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Behavioral Health and Developmental Disabilities Administration

SFY 2018–2019 External Quality Review Technical Report *for* Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' performance related to the quality of, timeliness of, and access to care and services provided by each entity, 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.

MDHHS administers and oversees the Michigan Medicaid managed care program. The Michigan Medicaid managed care program's managed care entities include 10 MDHHS-contracted prepaid inpatient health plans (PIHPs). 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 Community Mental Health Services Programs (CMHSPs) and other providers within the region to deliver Medicaid-funded mental health, substance use disorder (SUD), and intellectual and developmental disability (IDD) supports and services. The PIHPs include the following:

- Region 1—NorthCare Network
- Region 2—Northern Michigan Regional Entity
- Region 3—Lakeshore Regional Entity
- Region 4—Southwest Michigan Behavioral Health
- Region 5—Mid-State Health Network
- Region 6—Community Mental Health Partnership of Southeast Michigan
- Region 7—Detroit Wayne Integrated Health Network[1-1]
- Region 8—Oakland Community Health Network[1-2]
- Region 9—Macomb County Community Mental Health
- Region 10 PIHP

Member populations receiving services through the PIHPs are commonly referenced throughout this report using the following abbreviations.

- SED Children—Children diagnosed with serious emotional disturbance (SED)
- MI Adults—Adults diagnosed with mental illness
- IDD Children—Children with intellectual and developmental disability

[1-1] Formally known as Detroit Wayne Mental Health Authority.
[1-2] Formally known as Oakland County CMH Authority.

- IDD Adults—Adults with intellectual and developmental disability
- MI/IDD Adults—Adults dually diagnosed with mental illness and intellectual and developmental disability
- Medicaid SUD—Adults diagnosed with substance use disorder

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to provide valid and reliable data and information about the PIHPs' performance. For the 2018–2019 assessment, HSAG used findings from the following mandatory EQR activities to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each PIHP. More detailed information about each activity is provided in ***Section 4*** of this report.

- **Compliance monitoring:** The 2018–2019 reporting period was the second year of the three-year compliance review cycle. HSAG reviewed approximately 50 percent of federally mandated standards and their associated State-specific requirements, when applicable.
- **Validation of performance measures:** HSAG validated the performance measures identified by MDHHS to evaluate the accuracy of the rates reported by or on behalf of each PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed the specifications established by MDHHS.
- **Validation of performance improvement projects (PIPs):** For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported about the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the performance of the PIHPs in providing quality, timely, and accessible healthcare services to Michigan Medicaid members. For each PIHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the PIHP's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each PIHP, please refer to ***Section 5*** of this report.

The overall findings and conclusions for all PIHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Michigan Medicaid managed care program and, specifically, the Medicaid program managed by the Behavioral Health and Developmental Disabilities Administration (BHDDA). For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the Michigan Medicaid managed care program under BHDDA, please refer to ***Section 6*** of this report.

Michigan Behavioral Health and Developmental Disabilities Administration

Through completion of this annual comprehensive EQR, HSAG aggregated and analyzed the performance results for BHDDA, identifying areas of strength across the program. Through the compliance monitoring review activity, the program demonstrated areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Three of the nine program standards evaluated during the review received PIHP aggregated scores of 90 percent or higher. Additionally, as demonstrated through the performance measure activities, statewide average scores exceeded corresponding MDHHS-established performance standards for 17 of 19 indicators related to providing high-quality, assessible, and timely behavioral health and SUD services. Further, through participation in PIPs, the PIHPs are focusing efforts on specific quality outcomes, with an end goal to improve the health outcomes of Michigan Medicaid members.

This annual comprehensive assessment of the program through this EQR also revealed that predominant areas of the program had opportunities for improvement when overall performance of the program was evaluated. Quality measurement and improvement activities within the quality assessment and performance improvement program (QAPIP); the adherence to utilization management program requirements, including authorization of services functions; appropriate management of provider credentialing; and the establishment of written processes for the use and disclosure of protected health information (PHI) are key areas of opportunity for BHDDA and the Michigan Medicaid managed care program. Additionally, although statewide average performance measure scores exceeded their corresponding MDHHS-established performance standards for most indicators, all PIHPs had at least one performance measure rate that fell below the established standard, indicating that network deficiencies or other barriers to receiving timely access to services may exist for some members.

To improve statewide performance in the quality and timeliness of and access to care, HSAG makes the following recommendations to BHDDA and MDHHS:

1. Consider requiring each PIHP to incorporate efforts for improvement as part of its quality improvement strategy within the QAPIP to address any performance areas not meeting MDHHS, federal, and/or PIHP-specific standards. The quality improvement program description and work plan should be provided to MDHHS at least annually at an MDHHS-designated time frame.
2. Conduct a comprehensive evaluation of each submitted PIHP QAPIP work plan for completeness and to ensure the documented interventions have the ability to positively impact performance improvement.
3. Conduct a comprehensive review of the annual evaluation of each PIHP's QAPIP that includes an analysis of the interventions and the effectiveness of those interventions on the PIHP's established goals and objectives.
4. Consider reviewing and revising the performance measure specifications for performance indicators that consistently meet the minimum performance standard (MPS) to further promote quality improvement.
5. Require each PIHP to complete an annual formal report on its analyses of critical incidents, sentinel events, and risk events, and on the assessment of member experience with services.

6. As some PIHPs expressed concern over the complex or confusing language in letter templates used for utilization decisions, convene a workgroup inclusive of MDHHS and PIHP participants to develop and/or update State-specific letter templates.
7. Establish uniform delegation oversight monitoring criteria that each PIHP must follow that, at a minimum, addresses oversight of the PIHPs' delegated entities' credentialing and utilization management functions and includes a comprehensive auditing plan to ensure implementation of program requirements.
8. Mandate that PIHPs follow established National Committee for Quality Assurance (NCQA) credentialing requirements.
9. Mandate a time frame standard in which PIHPs must complete the credentialing process.
10. Mandate PIHP reporting of all breaches to MDHHS within a specified time period.
11. Develop a standardized breach reporting log for the PIHPs to submit to MDHHS at least annually.

