP must adopt practice guidelines that are reviewed and updated periodically as appropriate. • In response to HSAG audit findings and in accordance with its Corrective Action Plan (CAP) the NMRE's Quality Assessment and Performance Improvement Program Description, Evaluation, and Workplan was revised and approved by the NMRE Board of Directors on June 28, 2023. The revised QAPIP Description, Evaluation, and Workplan was developed to align with MDHHS' QAPIP [Quality Assessment and Performance Improvement Program] checklist. Although the elements of the checklist have been included, because of the recent implementation of the document, the NMRE has yet to observe trends in service delivery and health outcomes over time. This will be an ongoing goal of the NMRE's QAPI Program.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With regard to provider selection, in Q2 2022, one regional CMHSP was unfamiliar with requirements, was not able to produce required documentation, and full overhaul of their credentialing system was required as a result, including a demo of the new system and new samples. During the same quarter, another CMHSP was not completing applications for recredentialing. By Q2 2023, due to new samples and roundtable sessions, both CMHSPs had remediated their process to nearly full compliance with MDHHS standards. • The PIHP has begun a process where the Practice Guidelines are being reviewed and adopted at the regional Clinical Leadership meetings, Quality and Compliance Oversight Committee (QOC) as well as Provider Network Managers Meetings (PNM), and other committees of interest. Practice guidelines were reviewed and adopted by the interested parties, communication, and copies were disseminated at the PNM meeting, QOC meeting, Customer Service meeting. Copies are posted on PIHP's website. The NMRE will begin sending annual mailing to consumers, providers, and stakeholders including directions to access current Practice guidelines on the NMRE website.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
• Due to staff turnover, the Quality and Compliance Oversight Committee (QOC) is currently being chaired by the NMRE's Clinical Services Director. This staff is also a member of the regional Clinical Leadership Committee. Having a clinical staff at the helm of this committee will allow for a greater focus on health outcomes as a result of QAPIP activities. HEDIS measures are being followed, reviewed, and monitored. High performance has been evidenced by NMRE receiving 100% PBIP.
c. Identify any barriers to implementing initiatives: • Post Public Health Emergency Medicaid Redetermination outcomes may affect Medicaid enrollment numbers affecting outcomes.
HSAG Assessment: HSAG has determined that **Northern Michigan Regional Entity** partially addressed the prior year's recommendations. While the responses provided by **Northern Michigan Regional Entity** generally addressed HSAG's recommendations, the SFY 2023 compliance review activity confirmed that the PIHP implemented its action plans to address all deficiencies related to the Provider Selection program area. However, the SFY 2023 compliance review activity also confirmed that four elements in the Practice Guidelines and Quality Assessment and Performance Improvement program areas did not demonstrate compliance, and **Northern Michigan Regional Entity** was required to submit an updated action plan. As such, HSAG recommends that **Northern Michigan Regional Entity** prioritize efforts to ensure its updated action plans are fully implemented. Additionally, **Northern Michigan Regional Entity** should continue to strengthen oversight and monitoring of the processes completed by the PIHP and/or by its delegates to ensure continued remediation and compliance with Practice Guidelines and Quality Assessment and Performance Improvement program requirements.

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: • 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.
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 order to identify barriers to care and initiate interventions to address said barrier in a timely manner, Lakeshore Regional Entity (LRE) implemented an enhanced Key Driver Diagram (KDD+) tool that includes: – Key Drivers, – Initiation Date, – Responsible Staff, – Interventions by Priority, – Status, – Intervention Type, – Evaluation Process, – Evaluation Results, and – Next Steps. • By utilizing the KDD+, LRE was able to identify interventions to: – Implement a robust FUH Technical Specification for CMHSP reporting to improve FUH data accuracy and availability. – Modify its programming logic in its Key Performance Indicators (KPI) Data Warehouse ensuring FUH race and ethnicity data integrity outside of the MDHHS CC360 Data Warehouse. – Develop a FUH model utilizing its KPI Data Warehouse to predict the MDHHS CC360 Data Warehouse FUH metrics. • Collaborate with Mental Health Plans (MHPs) elevating the visibility of FUH within the CMHSPs and MHPs and developing joint FUH training materials to improve FUH metrics.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LRE identified the following improvements as a result of its implemented interventions: – Enhanced FUH Technical Specification: o LRE staff now spends 60 minutes a week instead of 720 minutes (12 hours) – a 83% efficiency gain in IT [information technology] resource availability, o CMHSP FUH weekly data submissions increased by 67% making FUH more readily available to MHPs for timely follow-up, and o CMHSP average monthly data errors decreased by almost 70%, down to 1.7% error rate.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
– Updated Programming Logic for LRE's KPI Data Warehouse: o Improved race and ethnicity data integrity matching MDHHS CC360 Data Warehouse data more than 95% of the time. – Developed FUH Predictive Model: o LRE continues to analyze its FUH Predictive Model to understand its correlation to MDHHS' CC360 Data Warehouse data. o LRE has sent the FUH Predictive Model to key CMHSPs for feedback. – Collaborated with Mental Health Plans (MHPs): • Improved relationships with MHPs through monthly or quarterly meetings to review FUH data and develop collaborative improvement opportunities.
d. Identify any barriers to implementing initiatives: • Depending on the correlation of LRE's FUH Predictive Model to MDHHS' CC360 Data Warehouse FUH data, LRE may continue to experience barriers in tracking Regional responses to Interventions if LRE has to rely on the MDHHS CC360 Data Warehouse since the FUH data from MDHHS lags six (6) months making it difficult to make rapid changes in interventions that are not positively impacting FUH outcomes.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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. **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. • 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. 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.
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):**

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
• In order to identify "individual user error in documentation of system data" so that errors are readily identified and corrected to avoid potential impact to members and performance indicator data, LRE implemented the following initiatives: – Requires CMHSPs to investigate any MMBPIS cases that meet the following conditions: 1. Request Date equals Assessment Date 2. Request Date equals First Service Date 3. Assessment Date equals First Service Date o CMHSPs must provide commentary in its MMBPIS submission stating the case was fully investigated and explaining why any of these three conditions occurred, such as consumer request. – Deployed programming logic within its EHR that rejects any MMBPIS cases attempting to be uploaded by a CMHSP that meets the following conditions: 1. Assessment Date comes before the Request Date 2. First Service Date comes before the Request Date 3. First Service Date comes before the Assessment Date o CMHSPs must fully investigate any MMBPIS submission rejections and remedy the error prior to resubmission. o LRE tests its EHR quarterly with a "rogue" MMBPIS case file ensuring the programing logic remains intact and operates properly by identifying all cases that match the rejection programming logic. – Through Primary Source Verification (PSV), LRE audits 15-20 MMBPIS cases per CMHSP each quarter to avoid potential negative impact to members and ensure accurate performance indicator data is submitted to MDHHS. Any error found during LRE's PSV must be corrected by the CMHSPs prior to finalization of the MMBPIS data within LRE's EHR. LRE continues to have quarterly meetings, or more frequently if required, discussing rejection rates and PSV findings. • In order to ensure LRE's validation process accounts for discrepancies in member records with discrepant employment and minimum wage BH-TEDS data, LRE deploys BH-TEDS Coding Instructions and utilizes its Power BI Dashboard to analyze full BH-TEDS mental health record counts for accuracy and completeness. LRE meets quarterly with the BH-TEDS workgroup to discuss data and trends.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In the last three quarters, LRE has not found any errors in MMBPIS cases where the Request Date, Assessment Date, or First Service Date is the same. • For FY23, Quarter 3, LRE did not have any MMBPIS case submission rejections related to the following conditions: Assessment Date comes before the Request Date, First Service Date comes before the Request Date, or First Service Date comes before the Assessment Date. • LRE begins its "rogue" MMBPIS case file testing in October with HealthWest slated to upload the first "rogue" test file. • During PSV, LRE continues to find exception assignment errors when nuanced MMBPIS cases present themselves. LRE discusses these nuanced cases during its quarterly MMBPIS meetings and documents the outcome in its MMBPIS Frequently Asked Questions, which is available to all CMHSPs. • For FY23 year to date, LRE can confirm that any consumer with BH-TEDS identifying the consumer as earning less than, equal to, or greater than minimum wage has an employment status of full-time,

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
part-time, Not Applicable – Under 16 years old, Not in Labor Force, or Unknown for this Crisis Event and an acceptable detail for not being in the Labor Force, such as, Enclave, Facility-Based Activities Program, Receiving Services in an Institution, etc. During the FY23 Health Service Advisory Group's (HSAG's) External Quality Review of LRE, HSAG found no discrepant employment and minimum wage BH-TEDS data.
c. Identify any barriers to implementing initiatives: • No barriers have been identified in implementing the MMBPIS and BH-TEDS initiatives.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** fully addressed the prior year's recommendations. **Lakeshore Regional Entity** fully addressed the prior year's recommendation to work closely with its CMHSPs to conduct evaluation of their routine auditing of staff members' data entry. **Lakeshore Regional Entity** implemented various initiatives such as requiring its CMHSPs to review and provide an explanation for cases flagged based on certain conditions, programming logic revisions to capture potential errors, and conducting PSV for a sample of cases per CMHSP quarterly. In addition, during the SFY 2023 audit, **Lakeshore Regional Entity** discussed staffing shortages having less of a negative impact on data accuracy and increased data accuracy as a result of HealthWest using the PCE system. **Lakeshore Regional Entity** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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).
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • LRE developed an internal contracting process to ensure all agreements are reviewed by appropriate parties prior to being executed. LRE's new review process ensures all elements required in 42 CFR

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
§438.230(c)(3)(i-iv) are included in any agreement into which LRE enters with any other party. On September 21, 2022, LRE trained all staff with contract responsibilities on the new review process. • LRE revised its delegation grid and amended its CMHSP subcontractual agreements to more clearly defined CMHSP responsibilities for the performance of delegated functions. LRE reviews the current CMHSP Site Review tools to ensure delegated functions assigned to the CMHSP members are reviewed as part of the ongoing quality monitoring and oversight practices of LRE. LRE reviews and, where appropriate, revises its Site Review Tools. • LRE issues Corrective Action Plans for any CMHSP that underperforms with respect to delegated functions. LRE revised the language around the responsibilities of CMHSP when underperformance with delegated function is noted at any point during the term of the contract.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LRE's Contract Templates comply with 42 CFR §438.230(c)(3)(i-iv). • Region 3's CMHSPs are in possession of the revised Delegation Grid and incorporated in each PIHP-CMHSP Contract. • Current fiscal year to date, LRE has issued two Corrective Action Plans to two CMHSPs who underperformed with respect to delegated functions. • LRE is currently in the process for revising its Site Review tools ensuring compliance with Federal Regulations and Contractual Obligations for the upcoming FY24 CMHSP Site Review Season.
c. Identify any barriers to implementing initiatives: • No barriers have been identified in implementing the Subcontractual Relationship and Delegation initiatives.
HSAG Assessment: HSAG has determined that **Lakeshore Regional Entity** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the two deficiencies under the Subcontractual Relationships and Delegation program area have been remediated.

