MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PREPAID INPATIENT HEALTH PLANS

Revised: June, 2021

The State of Michigan requires that each Prepaid Inpatient Health Plan (PIHP) have a Quality Assessment and Performance Improvement Program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act (BBA) of 1997, Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects concepts and standards more appropriate to the population of persons served under Michigan's current specialty services and supports waiver; Michigan state law; and existing requirements, processes, and procedures implemented in Michigan.

Michigan Standards:

I. The PIHP must have a written description of its QAPIP which specifies 1.) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2.) the components and activities of the QAPIP including those as required below; 3.) the role for recipients of service in the QAPIP; and 4.) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement. The updated QAPIP description and associated work plan must be submitted to MDHHS annually by February 28th.

II. The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QAPIP – There is documentation that the Governing Body has approved the overall QAPIP and an annual Quality Improvement (QI) plan.

B. QAPIP progress reports – The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken, and the results of those actions.

C. Annual QAPIP review – The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

D. The Governing Body submits the written annual report to the Michigan Department of Health and Human Services (MDHHS) by February 28th.b. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and individuals in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection, and analysis of valid and reliable data.

A. The PIHP must utilize performance measures established by the MDHHS in the areas of access, efficiency, and outcome and report data to the State as established in the contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the MDHHS and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHPs QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable, and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances, trends, and patterns of substantiated Recipient Rights complaints as well as access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed.

C. Performance improvement projects may be directed at the State or the PIHP established aspects of care. Future State-directed projects will be selected by the MDHHS with consultation from the Quality Improvement Council (QIC) and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. The PIHPs may collaborate with other PIHPs on projects subject to the approval of the MDHHS.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put individuals at risk of harm.

A. At a minimum, sentinel events as defined in the MDHHS contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has **three (3) business days** after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has **two (2) subsequent business days** to commence a root cause analyses of the event.

B. Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate).

2. Involvement of medical personnel in the mortality reviews.

3. Documentation of the mortality review process, findings, and recommendations.

4. Use of mortality information to address quality of care.

5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to the MDHHS (See Section 6.1 of this Contract), the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. <u>Critical Incident Reporting System</u>

The Critical Incident Reporting System collects information on critical incidents that can be linked to specific service recipients. This Critical Incident Reporting System became fully operational and contractually required October 1, 2011. Refer to the PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries.

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of the individual. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze, at least quarterly, the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The MDHHS will request documentation of this process when performing site visits.

The MDHHS has developed formal procedures for analyzing the event data submitted through this System. This includes criteria and processes for the MDHHS follow-up on individual events as well as processes for systemic data aggregation, analysis, and follow-up with the PIHPs.

F. Risk Events Management – The QAPIP has a process for analyzing additional critical incidents that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The MDHHS will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves.
- Actions taken by individuals who receive services that cause harm to others.
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a **12-month period**.

Following immediate event notification to the MDHHS (See Section 6.1 of the Contract – Critical Incidents) the PIHP will submit to the MDHHS, within **60 days** after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within **one year** of the individual's discharge from a State-operated service.

IX. The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning (PCP) by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per individual.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the individuals served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:

1. Takes specific action on individual cases as appropriate;

2. Identifies and investigates sources of dissatisfaction;

3. Outlines systemic action steps to follow-up on the findings; and

4. Informs practitioners, providers, recipients of service, and the Governing Body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization ensures the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by the MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with the MDHHS Credentialing and Re-Credentialing Processes, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying, and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also ensure, regardless of funding mechanism (e.g., voucher):

A. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

1. Educational background,

2. Relevant work experience,

3. Cultural competence, and

4. Certification, registration, and licensure as required by law.

B. A program shall train new personnel regarding their responsibilities, program policy, and operating procedures.

C. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHPs QAPIP must address how it will verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates (as applicable), providers, and subcontractors.

A. The PIHP must submit to the State for approval its methodology for verification.

B. The PIHP must annually submit its findings from this process and provide any follow-up actions that were taken because of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan – Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

B. Scope – The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures – Prospective (preauthorization), concurrent, and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.

3. The reasons for decisions are clearly documented and available to the member.

4. There are well-publicized and readily available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.

5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction, or other appropriate measures.

7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHP shall continually evaluate its oversight of “vulnerable” individuals to determine opportunities for improving oversight of their care and outcomes. The MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable individuals.

The PIHP shall review and approve corrective action plans that result from identified areas of non-compliance and follow up on the implementation of the plans at the appropriate interval. Reports of the annual monitoring and corrective action plans shall be subject to the MDHHS review.