For a more detailed discussion on preceding quality strategy recommendations to improve the quality, timeliness, and accessibility of behavioral healthcare and SUD services to Michigan's Medicaid managed care members, please refer to ***Section 6*** of this report.

NorthCare Network

Based on the aggregated results of the 2018–2019 EQR activities, **NorthCare Network** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **NorthCare Network** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review, slightly above the statewide average.
- **NorthCare Network** scored 90 percent or above in the Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **NorthCare Network** scored 88 percent, 75 percent, 75 percent, 69 percent, 85 percent, and 56 percent respectively in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, and Credentialing standards, indicating that additional focus is needed in these areas.
- **NorthCare Network**'s performance measure rates were above the MDHHS-established MPS for 18 of the 19 indicators, indicating strengths in these areas. Additionally, indicator *#4b* (timely follow-up care after discharge from a substances abuse detox unit) increased by more than 13 percentage points from the prior year.
- **NorthCare Network**'s MPS related to timely assessments for new Medicaid members for the Medicaid SUD population was not met, indicating opportunities for improvement in this area. Further, this indicator did not meet the MPS for the Medicaid SUD population for both the current and prior years. Additionally, a greater than 5 percent increase in readmissions to an inpatient psychiatric unit for adults from the prior year occurred, suggesting that focus on this measure should be heightened to ensure that the rate does not continue to increase.

- **NorthCare Network** designed a scientifically sound PIP related to *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*, which was supported by the use of key research principles, meeting all requirements in the Design stage (Steps I through VI). **NorthCare Network** accurately calculated and interpreted the baseline results for each study indicator. However, **NorthCare Network** documented interventions that began prior to the baseline measurement period. By initiating interventions prior to the baseline, the baseline performance should be interpreted with caution.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **NorthCare Network** to members, HSAG recommends that **NorthCare Network** develop a quality improvement strategy to address the performance indicators requiring improvement, listed in ***Section 5***. **NorthCare Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **NorthCare Network** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **NorthCare Network** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Northern Michigan Regional Entity

Based on the aggregated results of the 2018–2019 EQR activities, **Northern Michigan Regional Entity** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Northern Michigan Regional Entity** received a total compliance score of 70 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was lower than the statewide average. Additionally, **Northern Michigan Regional Entity** was the overall second lowest-performing PIHP.
- **Northern Michigan Regional Entity** scored 90 percent or above in the Staff Qualifications and Training, and Coordination of Care standards, indicating strong performance in these areas.
- **Northern Michigan Regional Entity** scored 63 percent, 50 percent, 75 percent, 56 percent, 85 percent, 56 percent, and 60 percent respectively in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, Credentialing, and Confidentiality of Health Information, indicating that additional focus is needed in these areas.
- **Northern Michigan Regional Entity**'s performance measure rates were above the MDHHS-established MPS for seven of the 11 reportable indicators, indicating strengths in these areas. Additionally, indicator *#4a* (timely follow-up care for children after discharge from a psychiatric inpatient unit), increased by more than 13 percentage points from the prior year. Further, while the MPS for indicator *#4b* (timely follow-up care after discharge from a substance abuse detox unit) was not met, performance in the area increased by more than 16 percentage points from the prior year.

- **Northern Michigan Regional Entity**'s MPS related to starting ongoing services for new Medicaid members timely for the IDD Children and IDD Adults populations, timely follow-up care for adults after discharge from psychiatric inpatient units and timely follow-up care after discharge from a substance abuse detox unit were not met, indicating opportunities for improvement in these areas. Additionally, while the performance standard was met for indicator *#3* (starting ongoing services for new Medicaid members timely) for the Medicaid SUD population, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **Northern Michigan Regional Entity** should focus efforts on ensuring the rate in this area remains stable. Further, **Northern Michigan Regional Entity**'s rates were deemed *Not Reported* for eight performance measure rates related to timely preadmission screening for psychiatric inpatient care and timely assessments for new Medicaid members, demonstrating that **Northern Michigan Regional Entity** did not calculate these performance indicators according to the MDHHS Codebook specifications.
- **Northern Michigan Regional Entity** designed a scientifically sound project related to *Follow-Up Care for Children Prescribed ADHD Medication*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity** to members, HSAG recommends that **Northern Michigan Regional Entity** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Northern Michigan Regional Entity** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other improvement effort targets. **Northern Michigan Regional Entity** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Northern Michigan Regional Entity** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Lakeshore Regional Entity

Based on the aggregated results of the 2018–2019 EQR activities, **Lakeshore Regional Entity** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Lakeshore Regional Entity** received a total compliance score of 65 percent across all standards reviewed during the 2018–2019 compliance monitoring review, 14 percent below the statewide average. Additionally, **Lakeshore Regional Entity** was the overall lowest-performing PIHP.
- **Lakeshore Regional Entity** scored 90 percent or above in the Staff Qualifications and Training, and Coordination of Care standards, indicating strong performance in these areas.
- **Lakeshore Regional Entity** scored 63 percent, 63 percent, 75 percent, 56 percent, 77 percent, 56 percent, and 20 percent respectively in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, Credentialing, and Confidentiality of Health Information, indicating that additional focus is needed in these areas.
- **Lakeshore Regional Entity**'s performance measure rates were above the MDHHS-established MPS for 11 of the 19 indicators, indicating strengths in these areas. Additionally, the number of reportable indicators increased to 19 from zero reportable measure rates the prior year, demonstrating that **Lakeshore Regional Entity** improved adherence with the MDHHS Codebook specifications.
- **Lakeshore Regional Entity**'s MPS related to timely preadmission screening for psychiatric inpatient care for children and adults, timely assessments for new Medicaid members for the Medicaid SUD population, starting ongoing services for new Medicaid members timely for the SED Children and IDD Children populations, timely follow-up care for children and adults after discharge from a psychiatric inpatient unit, and timely follow-up care after discharge from a substance abuse detox unit were not met, indicating opportunities for improvement in these areas.
- **Lakeshore Regional Entity** designed a scientifically sound project related to *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity** to members, HSAG recommends that **Lakeshore Regional Entity** develop a quality improvement strategy to address the performance indicators requiring improvement, listed in ***Section 5***. **Lakeshore Regional Entity** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Lakeshore Regional Entity** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Lakeshore Regional Entity** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Southwest Michigan Behavioral Health