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: • 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.
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 organized an internal Performance Improvement Project (PIP) workgroup to conduct a causal-barrier analysis. The workgroup gathered input from stakeholders, conducted a literature review, and reviewed SWMBH-specific data to inform the causal-barrier analysis. Through this process, the workgroup identified barriers to health equity in metric FUA-30 [Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30 days]. The workgroup then ranked the identified barriers based on risk and selected the top-ranked barriers as the focal point for initial intervention development.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The following interventions were developed in response to the causal-barrier analysis: – New encounter reporting for Peer Emergency Department (ED) follow up services in Kalamazoo County. – New Peer Emergency Department (ED) follow up program in Van Buren County. – New Health Disparities Grant Coordinator position – Retained MPHI to work with the 8 Community Mental Health Service Providers (CMHSPs) to implement health equity initiatives. – Implemented a regionwide anti-stigma marketing campaign.
c. Identify any barriers to implementing initiatives: • The Health Disparities Grant Coordinator position has recently been filled; however, recruitment took longer than expected. All interventions are progressing steadily since hire. It is maintained that true impact in terms of reducing stigma and decreasing provider biases will require a variety of sustained efforts over time.
HSAG Assessment: HSAG has determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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). 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. • 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. 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. • 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. 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. • 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. 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • Indicator #2 – SWMBH implemented an updated MMBPIS reporting template in October 2022 with additional conditional formatting to easily identify events with outcomes containing negative numbers. SWMBH also worked with Integrated Services of Kalamazoo (ISK) to update their EHR code and ensure assessment dates do not pre-date the request for service dates. • Indicator #4b – In July 2022, SWMBH further modified the Tableau report to ensure non-Medicaid members are not included in the final Indicator 4b data. SWMBH QAPI department also verifies eligibility for a sample of Indicator 4b events every quarter for further data validation. • Indicator #10 – SWMBH implemented an updated MMBPIS reporting template in October 2022 with enhanced formulas to ensure both "Y" and "Yes" responses are captured correctly. Instructions are routinely

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
reviewed during SWMBHs regional Quality Management Committee meetings and will also be included in a MMBPIS PPT training to be finalized by 12/31/23. • BH Teds – In early FY23, SWMBH implemented additional enhancements to the validation process for BH TEDS capturing employment and minimum wage values. Prompts that assist the provider with choosing the correct value based on employment status were also added. SWMBH also maintains a BH TEDS presentation that is utilized for onboarding SUD providers or give further feedback to providers experiencing issues with TEDS as well.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • While regional indicator 4b outcomes slightly dipped in the first quarter of FY23, SWMBH notes an overall improvement. Tableau report coding changes and increased validation of qualifying cases for this indicator have been implemented with success. Template revisions resulted in decreased time spent doing manual auditing of the data for both the CMHSPs and the PIHP.
c. Identify any barriers to implementing initiatives: • No identified barriers for the performance indicator findings. Should any discrepant employment data in BH TEDS records be identified in future PMV reviews, SWMBH requests the member event IDs to make all necessary remediation with the CMHSPs and providers.
HSAG Assessment: HSAG has determined that **Southwest Michigan Behavioral Health** fully addressed the prior year's recommendations. **Southwest Michigan Behavioral Health** fully addressed the prior year's recommendation for indicator #2 to work with a CMHSP to complete updates to programming code to ensure that historical dates prior to the service request are not used for reporting. During the SFY 2023 virtual review, **Southwest Michigan Behavioral Health** reported that the CMHSP converted to a PCE EHR, which provided a number of front-end validations during data entry at the point of care as well as validations when creating file extracts for reporting to **Southwest Michigan Behavioral Health**. Programming logic was developed with PCE and thoroughly tested and vetted by both CMHSP and PCE staff prior to implementation. No further related issues were identified during the SFY 2023 PMV audit. **Southwest Michigan Behavioral Health** fully addressed the prior year's recommendation for indicator #4b to 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. During the SFY 2023 virtual review, **Southwest Michigan Behavioral Health** reported reviewing a larger sample of the raw data at least quarterly as an extra validation step and adjusting its source code to ensure the correct populations are included in each indicator. Additionally, **Southwest Michigan Behavioral Health** added conditional formatting to the reporting template to quickly point out date issues (e.g., service date before request date). No further related issues were identified during the SFY 2023 PMV audit. **Southwest Michigan Behavioral Health** fully addressed the prior year's recommendation for indicator #10 to update the formulas in the reporting template to be inclusive of both "Yes/Y" to ensure accurate reporting and remind CMHSPs of the template instructions and requirements for each column. During the SFY 2023 virtual review, **Southwest Michigan Behavioral Health** reported evaluating the process for checking the

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
completeness and accuracy of the reporting template during committee meetings with the CMHSPs. **Southwest Michigan Behavioral Health** also reported that it resolved the formula issues in the reporting template and updated the validation process to ensure a more comprehensive review. No further related issues were identified during the SFY 2023 PMV audit. **Southwest Michigan Behavioral Health** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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). • **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. 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.
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):** • Provider Selection: – In March 2023, SWMBH held a training for CMH staff who perform delegated credentialing functions, which included specific citations from HSAG and remediation requirements.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
– In April 2023, SWMBH completed the annual CMH Site Review process. As part of this process, SWMBH enhanced the Credentialing File Review Tool. Enhancements included pulling separate samples for initial credentialing and recredentialing (previously only a single sample inclusive of initial and recredentialing files was pulled) and modifying the tool to mirror the HSAG Provider Selection standards/elements. – Another credentialing training is scheduled for October 19, 2023, to be delivered at the Regional Provider Network Management Committee meeting. – SWMBH is evaluating the impact and resource requirements of moving from an annual credentialing file review to a quarterly credentialing file review. This type of a frequency change was implemented for two other delegated functions beginning in FY23 Q3 and is currently being evaluated before moving other delegated functions to this schedule. • QAPI: – SWMBH conducted a comprehensive review of all HSAG and MDHHS requirements around PIHP QAPI program descriptions, workplans and evaluations. This resulted in multiple updates that were included in SWMBH's FY23 annual submission. – SWMBH will complete a crosswalk of each individual QAPI provision in the MDHHS/PIHP contract to include with its next annual QAPI submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • <u>Provider Selection:</u> – The initiatives described above met HSAG requirements during the HSAG CAP Monitoring review that was completed in August 2023. • <u>QAPI:</u> – The FY23 annual QAPI submission met HSAG and MDHHS requirements during the HSAG CAP Monitoring review that was completed in August 2023. – Currently working on the crosswalk of contractual requirements. Any identified gaps will be analyzed and addressed by the QAPI department. The crosswalk will be included in the FY24 annual submission.
• Identify any barriers to implementing initiatives: • <u>Provider Selection:</u> – SWMBH has not identified any barriers to implementing initiatives, but has identified a continuing lack of understanding and/or awareness of the delegated credentialing requirements even after implementing the initiatives and is working to remediate those through additional education and potentially changing the frequency of file reviews. • <u>QAPI:</u> – SWMBH has not identified any barriers to implementing these initiatives.
HSAG Assessment: HSAG has determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the 14 deficiencies under the Provider Selection and Quality Assessment and Performance Improvement program areas have been remediated.

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, 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.
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):** • Mid-State Health Network chose the topic Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population. A causal factor analysis was completed using the Fishbone Diagram. Interventions were identified, prioritized, and assigned with timelines to address barriers allowing impact to occur for the first remeasurement period.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable. This will be evaluated following the CY 2023 data analysis.
c. Identify any barriers to implementing initiatives: • None noted at this time.
HSAG Assessment: HSAG has determined that **Mid-State Health Network** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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). 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. • 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. 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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
check of any records that show as compliant in the BH-TEDS record but do not have a corresponding encounter for the same date. • 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. 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. • 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. 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. • 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. 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*.
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 Recommendation 1 (Indicator 2): Mid-State Health Network implemented a validation process to include a requirement that the date of request be prior to the date of assessment and the date of assessment prior to the date of service. Records that do not pass validation are rejected and reviewed by the relevant Community Mental Health Services Programs (CMHSP) prior to resubmission. • HSAG Recommendation 2 and 3 (Indicators 3, 4a, and 10): The affected CMHSPs reviewed and modified programming logic to ensure submission of records consistent with the specifications within the Michigan's Mission-Based Performance Indicator System Codebook. Mid-State Health Network completes primary source verification prior to submission of affected CMHSPs to ensure programming changes were effective in addressing the issues related to the dispositions of "In Compliance", "Out of Compliance", and "Exception". • HSAG Recommendation 4 (BH-TEDS data): MDHHS has implemented validations to address discrepant data. Mid-State Health Network runs a report to identify illogical combinations. No new records have demonstrated a discrepancy. This report process continues to be monitored during the delegated managed care reviews. • HSAG Recommendation 5 (Timeliness): Mid-State Health Network continues to require corrective action for those providers that are below the standard. This includes the identification of barriers and

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
development of interventions to improve timeliness of appointments. Specific interventions include the following: Provide training on access requirements, and coordination process including the assurance that appropriate releases are in place for community treatment. Review each case for any process variation and develop appropriate action steps. Development of processes to ensure coverage is available for hospital discharge appointments in the event of an unexpected staff absence, and a process for discharge planning with internal staff and hospital.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through primary source verification of member level detail Mid-State Health Network has been able to identify any programmatic issues and improve the accuracy of the records supporting the Michigan's Mission-Based Performance Indicator System submission to MDHHS. • Mid-State Health Network initiatives have demonstrated and continue to demonstrate overall improvement for Indicator 4a-Adults.
c. Identify any barriers to implementing initiatives: • No barriers to implementing interventions have been identified.
HSAG Assessment: HSAG has determined that **Mid-State Health Network** fully addressed the prior year's recommendations. **Mid-State Health Network** fully addressed the prior year's recommendation for indicator #2 to 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. During the SFY 2023 audit, **Mid-State Health Network** indicated that a CAP had been issued and that it had been monitoring this specific indicator. **Mid-State Health Network** also incorporated additional validations to check for any assessment dates that occurred prior to service request dates, and the CMHSPs added validations to the login within their systems as well. **Mid-State Health Network** reviewed the validations and the outcome of CMHSP monitoring during the annual reviews, verified that no issues existed, and had proceeded with a process to efficiently close old records. No further related issues were identified during the SFY 2023 PMV audit. **Mid-State Health Network** fully addressed the prior year's recommendation for indicator #3 to ensure that programming code for all delegated CMHSPs is not identifying no-show appointments as a compliant record for the performance indicator and 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. During the SFY 2023 audit, **Mid-State Health Network** indicated that a CAP had been issued and that it had been monitoring this specific indicator. **Mid-State Health Network** also discussed programming changes that were made to address inconsistencies in the methodology for **Mid-State Health Network** exceptions and no-shows by those CMHSPs identified during the previous review. Additional validations were added for indicator #3 to require the appropriate sequence of events, such as the assessment must be prior to the first service. **Mid-State Health Network** reviewed the validations and the outcome of CMHSP monitoring during the annual reviews, verified no issues existed, and proceeded with a process to efficiently close old records. No further related issues were identified during the SFY 2023 PMV audit. **Mid-State Health Network** fully addressed the prior year's recommendation for indicators #4a and #10 to ensure that all delegated CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator and ensure that all delegates are interpreting the scenarios

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
consistently and in accordance with the specifications. During the SFY 2023 audit, **Mid-State Health Network** indicated that a CAP had been issued and that it had been monitoring these specific indicators. **Mid-State Health Network** discussed programming changes that were made to address inconsistencies and that these and similar issues were discussed during the quarterly Quality Improvement Committee meetings. No further related issues were identified during the SFY 2023 PMV audit. **Mid-State Health Network** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit. **Mid-State Health Network** fully addressed the prior year's recommendation for indicator #4a for the adult population. **Mid-State Health Network** employed corrective action, identified barriers, and developed interventions for those providers that fell below the standard, in addition to implementing processes to ensure coverage for hospital discharge appointments and discharge planning with internal and hospital staff. **Mid-State Health Network**'s initiatives have resulted in overall improvement as the reported rate increased from SFY 2022 to SFY 2023 and exceeded the established MPS for SFY 2023.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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).
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):** • Mid-State Health Network has modified policies and procedures to reflect changes in recent MDHHS policy updates. Mid-State Health Network has implemented a new Credentialing Reporting and Monitoring procedure which includes increased reporting and monitoring for providers below 90% compliance. Mid-State Health Network has participated in the development and subsequent piloting of the MDHHS Universal Credentialing program expected to be implemented FY24.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable.
c. Identify any barriers to implementing initiatives: • None.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG has determined that **Mid-State Health Network** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the four deficiencies under the Provider Selection program area have been remediated.

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: • 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.
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):** • Causal/barrier analysis methods were used by CMHPSM to identify barriers and initiate interventions for the current PIP in both FY22 and FY23. For the causal/barrier analysis process, each CMHSP gathered feedback from persons served, consumer advisory groups and key stakeholders in their community on the barriers people experience in accessing and attending the initial BPS in general. Feedback was sought specific to the experiences and concerns of individuals experiencing racial disparities. The Regional CPT [Clinical Performance Team] Committee reviewed this feedback through fishbone diagram analysis and conducted a prioritization of the barriers. Using the prioritization criteria and consensus as the foundations for decision making, each CMHSP proposed the interventions they would pursue based on local needs and barriers, using QI tools recommended/acquired through HSAG QI consultation/trainings. Where barriers were the same or similar and where possible, partners sought to create the same interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Intervention initiatives identified through this process resulted in interventions more relevant to local needs, and the ability to track interventions more clearly in the EHR. The above update/revision to CMHPSM's causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers was included in the FY23 PIP submission with no findings.
c. Identify any barriers to implementing initiatives: • Barriers have included needed revisions/training in how the interventions are documented in the EHR for more accurate data analysis, and creating structure in the EHR to prevent inaccurate omissions of intervention data.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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. 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. • 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. 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. • 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. 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*.
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):** • PSV (SUD Cases): CMHPSM conducted closer analysis of data reporting and documentation for Indicator #4b and continued this into FY23. • BH-TEDS: CMHPSM developed a specific regional work group and work plan with the CMHSPs to employ additional enhancements to their BH-TEDS validation process to ensure no discrepant data is entered. • MMBPIS Indicator #4a: CMHPSM through Regional CPT required and oversaw CMH corrective action plans of this indicator.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
• PSV (SUD Cases): CMHPSM FY23 data shows improvements thus far from QI at 95.73% to Q2 at 98.5% • BH-TEDS: Most recent BHTEDS data from the state show CMHPSM exceeding the 95% threshold for all BHTEDS data/encounter reporting (MH [mental health], Crisis, SUD) • MMBPIS Indicator #4a: CMHPSM improvement efforts showed improvement in FY23 from QI at 94.44%.to Q2 at 97.83%.
c. Identify any barriers to implementing initiatives: • PSV (SUD Cases): None • BH-TEDS: None related to the improvement plan; more generally related to staff turnover and training of new staff. • MMBPIS Indicator #4a: None on a regional level. Barriers more related to low denominator values and case-specific clinical matters.
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 2023 PMV audit confirmed continued opportunities for improvement in some areas. **Community Mental Health Partnership of Southeast Michigan** fully addressed the prior year's recommendation for indicator #4b to require the CMHSP to deploy additional quality assurance steps to more readily detect and correct employees' manual documentation errors. During the SFY 2023 audit, **Community Mental Health Partnership of Southeast Michigan** shared that, excluding this isolated error, it had not identified this type of override. However, **Community Mental Health Partnership of Southeast Michigan** indicated that it worked with SUD providers on being more responsive and addressing matters more proactively. Additionally, provider education was ongoing, and education was provided in this particular case. No further related issues were identified during the SFY 2023 PMV audit. **Community Mental Health Partnership of Southeast Michigan** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit. While **Community Mental Health Partnership of Southeast Michigan** put forth effort toward improving its follow-up rate for indicator #4a for the child population, and the rate increased by more than 4 percentage points for SFY 2023, the rate fell slightly below the established MPS. As such, HSAG recommends **Community Mental Health Partnership of Southeast Michigan** continue its improvement efforts and monitoring of discharges within the critical seven-day post-discharge time frame.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. While **Community Mental Health Partnership of Southeast Michigan** was required to develop a CAP, HSAG recommends that the PIHP