Based on the aggregated results of the 2018–2019 EQR activities, **Southwest Michigan Behavioral Health** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Southwest Michigan Behavioral Health** received a total compliance score of 90 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was above the statewide average. Additionally, **Southwest Michigan Behavioral Health** was the overall highest-performing PIHP.
- **Southwest Michigan Behavioral Health** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **Southwest Michigan Behavioral Health** scored 88 percent, 81 percent, and 56 percent respectively in the Quality Measurement and Improvement, Utilization Management, and Credentialing standards, indicating that additional focus is needed in these areas.
- **Southwest Michigan Behavioral Health**'s performance measure rates were above the MDHHS-established MPS for 16 of the 19 indicators, indicating strengths in these areas.
- **Southwest Michigan Behavioral Health**'s MPS related to timely starting of ongoing services for new Medicaid members for the SED Children and IDD Children populations and timely follow-up care after discharge from a substance abuse detox unit were not met, indicating opportunities for improvement in these areas. Additionally, while the MPS was met for indicator *#2* (timely meetings for new Medicaid beneficiaries) for the IDD Children population, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **Southwest Michigan Behavioral Health** should focus efforts on ensuring that the rate in this area remains stable.
- **Southwest Michigan Behavioral Health** designed a scientifically sound study related to *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health** to members, HSAG recommends that **Southwest Michigan Behavioral Health** develop a quality improvement strategy to ensure that all performance indicators remain stable. **Southwest Michigan Behavioral Health** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Southwest Michigan Behavioral Health** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Southwest Michigan Behavioral Health** should take proactive steps to

ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Mid-State Health Network

Based on the aggregated results of the 2018–2019 EQR activities, **Mid-State Health Network** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Mid-State Health Network** received a total compliance score of 87 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was above the statewide average. Additionally, **Mid-State Health Network** was the overall second highest-performing PIHP.
- **Mid-State Health Network** scored 90 percent or above in the Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **Mid-State Health Network** scored 88 percent, 75 percent, 75 percent, and 56 percent in the QAPIP Plan and Structure, Quality Measurement and Improvement, Utilization Management, and Credentialing standards, indicating that additional focus is needed in these areas.
- **Mid-State Health Network**'s performance measure rates were above the MDHHS-established MPS for 17 of the 19 indicators, indicating strengths in these areas.
- **Mid-State Health Network**'s MPS related to starting ongoing services for new Medicaid members timely for the IDD Children population and timely follow-up care for adults after discharge from a psychiatric inpatient unit were not met, indicating opportunities for improvement in these areas. Additionally, while the MPS were met for indicator *#3* (starting ongoing services for new Medicaid members timely) for the IDD Adults population and indicator *#4b* (timely follow-up care after discharge from a substance abuse detox unit), performance in these areas decreased by more than 2 percentage points from the prior year, indicating that **Mid-State Health Network** should focus efforts on ensuring that the rates in these areas remain stable.
- **Mid-State Health Network** designed a scientifically sound study related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommends that **Mid-State Health Network** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Mid-State Health Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Mid-State Health Network** should also develop comprehensive and effective plans

of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Mid-State Health Network** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Community Mental Health Partnership of Southeast Michigan

Based on the aggregated results of the 2018–2019 EQR activities, **Community Mental Health Partnership of Southeast Michigan** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Community Mental Health Partnership of Southeast Michigan** received across all standards reviewed during the 2018–2019 compliance monitoring review a total compliance score of 77 percent, which was slightly lower than the statewide average.
- **Community Mental Health Partnership of Southeast Michigan** scored 90 percent or above in the Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **Community Mental Health Partnership of Southeast Michigan** scored 63 percent, 50 percent, 75 percent, 67 percent, 88 percent, 77 percent, and 56 percent respectively in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Members' Rights and Protections, and Credentialing standards, indicating that additional focus is needed in these areas.
- **Community Mental Health Partnership of Southeast Michigan**'s performance measure rates were above the MDHHS-established MPS for 14 of the 18 reportable indicators, indicating strengths in these areas.
- **Community Mental Health Partnership of Southeast Michigan**'s MPS related to starting ongoing services for new Medicaid members timely for the MI Adults, IDD Children, IDD Adults, and Total populations were not met, indicating opportunities for improvement in this area. Additionally, while the MPS was met for indicator *#2* (timely meetings for new Medicaid beneficiaries) for the IDD Adults population, indicator *#3* (starting ongoing services for new Medicaid members timely) for the SED Children population, and indicator *#4a* (timely follow-up care for children after discharge from a psychiatric inpatient unit), performance decreased in these areas by more than 2 percentage points from the prior year. Further, **Community Mental Health Partnership of Southeast Michigan**'s rates were deemed *Not Reported* for one performance measure rate related to timely follow-up care after discharge from a substance abuse detox unit, demonstrating that **Community Mental Health Partnership of Southeast Michigan** did not calculate this performance indicator according to the MDHHS Codebook specifications.
- **Community Mental Health Partnership of Southeast Michigan** designed a scientifically sound PIP related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, which was supported by the use of key research principles, and accurately calculated and interpreted the baseline results. **Community Mental Health Partnership of Southeast Michigan** provided its quality improvement activities with the reporting of baseline data; however, **Community Mental**

Health Partnership of Southeast Michigan did not clearly identify barriers and implement interventions that were logically linked to the barriers and have the potential to impact the PIP study indicator outcomes.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Community Mental Health Partnership of Southeast Michigan** to members, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Community Mental Health Partnership of Southeast Michigan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Community Mental Health Partnership of Southeast Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Community Mental Health Partnership of Southeast Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Detroit Wayne Integrated Health Network

Based on the aggregated results of the 2018–2019 EQR activities, **Detroit Wayne Integrated Health Network** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Detroit Wayne Integrated Health Network** received a total compliance score of 79 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was equal to the statewide average.
- **Detroit Wayne Integrated Health Network** scored 90 percent or above in the QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care standards, indicating strong performance in these areas.
- **Detroit Wayne Integrated Health Network** scored 75 percent, 75 percent, 67 percent, 81 percent, 56 percent, and 50 percent respectively in the Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Credentialing, and Confidentiality of Health Information standards, indicating that additional focus is needed in these areas.
- **Detroit Wayne Integrated Health Network**'s performance measure rates were above the MDHHS-established MPS for one of the two reportable indicators, indicating strengths in this area.
- **Detroit Wayne Integrated Health Network**'s MPS related to timely preadmission screening for psychiatric inpatient care for new Medicaid members for children was not met, indicating opportunities for improvement in this area. Additionally, **Detroit Wayne Integrated Health Network**'s rates were deemed *Not Reported* for 17 of the 19 measure indicators related to timely assessment for new Medicaid members, starting ongoing services for new Medicaid members

timely, timely follow-up care after discharge from a psychiatric inpatient unit, timely follow-up after discharge from a substance abuse detox unit, and readmissions to an inpatient psychiatric unit, indicating opportunities for improvement in most measures. Further, **Detroit Wayne Integrated Health Network**'s rates were deemed *Not Reported* for indicators *#2* (timely meetings for new Medicaid beneficiaries), *#3* (starting ongoing services timely for new Medicaid members), *#4a* (timely follow-up care after discharge from a psychiatric inpatient unit), *#4b* (timely follow-up after discharge from a substance abuse detox unit), and *#10* (readmissions to an inpatient psychiatric unit) for the previous and current year, demonstrating continued challenges for **Detroit Wayne Integrated Health Network** to calculate these performance indicators according to the MDHHS Codebook specifications.

- **Detroit Wayne Integrated Health Network** designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Integrated Health Network** to members, HSAG recommends that **Detroit Wayne Integrated Health Network** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Detroit Wayne Integrated Health Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Detroit Wayne Integrated Health Network** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Detroit Wayne Integrated Health Network** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Oakland Community Health Network

Based on the aggregated results of the 2018–2019 EQR activities, **Oakland Community Health Network** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Oakland Community Health Network** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was slightly above the statewide average.
- **Oakland Community Health Network** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **Oakland Community Health Network** scored 63 percent, 69 percent, 85 percent, and 56 percent respectively in the Quality Measurement and Improvement, Utilization Management, Members' Rights and Protections, and Credentialing standards, indicating that additional focus is needed in these areas.
- **Oakland Community Health Network**'s performance measure rates were above the MDHHS-established MPS for 16 of the 19 indicators, indicating strengths in these areas.
- **Oakland Community Health Network**'s MPS related to timely preadmission screenings for psychiatric care for children, timely assessments for new Medicaid members for the SED Children population, and readmissions of adults to an inpatient psychiatric unit were not met, indicating opportunities for improvement in these areas. Additionally, while the performance standard was met for indicator *#3* (starting ongoing services for new Medicaid members timely) for the Medicaid SUD population, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **Oakland Community Health Network** should focus efforts on ensuring that the rate in this area remains stable.
- **Oakland Community Health Network** designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Oakland Community Health Network** to members, HSAG recommends that **Oakland Community Health Network** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Oakland Community Health Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Oakland Community Health Network** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Oakland Community Health Network** should take proactive steps to ensure a

successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Macomb County Community Mental Health

Based on the aggregated results of the 2018–2019 EQR activities, **Macomb County Community Mental Health** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Macomb County Community Mental Health** received a total compliance score of 78 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was slightly below the statewide average.
- **Macomb County Community Mental Health** scored 90 percent or above in the Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas.
- **Macomb County Community Mental Health** scored 75 percent, 50 percent, 50 percent, 63 percent, and 50 percent respectively in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, and Credentialing standards, indicating that additional focus is needed in these areas.
- **Macomb County Community Mental Health**'s performance measure rates were above the MDHHS-established MPS for six of the 11 reportable indicators, indicating strengths in these areas. Additionally, indicator *#4a* (timely follow-up for adults after discharge from a psychiatric inpatient unit) increased by more the 13 percentage points from the prior year.
- **Macomb County Community Mental Health**'s MPS related to starting ongoing services for new Medicaid members timely for the SED Children, MI Adults, IDD Children, and IDD Adults populations, and timely follow-up care for adults after discharge from a psychiatric inpatient unit were not met, indicating opportunities for improvement in these areas. Additionally, while the performance standard was met for indicator *#3* (starting ongoing services for new Medicaid members timely) for the Total population, performance in this area decreased by more than 2 percentage points from the prior year. Further, performance for indicator *#3* decreased (ranging from a 2.54 to 11.43 percent decrease) in five of the six populations from the prior year, indicating that **Macomb County Community Mental Health** should focus efforts on ensuring the rate in this area remains stable. Lastly, **Macomb County Community Mental Health**'s rates were deemed *Not Reported* for eight indicators related to timely preadmission screening for psychiatric inpatient care and timely assessments for new Medicaid members, demonstrating that **Macomb County Community Mental Health** did not calculate these performance indicators according to the MDHHS Codebook specifications.
- **Macomb County Community Mental Health** designed a scientifically sound study related to *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness*, which was supported by the use of key research principles, meeting all requirements in the Design stage. However, **Macomb County Community Mental Health** did not provide a complete narrative interpretation of

PIP study indicator results. **Macomb County Community Mental Health** was to have included the baseline rate and a description of how the baseline rate was calculated.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Macomb County Community Mental Health** to members, HSAG recommends that **Macomb County Community Mental Health** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Macomb County Community Mental Health** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Macomb County Community Mental Health** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Macomb County Community Mental Health** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Region 10 PIHP