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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). • **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. 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). • **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. While **Community Mental Health Partnership of Southeast Michigan** h 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.
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):** • Provider Selection: Findings were related primarily to professional CMH staff directed employed by CMHs, and some LIP [licensed independent practitioners] cases. CMHPSM retrained staff conducting LIP credentialing and made policy updates. For CMH employee-related matters, CMHPSM created a workgroup and developed training materials and policy revisions to ensure the reporting and review of staff. CMHPSM then created monitoring tools for credentialing and conducted a random sample

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
review of all credentialing cases during FY23 Quarter II as a baseline, with a second review of FY23 Quarter IV to be conducted. • Grievance and Appeal Systems: CMHPSM developed and implemented a grievance procedure and an appeals procedure, and retrained staff entering data in the EHR grievance and appeals module to ensure all staff were using the module consistently and correctly. The procedures also included ensuring all requirements of both the grievance and appeals requirements were followed, developed monitoring tools specific to these procedures/standards, and conducted monitoring of post training. Monitoring began in FY23 and will continue at least twice per fiscal year with data analysis reported as part of QAPIP oversight. • QAPIP: CMHPSM conducted the recommended analysis and made significant revisions in the FY23 QAPIP Plan and the FY22 QAPIP Evaluation, including the recommended analysis, and incorporated a work plan and reporting and monitoring structure based on that work plan.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Provider Selection: CMH professional employees were included in FY23 credentialing reporting to MDHHS and will continue for subsequent reporting. Baseline monitoring showed a marked improvement in compliance with credentialing cases for LIP and organizations. The next review will provide data on whether improvements are seen with CMH professional employee data as this was an initial baseline review of these cases. This was noted as an area on improvement in the FY23 EQR CAP review. • Grievance and Appeals Systems: The baseline monitoring showed a marked improvement in compliance and notable improvements in the FY23 EQR CAP review. • QAPIP: The CMHPSM received full compliance in the state review of the FY23 QAPIP Plan and FY22 QAPIP Evaluation submitted for FY23.
c. Identify any barriers to implementing initiatives: • Provider Selection: None within the region. Some discrepancies in state standards with CMH professional employees and how data reporting is to be operationalized with the state reporting system. • Grievance and Appeals Systems: None • QAPIP: None
HSAG Assessment: HSAG has determined that **Community Mental Health Partnership of Southeast Michigan** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the 21 deficiencies under the Provider Selection, Grievance and Appeal Systems, and Quality Assessment and Performance Improvement program areas have been remediated.

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: • 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.
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 Improvement Team had internal meetings to identify barriers to care and initiate interventions to address barriers timely. The internal meetings were held with DWIHN's Utilization Management Team, DWIHN's Crisis and Access Team, DWIHN's Access Center team, DWIHN's Integrated Health Care Team, DWIHN's Customer Service Team, DWIHN's Children's Team, DWIHN's Finance Team, Medical Director, and Clinical Officers. • The Performance Improvement topic (Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7 Days of Discharge from Psychiatric Inpatient Unit) was presented at DWIHN's Improving Practices Leadership Team Meeting on May 2022 for brainstorming with providers and the identified QI team members to address and develop interventions and improvement strategies. DWIHN will continue interdepartmental and CRSP brainstorming meetings as well as implementing the use of the Fishbone Diagram for the identification of the cause/effect of identified barriers. The QI tools will be used to identify and prioritize barriers to care and interventions during FY 2023-2024.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The data reveals a disparity gap between the percentage of African American (AA) members compared to white members who received follow-up care within 7 days of discharge from a psychiatric inpatient unit. Following the analysis of the baseline data, DWIHN initiated general Interventions to improve compliance with 7-day discharge appointments after psychiatric admissions. No improvements have been noted for Calendar Year 2022. Based on the observation and analysis from the preliminary data targeted interventions for AA members have been implemented.
c. Identify any barriers to implementing initiatives: • Social Determents- Greater needs, lack of transportation, internet, childcare, employment • Difficulty getting an appointment within required Timeframes- Staff shortages • Lack of care coordination between Hospital, Call Center, and Outpatient CRSPs • Failure to engage members- no shows, cancelations, rescheduling and refusal of appointments • Inpatient Hospital and Outpatient CRSPs lack of knowledge of the racial disparity • Member's view on importance of appointment- stigma

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 used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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. 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. • 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 [the PIHP's health information system] system for cases #4 and #5 after the members no showed for their appointments within 14 days of request of service. 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. • 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. 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.
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 Crisis Services Department has initiated a pre-admission review amendment process, so that if a change in disposition has been made, a separate document is completed to ensure dates and times are accurate within the process for performance indicator reporting PI #1. DWIHN has also conducted training with the screening entities to review the importance of accuracy in reporting while undergoing

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
crisis screenings via the pre-admission screening review process. The Crisis Services Department has collaborated with DWIHN's Information Technology Department to ensure that subsequent reevaluation of members does not affect the original date and time. The Crisis Services Department also conducts regular quality checks no less than twice per month to monitor and review cases that might appear to have anomalies. • DWIHN focused on three (3) initiatives based on HSAG's recommendations for PI#2a. – Throughout the year, the Quality Improvement department regularly reminded (Clinically Responsible Service Provider) CRSP Quality staff and leaders to ensure staff are documenting outreach attempts occur to members who miss appointments. This was discussed in several types of meetings including the 30–45-day CRSP meetings. DWIHN's outreach policy also changed this year from three (3) different outreach attempts to five (5). – DWIHN's Quality Improvement Monitoring team began auditing providers in 2023. The audit tool reviewed five randomized cases for each indicator to see if documentation for follow-up with a member within the 14-day window shows evidence of trying to meet MDHHS specifications for the indicator PI#2a. – Also, DWIHN has met with its electronic medical records vendor (PCE) regarding ways to have automated transfers of data and notes from CRSPs systems to DWIHN's MHWIN. This turned out to be much more of a complicated process than expected. Discussions continue with PCE to develop a streamlined process. • DWIHN has identified the following improvement efforts to ensure better outcomes for PI# 4a. – Implemented 30–45-day CRSP's Meetings to address and improve the timeliness of follow-up care provided to adults after discharge from a psychiatric inpatient unit. – During the 30–45-day meetings with the CRSPs, the use of Telemedicine as an option is discussed, only if agreeable and beneficial for the member. This initiative could assist with the improvement efforts related to follow-up care after hospitalization. – Share provider data through DWIHN's Quality Meetings – The providers have the ability to review and analyze their performance indicator data. – Continue to have Performance Indicator Workgroup meetings with DWIHN's provider network.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Crisis Services Department has implemented the process of reviewing and analyzing any anomalies in this area for PI#1. Reviews and quality checks have eliminated the issue of not correctly capturing data related to the pre-admission screening process. • Through the quality improvement monitoring process, the quality team has been able to demonstrate that providers are documenting follow-up attempts pursuant to DWIHN's Reengagement and CRSP Closure policy. • DWIHN has noted performance improvement for PI# 4a (Adults) as a result of initiatives implemented: – Q2 FY 2022 (95.94%) – Q3 FY 2022 (96.81%) – Q4 FY 2022 (98.11%) – Q1 FY 2023 (98.14%)

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
– Q2 FY 2023 (98.16%)
c. Identify any barriers to implementing initiatives: • No barriers identified for PI# 1 with the implementation of the noted initiatives. • The major barrier for PI#2a and documentation is the lack of continuity with each electronic medical health records of the PIHP and each of its providers. DWIHN is one of the largest networks in the state and each provider has its own systems/processes/procedures. • No barriers identified for PI#4a (Adults) with the implementation of the noted initiatives.
HSAG Assessment: HSAG has determined that **Detroit Wayne Integrated Health Network** fully addressed the prior year's recommendations. **Detroit Wayne Integrated Health Network** fully addressed the prior year's recommendation for indicator #1 to provide training to its providers to ensure they understand the process and procedures of correctly capturing data related to the pre-admission screening and review cases that might appear to be anomalies as a quality check. During the SFY 2023 audit, **Detroit Wayne Integrated Health Network** indicated that it had worked with providers on the data and processes surrounding indicator #1. A pre-admission review amendment is now being used, which allows providers to make updates without changing the original disposition date and time. No further related issues were identified during the SFY 2023 PMV audit. **Detroit Wayne Integrated Health Network** fully addressed the prior year's recommendation for indicator #2 to 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. During the SFY 2023 audit, **Detroit Wayne Integrated Health Network** discussed that it had implemented an audit tool for indicators #2, #3, and #4 to ensure that providers are conducting outreach. **Detroit Wayne Integrated Health Network** also updated its policy for provider outreach to reflect that five outreach attempts using different methods of outreach should be conducted for all members. Previously the policy reflected a requirement of three outreach attempts. Provider outreach was also discussed during monthly meetings. **Detroit Wayne Integrated Health Network** fully addressed the prior year's recommendation for indicator #4a for the adult population, as the reported rate for indicator #4a for the adult population increased from SFY 2022 to SFY 2023 and exceeded the established MPS for SFY 2023.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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).
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):** • As part of a comprehensive review process, DWIHN's Credentialing staff are assigned random credentialing files that are deemed clean by the Credentialing Verification Organization (CVO). Each file has a Verified Profile which is a summary of primary source activities. Credentialing staff review 100% of the profiles that are assigned to them to determine timelines of primary source verification. In addition, 10% of the clean files are validated to ensure that the elements on the verified profiles are compliant. Files that have timeliness issues or are mislabeled as Recredentialing when they are a Credentialing file are returned to the CVO for reprocessing. A spreadsheet of the returned files is created for tracking and monitoring.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Since April 2023, monitoring of credentialing files has resulted in a significant decrease in files being approved that has not met the 90-day timeline which starts with the completed credentialing application and concludes with the date of the practitioner/provider notification. This requirement complies with MDHHS credentialing standards.
c. Identify any barriers to implementing initiatives: • There were no identified barriers during the implementation of the noted initiatives.
HSAG Assessment: HSAG has determined that **Detroit Wayne Integrated Health Network** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the four deficiencies under the Provider Selection program area have been remediated.