Based on the aggregated results of the 2018–2019 EQR activities, **Region 10 PIHP** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Region 10 PIHP** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was slightly higher than the statewide average.
- **Region 10 PIHP** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, and Coordination of Care standards, indicating strong performance in these areas.
- **Region 10 PIHP** scored 88 percent, 75 percent, 56 percent, and 40 percent respectively in the Quality Measurement and Improvement, Utilization Management, Credentialing, and Confidentiality of Health Information standards, indicating that additional focus is needed in these areas.
- **Region 10 PIHP**'s performance measure rates were above the MDHHS-established MPS for 17 of the 18 reportable indicators, indicating strengths in these areas. Of the performance measure rates that met the MPS, none of these rates decreased by more than 2 percentage points, indicating stable performance.
- **Region 10 PIHP**'s MPS related to readmissions of children to an inpatient psychiatric unit was not met, indicating opportunities for improvement in this area. **Region 10 PIHP**'s rate was deemed *Not Reportable* for one indicator related to timely follow-up care after discharge from a substance abuse detox unit, demonstrating that **Region 10 PIHP** did not calculate this performance indicator according to the MDHHS Codebook specifications.
- **Region 10 PIHP** designed a scientifically sound study related to *Medical Assistance for Tobacco Use Cessation*, which was supported by the use of key research principles. The technical design of

the PIP was sufficient to measure and monitor PIP outcomes. **Region 10 PIHP** accurately calculated and interpreted the baseline results. However, **Region 10 PIHP** did not provide plan-specific data supporting the PIP study topic selection. The study topic should be selected based on data that identify an opportunity for improvement.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP** to members, HSAG recommends that **Region 10 PIHP** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in ***Section 5***. **Region 10 PIHP** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Region 10 PIHP** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. Further, **Region 10 PIHP** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

2. Introduction to the Annual Technical Report

Purpose of Report

States that provide Medicaid services through contracts with PIHPs are required to conduct EQR activities of the PIHPs and to ensure that the results of those activities are used to perform an external, independent assessment and to produce an annual report. The annual assessment evaluates each PIHP's performance related to the quality of, timeliness of, and access to the care and services it provides. To meet the requirement to conduct this annual evaluation and produce this report of results, MDHHS contracted with HSAG as its external quality review organization (EQRO).

Organizational Structure of Report

As mandated by CFR §438.364 and in compliance with the Centers for Medicare & Medicaid Services' (CMS') EQR protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from EQR activities conducted in accordance with §438.358 were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each PIHP's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the PIHPs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the PIHPs, including recommendations for each individual PIHP and recommendations for MDHHS to target Michigan's Quality Strategy to improve the quality of care provided by the Michigan Medicaid managed care program as a whole.
- Contains methodological and comparative information for all PIHPs.
- Assesses the degree to which each PIHP has addressed the recommendations for quality improvement made by the EQRO during the 2017–2018 EQR.

This report is composed of six sections: Executive Summary, Introduction to the Annual Technical Report, Overview of Michigan Medicaid Managed Care Program, External Quality Review Activities, Assessment of PIHP Performance, and PIHP Comparative Information With Recommendations for MDHHS. This report also includes summary tables of EQR activity results and review tools for the 2018–2019 EQR activities.

Section 1—Executive Summary

The Executive Summary section presents a high-level overview of the EQR activities, conclusions, and recommendations for the MDHHS managed care program and the PIHPs.

Section 2—Introduction to the Annual Technical Report

The Introduction to the Annual Technical Report section provides information about the purpose, contents, and organization of the annual technical report.

Section 3—Overview of Michigan Medicaid Managed Care Program

The Overview of Michigan Medicaid Managed Care Program section gives a description of the Michigan Medicaid managed care program, brief descriptions of each of the PIHPs that contract with MDHHS to provide services to members, and a brief overview of Michigan's Quality Strategy and goals for the health of Michigan's Medicaid population.

Section 4—External Quality Review Activities

The External Quality Review Activities section presents information about each of the EQR activities conducted, including the activity's objectives, technical methods of data collection and analysis, a description of the data obtained, and the time period under review.

Section 5—Assessment of PIHP Performance

The Assessment of PIHP Performance section presents the PIHP-specific results for each of the EQR activities conducted during the 2018–2019 review period.

Section 6—PIHP Comparative Information With Recommendations for MDHHS

The PIHP Comparative Information With Recommendations for MDHHS section presents summarized data and comparative information about the PIHPs' performance. This section also identifies areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement based on PIHP performance.

3. Overview of Michigan Medicaid Managed Care Program

Managed Care in Michigan and Overview of PIHPs

MDHHS oversees the health insurance programs for the State of Michigan. Under approval granted by CMS, MDHHS operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and IDD services, as well as certain covered SUD services, have been carved out from Medicaid primary physical healthcare plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with IDD. Additionally, CMS has approved an 1115 Demonstration project, the Healthy Michigan Plan, which provides healthcare coverage for adults who become eligible for Medicaid under section 1902(2)(10)(A)(i)(VIII) of the Social Security Act. Such arrangements have been designated as "Concurrent 1915(b)/(c)" programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs and the Healthy Michigan Plan are managed on a shared-risk basis by specialty PIHPs, selected through an Application for Participation process. Further, under the approval of the Substance Abuse and Mental Health Services Administration (SAMHSA), MDHHS operates a SUD prevention and treatment program under the SUD Community Grant.

MDHHS selected 10 PIHPs to manage the Concurrent 1915(b)/(c) programs, the Healthy Michigan Plan, and SUD Community Grant programs. The MDHHS-contracted PIHPs partner with CMHSPs and local recovery-oriented systems of care to provide a comprehensive array of specialty mental health and SUD services and supports to members in their designated service areas.

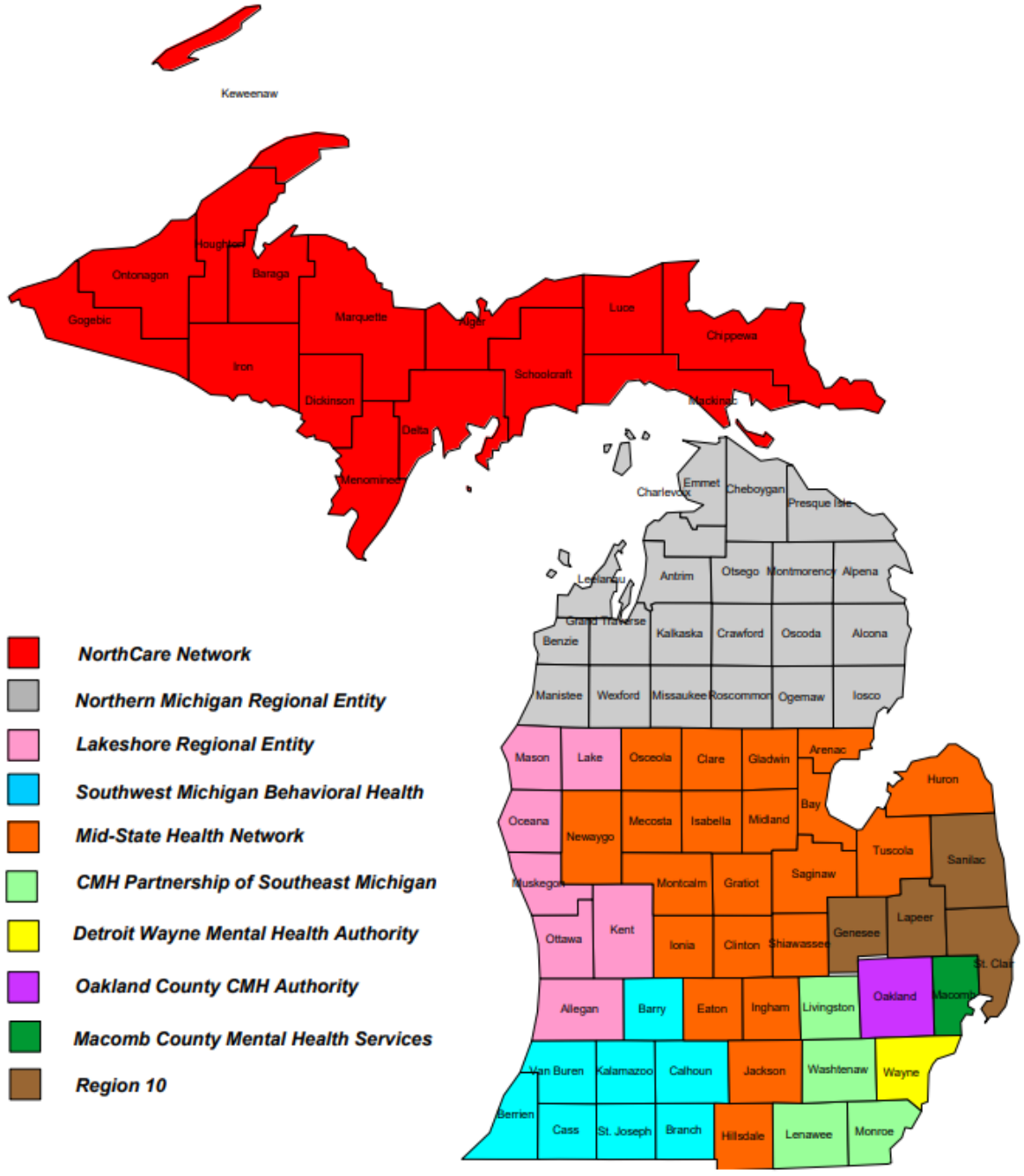
Overview of PIHPs

During the 2018–2019 review period, MDHHS contracted with 10 qualified PIHPs. Table 3-1 provides a profile for each PIHP. Each PIHP is responsible for managing one region of the State, and each region may comprise a single county or multiple counties. Figure 3-1 shows a visual representation of the counties included in each of the 10 PIHP regions.

Table 3-1—PIHP Profiles

PIHP	Operating Region	Affiliated CMHSP(s)
NorthCare Network (NorthCare)	Region 1	Pathways Community Mental Health (CMH), Copper Country CMH, Hiawatha CMH, Northpointe CMH, Gogebic CMH
Northern Michigan Regional Entity (NMRE)	Region 2	AuSable CMH, Centra Wellness Network, North Country CMH, Northern Lakes CMH, Northeast CMH
Lakeshore Regional Entity (LRE)	Region 3	Allegan CMH, Muskegon CMH, Network 180, Ottawa CMH, West MI CMH
Southwest Michigan Behavioral Health (SWMBH)	Region 4	Barry CMH, Berrien CMH, Kalamazoo CMH, Pines CMH, St. Joseph CMH, Summit Pointe CMH, Van Buren CMH, Woodlands CMH
Mid-State Health Network (MSHN)	Region 5	Bay-Arenac CMH, CMH for Central MI, Clinton-Eaton-Ingham (CEI) CMH, Gratiot CMH, Huron CMH, Ionia CMH, Lifeways CMH, Montcalm CMH, Newaygo CMH, Saginaw CMH, Shiawassee CMH, Tuscola CMH
Community Mental Health Partnership of Southeast Michigan (CMHPSM)	Region 6	Washtenaw CMH, Lenawee CMH, Livingston CMH, Monroe CMH
Detroit Wayne Integrated Health Network (DWIHN)	Region 7	Detroit-Wayne CMH
Oakland Community Health Network (OCHN)	Region 8	Oakland CMH
Macomb County Community Mental Health (MCCMH)	Region 9	Macomb CMH
Region 10 PIHP (Region 10)	Region 10	Genesee CMH, Lapeer CMH, Sanilac CMH, St. Clair CMH

Figure 3-1—Michigan PIHP Regions[3-1]



[3-1] Detroit Wayne Mental Health Authority is now known as Detroit Wayne Integrated Health Network. Oakland County CMH Authority is now known as Oakland Community Health Network.