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: • 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
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):** • New Strategies for Improvement: – Improve health literacy knowledge of members and Network staff through education on depression, screening, evidence-based practices, adherence strategies, and supportive intervention. – Work with Genoa pharmacy on Network education on integrative pharmacy services and adherence strategies to support psychotropic medication adherence, including the use of antidepressants. – Improve medication adherence through encouraging delivery medication services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Although FY22 was not a measurement year, the rate for African American/Black adult members who maintained antidepressant medication management for 84 days (12 days) improved by 11.3%, reducing the disparity. There was a -1.55% disparity change noted from 2021 to 2022.
c. Identify any barriers to implementing initiatives: • All barriers identified in the FY21 Performance Improvement Plan (PIP) still exist. New barriers and strategies were identified for FY23. – Need for health literacy knowledge of members and Network staff. – Need for integrative pharmacy services and adherence strategies to support psychotropic medication adherence, including the use of antidepressants. – Need to improve medication delivery services.
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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. HSAG recommends that **Oakland Community Health Network** notify MDHHS of all data discrepancies regardless of its ability to work around the discrepancy. • 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. 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. • 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. 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. • **Oakland Community Health Network**'s percentage of reported expired requests was an outlier in comparison amongst all PIHPs. 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. • 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. 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*.
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):**

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
• With multiple EQI [encounter quality initiative] reports due throughout the year, OCHN now monitors and reviews the data, which includes data from the 820, 834 and 270/271. This allows us to report any issues we are having with this data. IT and finance have created an internal EQI report to ensure this data is accurate for reporting. • OCHN adjusted 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. • Internal staff are continuing to monitor data for areas where we are over the 5% threshold for missing or unknown BH-TEDS data. If these areas are identified as an on-going issue, OCHN will work towards creating integrity reports for monitoring at the provider level. • Logic for indicator 2e was revised to include all Access screenings, including those without a treatment referral. Previous logic only captured those with a treatment referral as a result of the screening. • To improve rates for Indicator #1b, the OCHN crisis providers worked to recruit more staff to meet capacity. A weekly review of all out of compliance cases was implemented to identify any data entry errors. OCHN expanded capacity for children by adding a new children's crisis provider.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Following the logic revision for PI 2e, the number of expired requests increased from 30 to 146, with a 4-quarter average increasing from 34.5 (FY21 Q2 – FY22 Q1) to 149 (FY22 Q2 – FY23 Q1). • Indicator #1 is now in compliance (at or above 95%) for FY23 Q2-4.
c. Identify any barriers to implementing initiatives: • PI #1 Barriers: OCHN crisis provider reported that they are having barriers with retaining and hiring staff, which impacts staffing and the ability to meet this indicator. They have offered signing bonuses, employee referral plans, and incentivized late shift applicants. Some of the cases labeled out of compliance by the logic were not actually out of compliance. If there are am/pm data entry errors, or the documents are not complete or entered into ODIN [the PIHP's health information system] in the established order, the logic will show errors in the calculations. OCHN also requested that PCE set up the form so that it does not default to am or pm, and the user must select the correct time of day.
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** partially addressed the prior year's recommendations. While **Oakland Community Health Network** has engaged in efforts to address HSAG's recommendations, the SFY 2023 PMV audit confirmed continued opportunities for improvement in some areas. **Oakland Community Health Network** fully addressed the prior year's recommendation to notify MDHHS of all data discrepancies regardless of the PIHP's ability to work around the discrepancy. During the SFY 2023 audit, **Oakland Community Health Network** reported that its EQI team would review data with a greater than 5 percent difference compared to MDHHS' data three times a year, and that the review process had caught some discrepancies. No further related issues were identified during the SFY 2023 PMV audit. **Oakland Community Health Network** fully addressed the prior year's recommendation for indicator #10 to adjust its calculations to align with the specifications for indicator #10 by removing the condition that members must see their providers prior to readmission to be counted in the numerator. During the SFY 2023 audit, **Oakland Community Health Network** reported removing the condition immediately from its indicator #10 exception methodology. Members who interacted with their providers after discharge, but before readmission,

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
and who were readmitted within 30 days of discharge were now being included in the numerator. No further related issues were identified during the SFY 2023 PMV audit. **Oakland Community Health Network** fully addressed the prior year's recommendation for discrepant employment and minimum wage BH-TEDS data. HSAG did not find any discrepant data during the SFY 2023 audit. **Oakland Community Health Network** fully addressed the prior year's recommendation for indicator #2e to further explore its indicator #2e outlier percentage and determine if any potential for underreporting exists. During the SFY 2023 audit, **Oakland Community Health Network** reported reviewing its processes for indicator #2e expired requests and discovered that data from Q1 SFY 2022 were not reflecting the proper approach according to the specifications. After discovering the root cause of underreporting, **Oakland Community Health Network** updated the system logic, which has since resulted in the percentage of expired requests aligning more closely with the other PIHPs' percentages. **Oakland Community Health Network** has made efforts to improve its performance for indicator #1b. **Oakland Community Health Network** has initiated a weekly review of all out of compliance cases to identify any data entry errors, but has acknowledged barriers with retaining and hiring staff, which has impacted its ability to meet the standard for this indicator. In order to address staffing concerns, **Oakland Community Health Network** has offered signing bonuses, employee referral plans, and incentivized late shift applicants. **Oakland Community Health Network** has also worked with PCE to address issues noted with the logic to ensure cases are accurately assessed as compliant. However, there is still opportunity for improvement, as **Oakland Community Health Network**'s reported rate for indicator #1b decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG therefore recommends that **Oakland Community Health Network** continue to focus its efforts on increasing timely dispositions and expand upon interventions currently in place.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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). • **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. 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.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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).
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):**

- Practitioner Credentialing:
  - Notice to provider: Provider Network staff and OCHN Human Resources (HR) staff were trained on requirement to provide notification of credentialing decision. A template letter form was provided for this purpose. For credentialing files processed by our Credentials Verification Organization (CVO), OCHN issues notification to practitioners. This process began in October 2022. Evidence of provider notification of credentialing decision was provided at the FY23 HSAG Compliance Corrective Action Plan (CAP) site review.
  - Primary Source Verification (PSV): Providers were re-trained on this process during OCHN Credentialing Committee meeting 08/30/22. This has always been a requirement per OCHN Policy. Evidence of primary source verification as performed by the CVO was provided at the FY23 HSAG Compliance CAP site review.
  - Member concerns, grievance, appeals: A form to address member concerns, grievances, appeal information, or quality issues during credentialing process was developed and presented to contracted agencies and training completed at OCHN Provider Credentialing Committee meeting on 11/17/22. The form is submitted to OCHN simultaneously when the credentialing file is submitted to the CVO. For providers not yet transitioned to processing files via the CVO, the form will be maintained in the HR files at the provider site. Any "yes" response on the form requires an explanation. At the FY23 HSAG Compliance CAP site review, it was noted that appeals were not included on this form. The form has since been updated to include appeals and resubmitted to HSAG. At the PIHP level, we also document, track, and trend complaints, grievances and adverse events. This data is shared with the OCHN Credentialing Committee, reviewed and discussed and considered in credentialing decisions. Issues discussed are assessed and given a priority as level 0 – 2 as defined by our documented process on ongoing credentialing. The committee deliberates on the issue and determines if the file should be credentialed. Outcomes are noted in the minutes.
- Organizational Credentialing:
  - PSV: internal procedure for organizational provider credentialing were modified to indicate that all PSV of licensure for service delivery sites will be completed in accordance with MDHHS requirements. OCHN will rely on reciprocity processes for out of county locations and will comply with all MDHHS Universal Credentialing processes when enacted in the Customer Relationship Management [CRM].
  - Medicare and Medicaid checks: OCHN did not provide the Smartsheet tracking mechanism at the time of FY22 HSAG review, which shows the reviewer initials and date that exclusion checks were

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
validated for this organizational provider. Proof of the tracking mechanism's current and continued use was displayed at the FY23 HSAG Compliance CAP site review. – Recredentialed Provider list: OCHN has finalized a full credentialing cycle of the new organizational provider credentialing process that was initiated after the 2020 HSAG review. Effective FY24, all initial credentialing and re-credentialing decisions have been differentiated in all organizational provider credentialing documentation based on MDHHS standards. Evidence of the list of organizational providers recredentialed was displayed at the FY23 HSAG Compliance CAP site review. • Subcontractual Relationships: – All delegate contracts have been updated to include clear language regarding revocation of the delegation of activities or obligation, or other remedies in instances where the State or PIHP determine that the delegate has not performed satisfactorily. Additionally, all delegate contracts have been updated to include the necessary provisions indicating that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. Finally, all delegated contracts have been amended to ensure compliance with all provisions enumerated in 438.230©(3).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Practitioner Credentialing: – Currently auditing for FY23 credentialing activity. Performance data will be reviewed for compliance with deficiencies noted in the compliance audit. The expectation is that the corrective actions will result in improved performance. • Organizational Credentialing: – OCHN continues to implement the current organizational credentialing process as defined in our internal procedure and utilize the approved tracking mechanism for this process. – OCHN will move to the MDHHS Universal Credentialing System upon direction from MDHHS. • Subcontractor Relationships: – Delegated contracts align with applicable federal regulations.
c. Identify any barriers to implementing initiatives: • Practitioner Credentialing: N/A • Organizational Credentialing: The MDHHS Universal Credentialing System is not ready for use. • Subcontractor Relationships: N/A
HSAG Assessment: HSAG has determined that **Oakland Community Health Network** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the seven deficiencies under the Provider Selection and Subcontractual Relationships and Delegation program areas have been remediated.

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** 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. 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. • **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. 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.
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):** • Macomb County Community Mental Health (MCCMH) reviewed the PIP Completion Instructions to ensure that all requirements for each completed evaluation element were addressed. MCCMH sought technical assistance from HSAG to address listed areas of concern. MCCMH scheduled technical assistance calls with HSAG representatives to discuss outstanding questions and identify areas for improvement. • MCCMH provided additional documented detail to describe performance assessment, including statistical testing through a Chi-Square Test, the creation of a decision flowchart, and a priority matrix. These additional analytic reviews were developed and submitted for HSAG's review.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Based on its re-submission to HSAG on July 14, 2023, MCCMH received a Met score of 100 percent on Evaluation and Critical Elements for its Clinical Performance Improvement Project.
c. Identify any barriers to implementing initiatives: • No barriers have been identified at this time related to implementing initiatives.
HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** addressed the prior year's recommendations. The PIHP addressed all requirements for each completed evaluation element. Statistical testing was conducted between the subgroups to determine an existing disparity, and appropriate causal/barrier analysis methods were used to identify barriers to care.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- 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. 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.
- 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. 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.
- During PSV of member records, HSAG identified one member reported for indicator #2 that was reported as compliant in error. 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.
- 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. HSAG recommends that for future reporting of indicator #2e, **Macomb County Community Mental Health** ensure that all information, including information captured outside of FOCUS [the PIHP's information system] 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.
- 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. 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.
- 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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
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. 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*.
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):** • Macomb County Community Mental Health (MCCMH) developed and implemented a streamlined process to monitor key performance indicator (KPI) data on a weekly basis to increase validation checks that are indicator specific and ensure data completeness. Ongoing monitoring processes related to indicator #1 were created to ensure no dates were reported outside of the reporting period. MCCMH also implemented larger-scale enhancements to its electronic medical record (EMR) and report logic to ensure appropriate request dates are included in the correct reporting period. • MCCMH tracks omission/exclusion records for internal auditing purposes; reviews all exclusions and omitted records as part of its validation process; and uses applied formulas to performance indicator reports to ensure that dates not meeting compliance criteria are not included in numerator counts. • To decrease the possibility of human error, MCCMH reviews a sample of randomized in-compliance cases from the member-level detail files and performs primary source verification (PSV) to ensure the service was provided. PSV includes completing scrub reports to compare the claims and service activity logs (SALs) to ensure the dates and services are accurate. Manual overriding of member classifications has also decreased in FY22 and FY23 due to EMR enhancements to reduce overall human error and improve consistency between reporting periods. • MCCMH corrected the FOCUS report logic for indicator 2e, which now integrates all data sources for expired requests. Additionally, MCCMH added several checks and balances to address this issue, including having multiple staff members review the data entry process and perform data count checks to ensure numerator and denominator counts matched. Reports are now locked in EMR after reporting to prevent any lagging claims from impacting reporting or HSAG validation. • MCCMH implemented larger-scale fixes to our EMR and report logic to ensure correct ongoing service codes were captured in reporting for indicator #3. MCCMH performs PSV on a sample of cases to ensure dates were captured accurately. MCCMH also performs visual validation of files prior to submission to look for outliers and date mismatches. • MCCMH implemented targeted quality initiatives to monitor and ensure timely follow-up of services after hospitalization including topic area for our validated Clinical PIP. MCCMH has also worked closely with improving data transparency with the Provider Network to promote awareness and emphasize the importance of follow up appointments after hospitalization.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of the implemented initiatives, MCCMH has improved data validation processes, impacted data improvement on a larger scale, and reduced the potential for manual error.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
c. Identify any barriers to implementing initiatives: • Due to the degree of changes needed to MCCMH's EMR system, MCCMH may experience time delays in improvement implementation. MCCMH has worked closely with PCE as the EMR vendor to ensure that errors impacting reporting are prioritized and implemented as quickly as possible.

HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations. While **Macomb County Community Mental Health** has engaged in efforts to address HSAG's recommendations, the SFY 2023 PMV audit confirmed continued opportunities for improvement in some areas.

Macomb County Community Mental Health fully addressed the prior year's recommendation for indicator #1 to employ additional validation checks to ensure that the appropriate request dates are included in future reporting. During the SFY 2023 audit, **Macomb County Community Mental Health** reported that it monitored the data weekly to ensure no dates were reported outside of the reporting period. **Macomb County Community Mental Health** also indicated that it had implemented larger scale fixes to its EMR and report logic to ensure appropriate request dates were included in reporting. No further related issues were identified during the SFY 2023 PMV audit.

Macomb County Community Mental Health fully addressed the prior year's recommendation for indicator #2 to enhance its current validation process to check for cases with biopsychosocial assessment dates outside of the 14-calendar-day criteria prior to submitting member-level data to HSAG for review. During the SFY 2023 audit, **Macomb County Community Mental Health** reported that it reviewed all exceptions and omitted records as part of its validation process and applied formulas to performance indicator reports to ensure that dates which did not meet compliance criteria were not included in numerator counts. No further related issues were identified during the SFY 2023 PMV audit.