Quality Strategy

To carry out its mission to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for Michigan residents to be self-sufficient, MDHHS has established six strategic priority areas. Table 3-2 outlines the MDHHS strategic priorities.

Table 3-2—MDHHS Strategic Priorities

Priorities	
Children	Ensure that Michigan youth are healthy, protected, and supported on their path to adulthood.
Adults	Safeguard, respect, and encourage the well-being of Michigan adults in our communities and our care.
Family Support	Support families and individuals on their road to self-sufficiency through responsive, innovative, and accessible service delivery.
Health Services	Transform the healthcare system and behavioral health coordination to improve outcomes for residents.
Population Health	Promote and protect the health, wellness, and safety of all Michigan residents.
Workforce	Strengthen opportunities, promote diversity, and empower our workforce to contribute to Michigan's economic development.

The 10 PIHPs are instrumental in improving health and quality of care for the Michigan Medicaid population, which includes participating in MDHHS' efforts to achieve its goals and focus improvement efforts on the aforementioned priorities. To assist in these efforts, each PIHP has a QAPIP that includes the following components:

- Active participation of providers and members in the QAPIP processes.
- Performance measurement using standardized indicators in the areas of access, efficiency, and outcomes.
- PIPs 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 member satisfaction.
- Process for the review and follow-up of sentinel events and other critical incidents and events that put members at risk of harm.
- Periodic quantitative and qualitative assessments of member experiences with its services.
- Process for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices relevant to the members served.

- Written procedures to determine whether physicians and other healthcare professionals, who are licensed by the State and who are employees of the PIHP or under contract to the PIHP, are qualified to perform services.
- Process for verifying whether services reimbursed by Medicaid were actually furnished to members by affiliates (as applicable), providers, and subcontractors.
- 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.
- Annual monitoring of provider network(s), affiliates, and subcontractors.

Additionally, MDHHS emphasizes continuous evaluation of each PIHP's oversight of vulnerable members to determine opportunities for improving oversight of their care and outcomes. MDHHS continues to work with the PIHPs to develop uniform methods for targeted monitoring of vulnerable members. Further, MDHHS requires the PIHPs to annually analyze whether improvements have occurred in quality of healthcare and services for members as a result of quality assessment and improvement activities and implemented interventions.

In addition to the QAPIP activities, MDHHS has implemented several initiatives that focus on quality improvement. Examples of these initiatives include:

- **Performance Bonus Integration of Behavioral Health and Physical Health Services—**In an effort to ensure collaboration and integration among the PIHPs and Medicaid health plans (MHPs), MDHHS developed joint expectations for both entities. These expectations include implementing joint care management processes and working collaboratively to meet set standards for follow-up after hospitalization for mental illness within 30 days of discharge.
- **Recovery-Oriented Systems of Care Recovery—**In order to move toward a recovery-based system of services, MDHHS worked with the Recover-Oriented System of Care (ROSC) Transformation Steering Committee (TSC) to develop expectations for systems change. These expectations are included in a formal document called *Transformation Steering Committee, Recovery-Oriented System of Care Recovery Policy and Practice Advisory*. The recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The ROSC TSC created guiding principles of recovery and established expectations to guide organizations, including the PIHPs, in creating an environment and system of behavioral health services and supports that foster recovery and create a recovery-oriented system of care.
- **National Core Indicators (NCI)™ Program—**Since the 2011–2012 measurement period, MDHHS has voluntarily participated in the NCI program. The NCI program is an effort by State developmental disability agencies to track performance using a standardized set of member and family/guardian surveys with nationally validated measures. MDHHS uses the information gathered through the surveys to assess the outcomes of services for individuals in the areas of employment, rights, service planning, community inclusion, choice, health, and safety. The NCI program is coordinated by the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute.

Integration of Physical and Behavioral Health Services

On December 4, 2019, MDHHS presented BHDDA's vision for a strengthened behavioral health system, serving members with severe mental illness, SUDs, and IDDs. The new system will integrate physical and behavioral health services to improve outcomes and meet the growing demand for mental healthcare in Michigan.

According to the Medicaid Director, Robert Gordon, despite the strengths of the current public behavioral health system, Medicaid members continue to face challenges, such as a lack of coordination between physical health and mental health professionals. Members find the system confusing to navigate and it can be difficult for families to find the right services.

To improve the Michigan behavioral health system, MDHHS proposed a new approach that will lead to a greater choice of providers, better coordination of services, and an increased investment in behavioral health. To advance these goals, Director Gordon outlined three key principles for system design:

- Preserving a strong safety net
- Integrating physical and behavioral health in both care and financing
- Establishing Specialty Integrated Plans (SIPs)

SIPs will bring together the management skills of traditional insurance companies with the expertise and depth of behavioral health organizations. MDHHS' approach will maintain person-centered planning (ensuring members actively participate in the design of their care), member rights, and comprehensive services and supports. It will also create opportunities for further innovation in how care can be delivered. The new Medicaid-funded integrated health plan is anticipated to be begin in 2022.[3-2]

[3-2] State of Michigan Department of Health and Human Services: MDHHS presents new approach to strengthen behavioral health at joint legislative hearing. Dec. 4, 2019. Available at: https://content.govdelivery.com/attachments/MIDHHS/2019/12/04/file_attachments/1336849/BH%20Redesign%20NR.pdf. Accessed on: Dec 18, 2019.

Compliance Monitoring

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 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS has elected to review the full set of standards over two review periods, as displayed in Table 4-1.