Macomb County Community Mental Health fully addressed the prior year's recommendation for indicator #2 to implement additional validation checks to further ensure data accuracy for future reporting periods. During the SFY 2023 audit, **Macomb County Community Mental Health** reported that it reviewed a sample of random compliant cases from the member-level detail files and performed PSV to ensure the service was provided. **Macomb County Community Mental Health** also used scrub reports and compared them to claims and SALs to ensure the dates/services were accurate. **Macomb County Community Mental Health** also noted that some of the prior issues were related to staff members' ability to manually override case classifications. **Macomb County Community Mental Health** reported that since manual overriding of member classifications has decreased, the number of human errors has also decreased. No further related issues were identified during the SFY 2023 PMV audit.

Macomb County Community Mental Health fully addressed the prior year's recommendation to conduct a data count check across all reported performance indicators to ensure that this count aligns with the final reported counts to MDHHS. During the SFY 2023 audit, **Macomb County Community Mental Health** reported that it corrected the FOCUS report logic, which now integrates all data sources for expired requests. Additionally, **Macomb County Community Mental Health** reported that it added several checks and balances to address this issue, including having multiple staff members review the data entry process and ensure numerator and denominator counts matched. Finally, **Macomb County Community Mental Health** indicated

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
that the reports were locked in FOCUS after reporting to prevent any lagging claims from impacting reporting or HSAG validation. No further related issues were identified during the SFY 2023 PMV audit. **Macomb County Community Mental Health** fully addressed the prior year's recommendation for indicator #3 to enhance its validation processes to ensure that accurate dates are being captured within the system for performance indicator reporting. This enhancement was to 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 submitting to MDHHS. During the SFY 2023 audit, **Macomb County Community Mental Health** reported that it performed PSV on a sample of records to ensure dates were captured accurately for the records. **Macomb County Community Mental Health** also reported that it performed visual validation of files prior to submission to look for outliers and date mismatches. No further related issues were identified during the SFY 2023 PMV audit. **Macomb County Community Mental Health** made efforts to improve its performance for indicator #4a. **Macomb County Community Mental Health** implemented targeted quality initiatives to monitor and ensure timely follow-up of services after hospitalization including the topic area for the validated clinical PIP. **Macomb County Community Mental Health** also worked closely to improve data transparency with the provider network to promote awareness and emphasize the importance of follow-up appointments after hospitalization. However, there is still opportunity for improvement, as **Macomb County Community Mental Health**'s reported rates for indicator #4a decreased from SFY 2022 to SFY 2023 and fell below the established MPS for SFY 2023. HSAG therefore recommends that **Macomb County Community Mental Health** continue to focus its efforts on increasing timely follow-up of services after hospitalization and expand upon interventions currently in place.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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). • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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). • **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. 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. • **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. 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. • **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. 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.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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):**

- Macomb County Community Mental Health (MCCMH) developed process enhancements with its credentialing practices for both individual and organizational credentialing. To enhance oversight and monitoring practices, MCCMH created a Credentialing Committee to oversee organizational credentialing primary source verification and decision-making practices; and updated its Organizational Credentialing Policy and Procedure to reflect updated process flows. Moving forward, quality reviews will occur on credentialing files to ensure that updated system controls have been implemented appropriately.
- MCCMH reviewed the scope of managed care functions that it delegated within its network for fiscal year (FY) 2023 according to federal and state requirements, and created a formal list of delegated entities. For FY 2023, MCCMH delegated individual credentialing to its contracted providers and portions of utilization management to an external agency. MCCMH developed appropriate delegation agreements in its contracts with the delegates and redefined delegation monitoring process flows to ensure appropriate oversight moving forward.
- MCCMH developed a formalized procedure on Clinical Practice Guidelines (CPG) that addresses ongoing review and updates to the Guidelines. MCCMH ensures CPG's are reviewed on an annual basis. The following clinical practice guidelines were reviewed and updated by the Clinical Department in FY 2023 and disseminated to providers for review and approval: PTSD [post-traumatic stress disorder], ADHD [attention-deficit hyperactivity disorder] Combined, ADHD and Disruptive Behavior Disorders, Bipolar Disorder, Major Depressive Disorder, Schizophrenia, Coordination of Care Documentation, and Guidelines to Complete Specialized Nursing Assessment. MCCMH shared its CPG's with the Network for feedback. Once CPG's were approved and adopted through different meetings covering internal and external providers, MCCMH issued an official memo and the CPG's were disseminated to the Network and posted on MCCMH's website.
- MCCMH intends to implement a patient access API once it formally becomes a requirement, MCCMH currently provides patient access to their behavioral health record via patient portal access. MCCMH re-structured and launched its Utilization Management Committee which now focuses more concretely on comparative utilization reports by service, with comparisons between provider agencies and its network. Examples of utilization reports include but are not limited to: Intake Assessment Dashboard, Hospitalization Dashboard, Leadership Snapshot Dashboard, and Service Category Dashboard.
- MCCMH completed a comprehensive review of its Quality Assessment and Performance Improvement (QAPI) program, which included a comparison of each QAPI element and a gap analysis to identify areas for improvement. MCCMH redeveloped its QAPI Narrative and Workplan to adhere to MDHHS' standards. Based on the revisions made to the QAPI program, MCCMH's upcoming annual evaluation will be structured in a way to ensure compliance with unmet areas previously identified. MCCMH also developed a QAPI Procedure to outline workflows associated with MCCMH's ongoing review and development on its QAPI.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through an increased focus on data-informed decision making, MCCMH continues to prioritize efforts to improve the effectiveness of its service delivery and quality of care.
c. Identify any barriers to implementing initiatives: • MCCMH experienced significant staffing changes throughout FY 2023. Increased focus has been placed on the cross-training of staff to ensure well-balanced transitions in the future.
HSAG Assessment: HSAG has determined that **Macomb County Community Mental Health** partially addressed the prior year's recommendations. The response provided by **Macomb County Community Mental Health** and the SFY 2023 compliance review activity confirmed that the PIHP implemented its action plans to address all deficiencies related to the Provider Selection, Subcontractual Relationships and Delegation, and Practice Guidelines program areas. However, while **Macomb County Community Mental Health**'s responses generally addressed the Quality Assessment and Performance Improvement program area, the SFY 2023 compliance review activity confirmed that two elements did not demonstrate compliance, and **Macomb County Community Mental Health** was required to submit an updated action plan. As such, HSAG recommends that **Macomb County Community Mental Health** prioritize efforts to ensure its updated action plan is fully implemented. Further, while **Macomb County Community Mental Health** indicated that it would implement the API requirements once it formally becomes a requirement, as previously communicated to the PIHP, the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020, finalized its proposal requiring all Medicaid MCEs, including PIHPs, to comply with the regulations of 42 CFR §431.60 and 42 CFR §431.70 beginning January 1, 2021.[4-1] The SFY 2023 compliance review activity confirmed that **Macomb County Community Mental Health** had not made any efforts to implement the APIs. As such, HSAG strongly recommends that the PIHP immediately initiate efforts to fully implement CMS' API requirements as the PIHP has been out of compliance for nearly three years.

[4-1] While the APIs were required to be implemented by January 1, 2021, due to the COVID-19 PHE, CMS was not enforcing these requirements prior to July 1, 2021. Refer to https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf for additional details.

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, 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.
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 August 2023, Region 10 PIHP received the 2022-2023 Validation Tool for the Reducing Racial/Ethnic Disparities in Access to Substance Use Disorder (SUD) Services performance improvement project (PIP). The results indicated the resubmitted PIP had an overall Met validation status with all evaluation elements and critical elements met. • The root cause analysis process included the completion of the Five Whys method, a Fishbone Diagram, and a flowchart/process map of the current referral and intake process. In conjunction, a barrier analysis was completed (Kittle, Bonnie. 2017. [A] Practical Guide to Conducting a Barrier Analysis (2nd ed.). New York, NY: Helen Keller International). The barrier analysis was initiated by a representative group of SUD program leaders and PIHP Access staff via brainstorming and round robin techniques, followed by cluster analysis. Cluster analysis findings were further discussed by PIHP staff, and an SUD program network survey was developed to further explore potential key service access barriers. • The SUD program network survey was distributed to a representative group of SUD subject matter experts (persons-served and SUD program service staff). Survey analyses generated a comprehensive range of barriers, both in terms of identified Individual (persons-served) Factors and Program (staff/program service delivery) Factors. A follow up barrier analysis survey was developed, and, per point-in-time methodology, this survey was administered to all available subject matter experts. Quantitative data obtained from the barrier analysis survey were analyzed across both barrier analysis Factors and racial/ethnic groups. The barrier analysis identified four significant barriers. Findings from the root cause analysis / barrier analysis activities described above informed the development of service systems improvement action plans.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Remeasurement period data will not be available until the conclusion of calendar year 2023.
c. Identify any barriers to implementing initiatives: • There were no identified barriers to using appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Region 10 PIHP** addressed the prior year's recommendations. The PIHP used appropriate causal/barrier analysis methods to identify barriers to care and initiated interventions to address those barriers in a timely manner.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- 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. **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.
- 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. 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.
- 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. 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.
- 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. 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.
- 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. HSAG recommends

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
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*.
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 SFY2022 Performance Measure Validation (PMV) Review Report, Region 10 PIHP staff presented findings to the Quality Management Committee (QMC). The QMC includes representatives from the PIHP and CMHSPs. The committee meets monthly and performance indicators (PIs) are a standing agenda item. • A reminder was provided to the QMC members regarding the need for additional validation checks. The PIHP PI Team has also continued spot checking out of compliance, in compliance, and omission events for all indicators as part of the quarterly review process. Additionally, the CMHSP referred to in the above recommendation reported reviewing every indicator event as part of the validation checks. • The PIHP PMV Review Team met to review recommendations from the SFY2022 PMV Review. The team decided to ask CMHSP QMC members to respond via email with any issues related to encounter reporting, in addition to asking for verbal reports during monthly QMC meetings. If/when issues are reported to the PIHP, the PIHP will follow up with the CMHSP accordingly. Depending on the reported issue, follow-up may include a request for additional validation of performance indicators. • Regarding monitoring adults' discharges within the critical seven-day post-discharge time frame for indicator #4a, CMHSPs are required to conduct root cause analyses and prepare plans of correction if the 95% performance standard is not met. Examples of submitted plans of correction include making improvements to scheduling/availability, consideration for different levels out outreach to individuals, providing more detail regarding the array of services and service settings (including telehealth), and improved collaboration with hospitals. The PIHP monitors plans of correction through the contract monitoring process. • Regarding monitoring members' discharges within the critical seven-day post-discharge time frame for indicator #4b, Substance Use Disorder (SUD) Detox Providers are required to conduct root cause analyses and prepare plans of correction if the 95% performance standard is not met. Examples of submitted plans of correction include providing ongoing staff training regarding referrals after detox, increased education to persons served regarding detox protocols, the addition of Peer Support during admission and detox, and confirmation of scheduled appointments. The PIHP monitors plans of correction through the contract monitoring process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The weaknesses identified during the SFY2022 Performance Measure Validation Review were not identified as weaknesses during the SFY2023 Performance Measure Validation Review.
c. Identify any barriers to implementing initiatives: • No specific barriers identified.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
HSAG Assessment: HSAG has determined that **Region 10 PIHP** partially addressed the prior year's recommendations. While **Region 10 PIHP** has engaged in efforts to address HSAG's recommendations, the SFY 2023 PMV audit confirmed continued opportunities for improvement in some areas. **Region 10 PIHP** fully addressed the prior year's recommendation to identify and implement a mechanism through which it could monitor encounter data-dependent rate impact if the CMHSPs' encounters were delayed in the future. During the SFY 2023 audit, it was discussed that **Region 10 PIHP** uses its QMC as a place to discuss any encounter issues or barriers, with more frequent discussion and review of encounter data taking place over the past year. **Region 10 PIHP** included encounters as a discussion item on the monthly meeting agendas to help ensure timely capture of encounter issues before the quarterly reviews. No further related issues were identified during the SFY 2023 PMV audit. **Region 10 PIHP** fully addressed the prior year's recommendation to identify and implement a mechanism through which it could monitor encounter data-dependent rate impacts if the CMHSPs' encounters were delayed in the future. During the SFY 2023 audit, **Region 10 PIHP** indicated that it had resolved the identified issue with St. Clair County Community Mental Health by the end of the PMV activity the prior year. Additionally, **Region 10 PIHP** has since incorporated further discussion and monitoring of encounters monthly. No further related issues were identified during the SFY 2023 PMV audit. **Region 10 PIHP** fully addressed the prior year's recommendation for indicator #3 to employ additional oversight to their performance indicator validation processing to ensure service-level detail used for calculating performance measures captured and matched MDHHS specifications. During the SFY 2023 audit, **Region 10 PIHP** stated that this issue was discussed with the QMC and incorporated into the PIHPs' validation checks. Additionally, Lapeer County Community Mental Health now looks at every indicator event as part of its validation checks. No further related issues were identified during the SFY 2023 PMV audit. **Region 10 PIHP** has made efforts to improve its performance for indicator #4a for the adult population and indicator #4b. **Region 10 PIHP** required its providers to conduct root cause analyses and prepare plans of correction if the 95 percent performance standard was not met and monitored plans of correction through the contract monitoring process. However, there is still opportunity for improvement, as **Region 10 PIHP**'s reported rates for indicator #4a for the adult population and indicator #4b continued to fall below the established MPS for SFY 2023. HSAG therefore recommends that **Region 10 PIHP** continue to focus its efforts on ensuring timely follow-up is scheduled and expand upon interventions currently in place.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
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).
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):** • During FY2022, the PIHP completed a comprehensive review of network provider credentialing files. Findings of these reviews were shared with Network Providers and requests to come into compliance with identified areas of deficiencies were noted. During FY2023, the PIHP enhanced its methodology and review components in the evaluation of Network Provider credentialing records. Updates to these areas included changes to the format of reviews for documentation of trends over time and increased collaboration of PIHP team members for information sharing. The PIHP has completed updates to both credentialing application materials as well as internal guidance documents to enhance the PIHP's credentialing of its Organizations and Practitioners. Updates to these areas include technical corrections to the PIHP Practitioner Application and development of new PIHP internal guidance documents to address action steps necessary during both Organizational and Practitioner Application reviews. The PIHP also worked to enhance our internal practices for primary source verification, and this was discussed with Network Providers through the PIHP Corporate Compliance Committee as well. Updates to this area include addressing improvements in timeliness of Practitioner Application reviews as well as increased collaboration of PIHP team members. In June of 2023, the PIHP issued training materials to its Network Providers regarding credentialing requirements and expectations. During FY2023, the PIHP completed on-site visits with Network Providers in July and August and reviewed credentialing records during those scheduled evaluations. This was the first time the PIHP had visited Network Providers on-site since prior to the pandemic, and this led to enhanced opportunities for communication and education. For all areas identified as non-compliant in FY2023, Network Providers were issued Plans of Correction to address. The PIHP continues to discuss opportunities for both internal procedure enhancement as well as support for its Network Providers through its monthly PIHP Credentialing Committee.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • When comparing Network Provider performance in credentialing (credentialing record reviews) for FY2022 and FY2023, performance improvement has been demonstrated in Network Provider credentialing files. In FY2022, the PIHP identified significant non-compliance (94%) and in FY2023 the PIHP identified a strong improvement in this area with a decrease in non-compliance (50%). Although there has been improvement, this still represents an opportunity to strengthen Network Provider compliance in this area. The PIHP intends to conduct a comprehensive review of trends noted in FY2023 (e.g., by types of Network Providers, focus areas of non-compliance). In addition to ongoing monitoring of Network Provider Plans of Correction for noted areas of deficiencies, the PIHP intends to review and enhance credentialing record review methodologies and evaluation tools for its Network Providers in FY2024.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
c. Identify any barriers to implementing initiatives: • Uncertainty of MDHHS Universal Credentialing implementation impact on current PIHP policy and practice. Network Providers continue to communicate barriers regarding the ability to hire and maintain qualified staff.
HSAG Assessment: HSAG has determined that **PIHP 10 PIHP** addressed the prior year's recommendations based on the responses provided by the PIHP and the SFY 2023 compliance review activity, which confirmed the four deficiencies under the Provider Selection program area have been remediated.

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 2023 validation, the PIHPs submitted quality improvement strategies for their PIHP-specific PIP topic. HSAG's validation evaluated the technical methods the PIHPs' PIPs (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of each PIHP's PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 5-1 provides a comparison of the overall PIP validation ratings and the scores for the PIP Design stage (Steps 1 through 6) and Implementation stage (Steps 7 and 8), by PIHP. Table 5-1 also identifies whether a statistically significant racial or ethnic disparity was noted within the PIHP's data, and the disparate population that was targeted through the PIP, as applicable.

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

PIP Topics and Overall PIP Validation Rating, by PIHP			Design and Implementation Scores			Disparity (Yes/No) and Target Population
			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%	No
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%	No
LRE	*FUH Metric: Decrease in Racial Disparity Between Whites and African Americans/Black*	*Met*	100%	0%	0%	Yes, African American/ Black

PIP Topics and Overall PIP Validation Rating, by PIHP			Design and Implementation Scores			Disparity (Yes/No) and Target Population
			Met	Partially Met	Not Met	
SWMBH	*Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	*Met*	100%	0%	0%	Yes, African American/ Black
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%	Yes, African American/ Black
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%	Yes, African American/ Black
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%	Yes, African American/ Black
OCHN	*Improving Antidepressant Medication Management—Acute Phase*	*Met*	100%	0%	0%	Yes, African American/ Black
MCCMH	*Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations*	*Met*	100%	0%	0%	Yes, African American/ Black
Region 10	*Reducing Racial/Ethnic Disparities in Access to SUD Services*	*Met*	100%	0%	0%	Yes, African American/ Black

Performance Measure Validation

Table 5-2 presents the PIHP-specific results for the SFY 2023 validated performance indicators. For each indicator, green font is used to denote the highest-performing PIHP(s), while red font is used to denote the lowest-performing PIHP(s).

Table 5-2—SFY 2023 PIHP-Specific Performance Measure Rate Percentages

Performance Indicator		Region 1 NCN	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#1	Children—Indicator #1a	100%	99.20%	97.56%	96.39%	99.32%	100%	99.24%	94.56%	99.01%	100%
	Adults—Indicator #1b	100%	98.87%	98.22%	97.85%	99.42%	99.55%	98.12%	91.61%	99.01%	99.77%
#2	MI–Children—Indicator #2a	65.33%	59.24%	58.94%	50.23%	59.14%	62.13%	28.81%	30.89%	15.08%	58.48%
	MI–Adults—Indicator #2b	55.94%	51.29%	55.57%	67.47%	62.95%	58.41%	54.33%	53.53%	17.09%	53.64%
	I/DD–Children—Indicator #2c	51.85%	66.67%	60.64%	52.67%	49.21%	66.34%	28.71%	21.74%	17.95%	50.00%
	I/DD–Adults—Indicator #2d	53.33%	45.71%	66.20%	73.68%	57.29%	59.38%	43.55%	24.24%	23.81%	61.64%
	Total—Indicator #2	59.20%	54.43%	57.86%	61.15%	60.81%	60.34%	45.15%	44.97%	16.86%	54.99%
#2e	Consumers[1]	64.61%	65.43%	67.22%	62.34%	72.68%	60.32%	61.45%	81.71%	82.52%	72.21%

Performance Indicator		Region 1 NCN	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#3	MI–Children—Indicator #3a	70.73%	62.33%	52.58%	56.24%	56.86%	72.57%	85.36%	99.62%	66.20%	78.59%
	MI–Adults—Indicator #3b	69.09%	62.89%	56.31%	56.68%	59.47%	72.31%	88.80%	98.91%	72.40%	80.16%
	I/DD–Children—Indicator #3c	65.22%	71.67%	64.13%	57.58%	77.16%	85.11%	84.78%	100%	80.68%	85.82%
	I/DD–Adults—Indicator #3d	88.24%	50.00%	59.46%	80.00%	61.90%	89.29%	77.05%	97.22%	55.56%	81.97%
	Total—Indicator #3	70.28%	62.89%	55.28%	57.12%	59.53%	74.63%	87.24%	99.09%	71.45%	80.30%
#4a	Children	100%	96.88%	93.55%	94.74%	97.25%	94.44%	100%	96.15%	51.47%	97.30%
	Adults	96.74%	94.87%	96.20%	94.80%	95.60%	94.86%	98.14%	95.73%	38.93%	94.64%
#4b	Consumers	97.06%	90.08%	98.06%	98.92%	97.83%	95.73%	100%	100%	92.88%	94.95%
#5	Medicaid Recipients[2]	6.64%	7.43%	5.18%	6.37%	7.11%	6.21%	5.86%	7.31%	4.56%	6.82%
#6	HSW Enrollees[2]	98.06%	95.47%	95.29%	89.41%	96.76%	90.75%	93.54%	93.46%	94.92%	96.55%
#8	MI–Adults—Indicator #8a	20.27%	25.30%	21.77%	23.74%	21.67%	18.26%	17.44%	24.21%	21.71%	17.52%
	I/DD–Adults—Indicator #8b	9.01%	10.74%	10.82%	8.78%	8.77%	10.66%	8.79%	14.19%	5.94%	6.63%
	MI & I/DD–Adults—Indicator #8c	8.90%	15.67%	10.87%	10.00%	10.12%	9.18%	7.52%	11.01%	6.81%	8.56%

Performance Indicator		Region 1 NCN	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 MCCMH	Region 10 PIHP
#9	MI–Adults—Indicator #9a	100%	99.88%	99.85%	99.93%	99.85%	99.72%	99.84%	100%	100%	99.94%
	I/DD–Adults—Indicator #9b	92.00%	69.13%	95.41%	93.41%	92.53%	93.68%	94.35%	83.51%	94.35%	94.07%
	MI & I/DD–Adults—Indicator #9c	91.30%	93.50%	93.75%	92.45%	93.75%	93.33%	98.70%	80.00%	92.96%	94.40%
#10	MI & I/DD–Children—Indicator #10a*	5.71%	14.63%	9.92%	2.94%	8.75%	6.35%	7.51%	0.00%	4.23%	8.57%
	MI & I/DD–Adults—Indicator #10b*	9.82%	10.25%	8.90%	9.57%	13.01%	14.23%	14.69%	9.83%	15.36%	10.62%
#13	I/DD–Adults	17.31%	21.85%	15.02%	17.81%	19.69%	25.34%	21.08%	19.53%	15.50%	16.74%
	MI & I/DD–Adults	22.67%	32.76%	22.39%	21.45%	25.91%	29.24%	29.11%	26.88%	20.22%	24.49%
#14	MI–Adults	54.54%	50.36%	45.11%	48.25%	48.77%	35.86%	39.44%	33.64%	46.59%	46.36%

* A lower rate indicates better performance.

Best-performing PIHPs' rates are denoted in green font.

Worst-performing PIHPs' rates are denoted in red font.

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

[2] No red or green font is shown for PIHPs' rates for this performance indicator since the rates do not indicate best or worse performance among PIHPs.

Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., for all 10 PIHPs, the total number of adults who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., for all 10 PIHPs, the total number of adults discharged from psychiatric inpatient facilities). These calculations excluded raw data from any PIHP that received a *Do Not Report (DNR)* audit designation.

Table 5-3 presents the SFY 2022 and SFY 2023 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.

Table 5-3—SFY 2022 and SFY 2023 Statewide Performance Measure Rates

Performance Indicator	2022 Rate	2023 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	98.40%	98.60%
Adults—Indicator #1b	97.90%	98.11%
#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	60.48%	50.54%
MI–Adults—Indicator #2b	59.27%	55.21%
I/DD–Children—Indicator #2c	62.06%	43.69%
I/DD–Adults—Indicator #2d	56.33%	52.92%
Total—Indicator #2	59.78%	52.83%
#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	70.34%	68.56%
#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	72.27%	66.44%
MI–Adults—Indicator #3b	73.90%	71.53%
I/DD–Children—Indicator #3c	80.39%	78.59%
I/DD–Adults—Indicator #3d	76.05%	72.06%
Total—Indicator #3	73.95%	70.51%

Performance Indicator	2022 Rate	2023 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	92.07%	91.10%
Adults	89.91%	86.47%
#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	98.43%[2]	97.15%
#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.	6.07%	6.22%
#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.	88.22%	94.39%
#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	17.05%	20.62%
I/DD–Adults—Indicator #8b	8.61%	9.57%
MI and I/DD–Adults—Indicator #8c	8.41%	9.63%
#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	99.66%	99.89%
I/DD–Adults—Indicator #9b	79.93%	89.67%
MI and I/DD–Adults—Indicator #9c	82.77%	92.74%
#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	6.53%	7.38%
MI and I/DD–Adults—Indicator #10b	12.34%	12.62%
#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	19.39%	19.26%
MI and I/DD–Adults	26.24%	25.65%

Performance Indicator	2022 Rate	2023 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	44.11%	43.69%

The statewide rates that met or exceeded the MPS are denoted in green 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 SFY 2021 and SFY 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%**
X	80%	80%	60%	100%	100%	80%	80%	40%	20%	100%	**74%**

Standard[1, 2]	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
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 System
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 MHPs. 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.

Table 5-5 compares the number of total CAP elements, and the *Complete* and *Not Complete* elements across the PIHPs for the SFY 2023 CAP implementation review. The number of elements statewide are also provided.

Table 5-5—PIHP and Statewide Summary of 2023 CAP Implementation

PIHP	Total CAP Elements	*Complete*	*Not Complete*
NCN	30	25	5
NMRE	35	27	8
LRE	31	29	2
SWMBH	33	32	1
MSHN	24	23	1
CMHPSM	39	37	2
DWIHN	35	33	2
OCHN	27	24	3
MCCMH	42	37	5
Region 10	28	26	2
Total	**324**	**293**	**31**

Encounter Data Validation

Table 5-6 presents the EDV results for all PIHPs. Results for the administrative profile are stratified by category of service. For both analyses, cells with a "✓" indicate no or minor concerns noted, cells with a "—" indicate moderate concerns noted, and cells with an "x" indicate major concerns noted. For PIHP-specific results, refer to Section 3.

Table 5-6—EDV PIHP Comparison

Analysis		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
IS Review											
Encounter Data Sources and Systems		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payment Structures		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Quality Monitoring		—	✓	✓	✓	—	—	—	—	✓	✓
Administrative Profile											
Encounter Data Completeness	Professional	✓	✓	✓	✓	—	—	—	—	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Timeliness	Professional	✓	✓	x	x	✓	✓	✓	x	✓	✓
	Institutional	✓	x	✓	x	x	✓	✓	x	✓	x
Field-Level Completeness and Accuracy	Professional	—	—	—	—	—	—	—	—	—	—
	Institutional	—	—	—	—	—	—	—	—	—	—
Encounter Referential Integrity	Professional	—	—	—	—	—	—	—	—	—	—
	Institutional	—	—	—	—	—	—	—	—	—	—
Encounter Data Logic	Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓	No or minor concerns noted.
—	Moderate concerns noted.
x	Major concerns noted.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the PIHPs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Michigan Behavioral Health Managed Care program to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-1—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:** MDHHS has established the MMBPIS that measures performance in the domains of access to care, adequacy and appropriateness of services provided, efficiency, and outcomes and set MPSs for a subset of the performance indicators. Specifically, MDHHS set an MPS of 95 percent for indicators #1, #4a, and #4b, and an MPS of 15 percent (lower performance is better) for indicator #10. The SFY 2023 statewide rate met the MPS for three performance indicators: • *#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.* • *#4b: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.* • *#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.* The rates for these performance indicators also remained relatively stable year over year, with an increase or decrease in performance of 1.28 percentage points or less compared to SFY 2022, indicating that most members receive a timely pre-admission screening and timely follow-up care following an inpatient stay from a substance use detox unit. Additionally, most child and adult members are not being readmitted within 30 days after discharge from a psychiatric hospitalization. MDHHS has also established quantitative network adequacy standards and SUD admission standards for priority populations to assure PIHPs provide timely and accessible care. During the SFY 2021 compliance review, which is part of the current three-	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	year cycle of reviews (SFY 2021–SFY 2023), all PIHPs demonstrated gaps in their processes related to their annual network adequacy analysis, and most PIHPs demonstrated gaps in monitoring SUD priority population admission standards. However, the current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed remediation of all deficiencies in these program areas (i.e., Availability of Services and Assurances of Adequate Capacity and Services). MDHHS has also updated SFY 2024 contract language to require the PIHPs to submit an annual network adequacy report as opposed to a certification report. MDHHS is also requiring the PIHPs to participate in a new NAV activity in SFY 2024. The purpose of the NAV activity is to assess and validate the adequacy of each PIHP's network in accordance with MDHHS' established network adequacy standards. The findings from the NAV activity will provide MDHHS insight into whether the PIHPs maintain provider networks that are sufficient to provide timely and accessible care to Medicaid members across the continuum of services the PIHPs are responsible for and if the data being submitted to MDHHS are accurate and valid. However, while the rates for indicators #4b and #10 suggest that the Behavioral Health Managed Care program effectively provided transition of care planning, the results for indicator #4a indicate a need to improve timely follow-up care for children and adults following discharge from a psychiatric inpatient hospitalization. The MPS was not met for either the child or adult populations for indicator #4a, and while the rate for children declined by less than 1 percentage point, the rate for adults declined by 3.44 percentage points. Lack of timely and effective follow-up care may result in poorer outcomes, readmissions, and increased costs. Indicators #2, #2e, and #3 also measure timely access to care, but no MPSs have yet been established by MDHHS. However, all indicator rates experienced a decline from the prior year, with rates declining from 1.78 to 18.37 percentage points. These results indicate that fewer new members received a timely biopsychosocial assessment, received a timely face-to-face SUD service, and started medically necessary ongoing services timely. **Recommendations:** To further support its efforts to effectively monitor the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members, HSAG recommends that if	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	MDHHS continues to require the PIHPs to report these indicators that performance benchmarks are established for performance indicators #2, #2e, and #3. MDHHS should also consider requiring the PIHPs to submit CAPs for any deficiencies identified through MDHHS' monitoring processes for all performance indicators with an established MPS or benchmark. Setting an MPS or another type of benchmark and requiring remediation for underperformance may incentivize the PIHPs to improve rates for these indicators. Additionally, MDHHS should consider requiring the PIHPs to calculate and report on national performance measures, such as Child and Adult Core Set and HEDIS measures. This will allow MDHHS to assess performance against national benchmarks and will allow MDHHS to compare the PIHPs and the Behavioral Health Managed Care program's performance to other MCEs nationally.	
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS places a strong emphasis on person-centered planning though contract provisions and practice guidelines. Additionally, care management processes, including person-centered service planning, is reviewed as part of the compliance review activity. The SFY 2023 compliance review activity confirmed the PIHPs remediated all but one deficiency in the Coordination and Continuity of Care program area. MDHHS also requires that member service or treatment plans be developed in a manner consistent with the principals of person-centered planning, which should reflect the member's services, supports, preferences, and needs, such as employment and living arrangements. Two indicators of the MMBPIS focus on member employment and member residence. While MDHHS has not established MPSs for these indicators, the results of the PMV activity demonstrated that more adults diagnosed with an intellectual or developmental disability, or dually diagnosed with a mental illness and intellectual disability, were competitively employed and earned minimum wage or more from any employment activities compared to the prior year. Additionally, the percentage of adults diagnosed with an intellectual or developmental disability, or mental illness, who lived in a private residence remained relatively stable year over year. Choice of living arrangements and employment opportunities can improve the quality of life for members. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and identified two performance metrics to determine the impact the Behavioral Health Managed Care program has on	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	meeting Goal #2: *Percentage of Mobile Crisis Response Parent/Caregiver Experience Survey responses* and *Percentage of responses of a 3 or 4 on the following Mobile Crisis Response Parent/Caregiver Experience Survey item: "Do you feel you had voice and choice in the development of the follow-up plan?"* However, a statewide baseline performance rate and a statewide performance target have yet to be established. HSAG recommends that MDHHS proceed with establishing baseline rates and performance targets for these metrics.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)	**Conclusions:** One of MDHHS' objectives to support Goal #3 is to promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. This objective aligns with CMS' goal to advance interoperability with the mission of promoting the secure exchange, access, and use of electronic health information to support better informed decision making and a more efficient healthcare system. During the SFY 2022 compliance review, which is part of the current three-year cycle of reviews (SFY 2021–SFY 2023), all PIHPs had not implemented the Patient Access and Provider Directory API requirements in accordance with all requirements of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. The current SFY 2023 compliance review activity, which consisted of a CAP review of the deficiencies identified through the SFY 2021 and SFY 2022 compliance reviews, confirmed that none of the PIHPs had fully remediated all deficiencies in the Health Information Systems program area. Most of the PIHPs challenged the applicability of the interoperability requirements, suggesting that the PIHPs were not required to implement the requirements as MDHHS' contract with the PIHPs did not specifically include the requirements of 42 CFR 438.242(b)(5,6). However, the PIHPs, being a Medicaid MCE, are required to comply with the Medicaid managed care rule and guidance issued by CMS, including the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. While HSAG's concerns related to the PIHPs' lack of accountability were communicated to MDHHS, the absence of guidance from MDHHS for the PIHPs to proceed with implementation of the API requirements contributed to the PIHPs' lack of urgency to fully implement the interoperability requirements. **Recommendations:** While MDHHS' contract with the PIHPs already includes a provision requiring the PIHPs to comply with all State and federal laws, statutes, regulations, and administrative procedures, HSAG recommends that MDHHS issue guidance to the	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	PIHPs on the expectation that they adhere to all federal Medicaid managed care rules regarding interoperability, including the Patient Access and Provider Directory APIs. Additionally, HSAG recommends this guidance include contacts for subject matter experts at MDHHS for the PIHPs to contact should additional guidance or consultation be needed to ensure the PIHPs, and therefore MDHHS, come into compliance with the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) published May 1, 2020. Further, as CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F), MDHHS should proceed with also mandating the PIHPs to implement these new requirements.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2023, the PIHPs were responsible for continuing their PIP topics 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 PIHP-specific topics and performance indicator(s). Through the PIHPs' analyses of their data, eight of the 10 PIHPs identified existing racial and ethnic disparities. As demonstrated through the SFY 2023 PIP validation, all 10 PIHPs designed a methodologically sound PIP and implemented interventions based on the barriers identified through each PIHP's data analysis and quality improvement processes. MDHHS also requires the PIHPs to participate in a withhold program with the MHPs. As part of the SFY 2023 program, for two joint performance metrics, *J.2 Follow-Up After Hospitalization (FUH) for Mental Illness Within 30 Days* and *J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence*, data are stratified by race/ethnicity and provided to the PIHPs. The PIHPs are incentivized to reduce the disparity between the index population and at least one minority group. While results of the withhold program are not available to HSAG through the aggregated findings for the EQR activities, this program and the initiatives implemented through the PIHP's PIPs support improvement in health outcomes and reduce disparities within the Behavioral Health Managed Care program. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included three performance metrics for 2026. MDHHS has identified three performance metrics to allow an evaluation of the Behavioral Health Managed Care program: *Percentage of Persons of Color, aged 0-21, receiving a completed*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	biopsychosocial assessment from specialty behavioral health system; *Percentage of Persons of Color, aged 0-21, starting any medically necessary ongoing covered service from specialty behavioral health system after receiving a biopsychosocial assessment*; and *Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)*. However, a statewide baseline performance rate and a statewide performance target have yet to be established. HSAG recommends that MDHHS proceed with establishing baseline rates and performance targets for these metrics. Additionally, while MDHHS posts MMBPIS quarterly reports on its website, these reports do not include results stratified by race/ethnicity. If MDHHS continues to use MMBPIS to assess PIHP performance, or implements alternative measures to assess performance, HSAG recommends that MDHHS consider the benefit of requiring the PIHPs to report performance measure results, or a subset of results, by race/ethnicity. Analysis of these data could assist in identifying PIHP-specific or statewide health disparities to focus future performance improvement initiatives.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has established PIHP performance bonuses, through Withhold Arrangements, the PBIP, the Opioid Health Home Benefit, the Behavioral Health Home Benefit, and the CCBHC Demonstration Quality Bonus Payment. The aggregated findings for 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. However, the *Effectiveness Evaluation Appendix C—Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments*, as reported through the 2023–2026 CQS, confirmed that the Behavioral Health Managed Care program met Objective 5.1, *Promote the use of value-based payment models to improve quality of care*, under Goal #5, as performance bonus withholds are currently included in the PIHP contract, and the PIHPs are required to submit an annual summary of efforts, activities, and achievements to increase participation in patient-centered medical homes. MDHHS, through its contract with the PIHPs, administers Opioid Health Home and Behavioral Health Home programs to provide comprehensive care management and coordination services to Medicaid members diagnosed with an opioid use disorder, or an SMI or SED. Health homes receive reimbursement for providing mandated core services such as care management, health promotion,	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	and individual and family support, and are designed to improve member health outcomes while decreasing costs. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included four performance metrics with baseline performance and performance targets for 2026 for two of the Medicaid managed care programs in Michigan. However, no performance metrics related to the Behavioral Health Managed Care program were included. HSAG recommends that MDHHS add a performance metric for the Behavioral Health Managed Care program under Goal #5 or clarify the rationale for not including the Behavioral Health Managed Care program in MDHHS' evaluation of Goal #5 when value-based initiatives and payment reform are being implemented through the Behavioral Health Managed Care program.	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), PIHPs are required to have a comprehensive QAPIP, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must involve:

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

The primary objective of PIP validation is to determine the PIHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the PIHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PIHP improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the PIHP during the PIP.

MDHHS requires that each PIHP conduct at least one PIP subject to validation by HSAG. In SFY 2023, the PIHPs submitted quality improvement strategies for their PIHP-specific PIP topics. HSAG conducted validation on the PIP Design stage (Steps 1 through 6) and Implementation stage (Steps 7 through 8) of the selected PIP topic for each PIHP. The PIP topics chosen by PIHPs addressed CMS' requirements related

to quality outcomes—specifically, the quality of and access to care and services. MDHHS requested that the PIHPs also implement PIPs that focus on eliminating disparities within their populations, when applicable.

Technical Methods of Data Collection and Analysis

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019 (CMS EQR Protocol 1).[A-1] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[A-2]

Aligning with the CMS EQR Protocol 1, HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each PIHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS protocols identify 9 steps that should be validated for each PIP. For the SFY 2023 submissions, the PIHPs reported quality improvement strategies and were validated for Steps 1 through Step 8 in the PIP Validation Tool as appropriate.

The nine steps included in the PIP Validation Tool are listed below:

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

[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: Feb 20, 2024.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 20, 2024.

HSAG used the following methodology to evaluate PIPs conducted by the PIHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs (CMS EQR Protocol 1).

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. 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 rating (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 2023, the PIHPs submitted quality improvement strategies. The performance indicator measurement period dates for the PIP are listed in Table A-1.

Table A-1—Measurement Period Dates

Data Obtained	Measurement Period	Reporting Year (Measurement Period)
Administrative	Baseline	SFY 2022 (CY 2021)
Administrative	Remeasurement 1	SFY 2024 (CY 2023)
Administrative	Remeasurement 2	SFY 2025 (CY 2024)

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the PIHP provided to members, HSAG validated the PIPs to ensure the PIHP used a sound methodology in its design and PIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation rating 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 2023, which began October 1, 2022, and ended December 31, 2022. 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 Protocol 3 identifies key types of data that should be reviewed as part of the validation process. The type of data collected and how HSAG conducted an analysis of the data included:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' IS; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs and CMHSPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs/CMHSPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2022 performance indicator reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

PMV Activities

HSAG conducted PMV virtually with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the IS, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no

additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

Description of Data Obtained and Related Time Period

As identified in CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **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 Frames

Data Sources	Period to Which Data Applied
ISCAT (from PIHPs)	SFY 2022 and Q1 SFY 2023
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2022 and Q1 SFY 2023
Previous performance measure results reports (from MDHHS)	SFY 2022
Performance measure results (from PIHPs and MDHHS)	SFY 2022 and Q1 SFY 2023
Supporting documentation (from PIHPs and MDHHS)	SFY 2022 and Q1 SFY 2023
Virtual interviews and systems demonstrations (from PIHPs)	July 6–20, 2023

Table A-3 displays the performance indicators calculated by the PIHPs, and Table A-4 displays the performance indicators calculated by MDHHS that were included in the validation of performance measures, the subpopulations, the validation review period to which the data applied, and the agency responsible for calculating the indicator.

Table A-3—Performance Indicators Calculated by the PIHPs

Indicator		Sub-Populations	Measurement Period
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	Q1 SFY 2023
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Q1 SFY 2023
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Q1 SFY 2023

Indicator		Sub-Populations	Measurement Period
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults	Q1 SFY 2023
#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	Q1 SFY 2023
#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	Q1 SFY 2023

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	Q1 SFY 2023
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	Q1 SFY 2023
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	• HSW Enrollees	Q1 SFY 2023
#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 2022
#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 2022

Indicator		Sub-Populations	Measurement Period
#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 2022
#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 2022

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 2023 compliance review is the third 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). This SFY 2023 (Year Three) review consisted of a review of the standards and elements that required a CAP during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities.

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

Table A-5—Division of Standards Over Review Periods

Compliance Review Standards	Associated Federal Citations[1, 2]		Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of PIHPs' implementation of Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[3]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[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 MHPs. 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, which included a review of each PIHP's implementation of its CAP for each element that received a deficiency during the SFY 2021 and SFY 2022 compliance reviews. The review processes used by HSAG to evaluate the PIHPs' compliance were consistent with CMS EQR Protocol 3.

For each of the PIHPs, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools (i.e., CAP review tool).
- 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.
- 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 half-day 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 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 of *Complete* and *Not Complete* (as described below in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared a PIHP-specific report detailing the findings of HSAG's review.

- Conducted a mandatory technical assistance meeting with the PIHP to review any CAP element that received a score of *Not Complete* (unless otherwise noted in the CAP compliance review tool).

Data Aggregation and Analysis:

HSAG used scores of *Complete* and *Not Complete* to indicate the degree to which the PIHP's performance complied with the requirements. The scoring methodology is outlined below:

Complete 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 documentation, and IS reviews confirm implementation of the requirement.

Not Complete 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 documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Complete* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

To draw conclusions about the quality, timeliness, and accessibility of care and services the PIHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the PIHP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the PIHP's performance for each element that required a CAP.
- The total number of *Complete* CAPs and *Not Complete* CAPs for each standard.
- The overall number of *Complete* CAPs and *Not Complete* CAPs calculated across the standards.
- Whether the PIHP was required to participate in a mandatory technical assistance meeting.
- Documented recommendations for program enhancement, when applicable.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to MDHHS staff members for their review and comment prior to issuing final reports.

Technical Assistance Process:

For any CAP elements scored as *Not Complete*, the PIHP was required to participate in a mandatory technical assistance meeting with MDHHS and HSAG (unless otherwise noted in the CAP compliance review tool) to further discuss the requirement(s), expectations, and appropriate action plans to bring the element(s) into compliance. The PIHP was required to update its existing CAP(s) and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS' and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. HSAG will review the PIHP's implementation of the remaining action plans and level of compliance during the next three-year cycle of compliance reviews.

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:

- CAP workplans and timelines.
- Documentation supporting implementation of the CAPs (e.g., 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).
- Examples of case file documentation for the applicable program areas and elements that required a CAP (e.g., care management, service authorization denials, grievances, appeals, credentialing, and/or delegated entities).
- IS review of the data systems that the PIHP used in its operations applicable to the CAP elements under review.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the PIHP's key staff members. Table A-6 lists the major data sources HSAG used to determine the PIHP's performance in complying with requirements and the time period to which the data applied.

Table A-6—Description of PIHP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	Documentation effective as of the PIHP's site review date (i.e., August 14–25, 2023)
Information obtained through interviews	August 14–25, 2023
Information obtained post-site review	Documentation effective as of two business days after the PIHP's site review date
Information obtained through technical assistance sessions	October 30, 2023

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 (i.e., number of *Complete* and *Not Complete* elements) calculated for each standard. As any element not achieving compliance required a formal action plan, HSAG determined each PIHP's substantial strengths and weaknesses as follows:

- Strength—Any program area in which the PIHP received a *Complete* score for all elements.
- Weakness—Any program area with two or more elements with a *Not Complete* score; or any program area with one element that received a *Not Complete* score, but the deficiency was determined to be significant or egregious.

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.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted PIHPs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2023, MDHHS contracted with HSAG to conduct an EDV study. HSAG conducted the following two core evaluation activities for all 10 PIHPs:

- IS review—assessment of MDHHS' and the PIHPs' IS and processes. The goal of this activity is to examine the extent to which MDHHS' and the PIHPs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the PIHPs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- In Stage 1: HSAG conducted a document review, examining various documents related to MDHHS' encounter data initiatives. This review included data dictionaries, process flow charts, system diagrams, and other relevant materials. The information from this review was used to create a questionnaire for MDHHS.
- In Stage 2: HSAG worked with MDHHS to develop a customized questionnaire that delved into specific data processing procedures, staff responsibilities, and data acquisition capabilities. This assessment also considered additional data systems and key topics important to MDHHS.
- In Stage 3: HSAG followed up with key staff members to clarify questionnaire responses. These follow ups allowed HSAG to document current processes and create a process map highlighting crucial factors affecting the quality of encounter data submissions.

Administrative Profile

HSAG submitted a data submission requirements document to notify MDHHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist MDHHS in preparing the requested data files, HSAG took two actions. First, since it was the first-time requesting data from MDHHS' warehouse, HSAG asked for test files before the complete data extraction. These smaller test files, covering a month's encounters, served two purposes. They helped detect extraction issues early and allowed HSAG to begin analysis preparations while waiting for complete data. Details were provided in the data requirements document.

Secondly, after submitting the draft data submission requirements to MDHHS, HSAG scheduled a meeting to address questions about data preparation and extraction. Depending on the complexity, an updated/final document was submitted for MDHHS review and approval.

Once the data arrived from MDHHS, HSAG conducted a preliminary file review. This ensured that the data were reasonable for evaluation, checking data extraction, field presence, and value validity. If necessary, HSAG requested data resubmission based on these results.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P]) and 837 Institutional [837I]) and PIHP. However, when the results indicated a data quality issue(s), HSAG conducted an additional investigation to determine whether the issue was

for a specific category of service or subpopulation. HSAG documented all noteworthy findings in this aggregate report.

Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur or the last date of service): If the number of members remains stable and there are no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider National Provider Identifier (NPI), and date of service.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each PIHP based on the member enrollment data extracted by MDHHS.
- Paid amount PMPM by service month: This metric helps MDHHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount or detail paid amount to calculate this metric.
- Percentage of duplicate encounters: HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and documented the method in the final report. This metric will allow MDHHS to assess the number of potential duplicate encounters in MDHHS' database.

Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by MDHHS within 360 days, in 30-day increments, from the PIHP payment date. This metric allows MDHHS to evaluate the extent to which the PIHPs are in compliance with MDHHS' encounter data timeliness requirements.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS within two calendar months, three months, etc., from the service month. This metric allows MDHHS to evaluate how soon it may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters were complete and accurate through the two study indicators described in Table A-7 for the key data elements listed in Table A-8. In addition, Table A-7 shows the criteria HSAG used to evaluate the validity of each data element. These

criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table A-7—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table A-8 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-8.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-8.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-8. The criteria for validity are listed in Table A-8.

Table A-8—Key Data Elements for Percent Present and Percent Valid

Key Data Element	837P Encounters	837I Encounters	Criteria for Validity
Member ID[H]	√	√	• In member file • Enrolled in a specific PIHP on the date of service • Member date of birth is on or before date of service
Header Service From Date[H]	√	√	• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date[H]	√	√	• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date[D]	√	√	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	√	√	• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date

Key Data Element	837P Encounters	837I Encounters	Criteria for Validity
Billing Provider NPI[H]	√	√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	√		• In provider data when service occurred • Meets Luhn formula requirements
Attending Provider NPI[H]		√	• In provider data when service occurred • Meets Luhn formula requirements
Referring Provider NPI[H]	√	√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider Taxonomy Code[H]	√		• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		√	• In standard taxonomy code set • Matches the value in provider data
Primary Diagnosis Codes[H]	√	√	• In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2022, code set for services that occurred between October 1, 2021, and September 30, 2022)
Secondary Diagnosis Codes[H]	√	√	• In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes[D]	√	√	• In national CPT/HCPCS code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) AND satisfies CMS' Procedure-to-Procedure edits
Primary Surgical Procedure Codes[H]		√	• In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		√	• In national ICD-10-CM surgical procedure code sets for the correct code year
Revenue Codes[D]		√	• In national standard revenue code sets for the correct code year
Diagnosis-Related Group (DRG) Codes[H]		√	• In national standard All Patients Refined (APR)-DRG code sets for the correct code year
Type of Bill Codes[H]		√	• In national standard type of code set
National Drug Codes (NDCs)[D]	√	√	• In national NDC code sets

Key Data Element	837P Encounters	837I Encounters	Criteria for Validity
Submit Date[D]	√	√	• PIHP Submission Date (i.e., the date when PIHP submits encounters to MDHHS) ≥ PIHP Paid Date
PIHP Paid Date[D]	√	√	• PIHP Paid Date ≥ Detail Service To Date
Header Paid Amount[H]	√	√	• Header Paid Amount equal to sum of the Detail Paid Amount
Detail Paid Amount[D]	√	√	• Zero or positive
Header TPL Paid Amount[H]	√	√	• Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail TPL Paid Amount[D]	√	√	• Zero or positive

[H] Conduct evaluation at the header level
[D] Conduct evaluation at the detail level

Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that are in both the encounter and member enrollment files). If an encounter contained more than one NPI (e.g., rendering provider NPI and billing provider NPI on a professional encounter), HSAG included both unique NPIs in the analysis. Table A-9 lists the study indicators that HSAG calculated.

Table A-9—Key Indicators of Referential Integrity

Data Source	Indicator
Medical Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical Encounter
Medical Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical Encounter File

Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG developed logic-based checks to ensure the encounter data could appropriately support additional activities.

- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provides insight into how well encounter data may be used to support future analyses, such as Healthcare Effectiveness Data and Information Set (HEDIS®)[A-3] performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained and Related Time Period

Information Systems Review

Representatives from each PIHP completed the MDHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the PIHP's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2021, through September 30, 2022.
- Member demographic and enrollment data.
- Provider data.

Process for Drawing Conclusions

Information Systems Review

HSAG compiled findings from the review of the received questionnaire responses, identifying critical points that affected the submission of quality encounter data. HSAG made conclusions based on CMS EQR Protocol 5, the MCO contract, MDHHS' data submission requirements (e.g., companion guides), and HSAG's experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each PIHIP's encounter data submissions to MDHHS, HSAG evaluated the results based the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the PIHP's encounter data submissions to MDHHS. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to MDHHS.

[A-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).