Table 4-1—Division of Standards Over Review Periods

2017–2018	2018–2019
Standard VI—Customer Service	Standard I—Quality Measurement Improvement
Standard VII—Grievance Process	Standard II—Performance Measurement and Improvement
Standard IX—Subcontracts and Delegation	Standard III—Practice Guidelines
Standard X—Provider Network	Standard IV—Staff Qualifications and Training
Standard XII—Access and Availability	Standard V—Utilization Management
Standard XIV—Appeals	Standard VIII—Members' Rights and Protections
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	Standard XI—Credentialing
Standard XVII—Management Information Systems	Standard XIII—Coordination of Care
	Standard XVI—Confidentiality of Health Information

This report presents the results of the 2018–2019 review period. MDHHS and the individual PIHPs use the information and findings from the compliance monitoring reviews to:

- Evaluate the quality and timeliness of and access to behavioral healthcare 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 compliance reviews of the PIHPs, HSAG developed standardized tools for use during the reviews. The content of the tools was based on applicable federal regulations and the requirements set forth in the contract agreement between MDHHS and the PIHPs. The review processes and scoring methodology used by HSAG in evaluating the PIHPs' compliance were consistent with CMS' publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-1]

For each of the PIHP reviews, HSAG followed the same basic steps:

Pre-On-Site Review Activities

- Scheduling the Webex session and on-site review.
- Developing the compliance monitoring review and case file review tools.
- Preparing for and forwarding to each PIHP the compliance monitoring review tools and instructions for submitting the requested documentation.
- Hosting a training webinar for all PIHPs in preparation for the review.
- Generating the sample selection for the prior authorization denial and credentialing case file reviews.
- Conducting a Webex with each PIHP to walk through the selected case files.
- Conducting a desk review of all completed review tools and supporting documentation submitted by the PIHP. The desk review, along with the case file review, enabled HSAG reviewers to increase their knowledge and understanding of the PIHP's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Preparing and forwarding the on-site review agenda to the PIHP.

On-Site Review Activities

- An opening session, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- Interview sessions with the PIHP's key administrative and program staff members.
- A closing session during which HSAG reviewed summarized preliminary findings.

Reviewers used the compliance monitoring review tools to document findings regarding PIHP compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The *Documentation Request and Evaluation Tool* listed the score for each element evaluated.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Jan 27, 2020.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met*, *Not Met*, or *Not Applicable*. The overall score for each of the nine standards was determined by totaling the number of *Met* (1 point), *Not Met* (0 points), and *Not Applicable* (no value) elements, then dividing the summed score by the total number of applicable elements for that standard. The scoring methodology is displayed in Table 4-2.

Table 4-2—Scoring Methodology[4-2]

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • 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/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

[4-2] This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Description of Data Obtained and Related Time Period

To assess the PIHP's compliance with federal regulations and contract requirements, HSAG obtained information from a wide range of written documents produced by the PIHP, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Management/monitoring reports
- Member and provider materials
- Prior authorization denial records
- Credentialing, recredentialing, and home and community-based services (HCBS) organizational provider records
- Letter templates and redacted notices
- Narrative and/or data reports across a broad range of performance and content areas
- System demonstrations

Interviews with PIHP staff members (e.g., PIHP leadership, care manager, quality improvement staff members) provided additional information.

Table 4-3 lists the major data sources used by HSAG in determining the PIHP's performance in complying with requirements and the time period to which the data applied.

Table 4-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk review documentation	October 1, 2018, through April 30, 2019
Information obtained through interviews	October 1, 2018, through the end of each PIHPs' on-site review
File review records	• Prior authorization denials closed between October 1, 2018, through April 30, 2019 • Providers who have completed the credentialing process between October 1, 2018, and April 30, 2019

Validation of Performance Measures

Activity Objectives

As set forth in 42 CFR §438.358, the validation of performance measures calculated by 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 collected by the PIHP.
- Determine the extent to which the specific performance measures calculated 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 calculation process.

HSAG validated a set of 12 performance indicators developed and selected by MDHHS for validation. Six of these indicators were to be reported by the PIHPs quarterly, with MDHHS calculating the remaining six. Most performance indicators were reported and validated for the first quarter of the Michigan state fiscal year (SFY) 2019, as shown in Table 4-5.

Technical Methods of Data Collection and Analysis

CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, identifies key types of data that should be reviewed as part of the validation process. The list following indicates the type of data collected and how HSAG conducted an analysis of these data.

Pre-Audit Strategy

- **Information Systems Capabilities Assessment Tool (ISCAT) and Mini-ISCAT—**The PIHPs and CMHSPs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) and Mini-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 PIHP performance indicator reports provided by MDHHS for the first quarter of SFY 2019. 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.

On-Site Review Activities

HSAG conducted on-site visits with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening session—**The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance—**The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP 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.
- **Closing conference—**The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit and reviewed the documentation requirements for any post-on-site activities.

Post-On-Site Review Activities

For each performance measure calculated and reported by the PIHPs, the audit teams aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit teams assigned each measure one of four audit findings: (1) *Report* (the rate was valid and below the allowable threshold for bias), (2) *Not Applicable* (the PIHP followed the specifications but the denominator was too small to report a valid rate), (3) *No Benefit* (the PIHP did not offer the health benefits required by the measure), or (4) *Not Reported* (the measure was significantly biased, or the PIHP was not required to report the measure).

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool—**HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDHHS' and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each PIHP (if applicable) and from MDHHS (for the indicators calculated by MDHHS). If the PIHP did not produce source code to generate the performance indicators, the PIHP submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by MDHHS.
- **Previous Performance Measure Results Reports—**HSAG obtained these reports from MDHHS and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results—**HSAG obtained the calculated results from MDHHS and each PIHP.
- **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 on-site systems demonstrations.

Table 4-4 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table 4-4—PIHP Profiles

Data Sources	Period to Which Data Applied
ISCAT and Mini-ISCAT(s), if applicable (from PIHPs)	SFY 2018
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2018
Previous performance measure results reports (from MDHHS)	SFY 2018
Performance measure results (from PIHPs and MDHHS)	1st Quarter SFY 2019
Supporting documentation (from PIHPs and MDHHS)	SFY 2018
On-site interviews and systems demonstrations (from PIHPs and MDHHS)	During on-site visit

Table 4-5 displays the performance indicators 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 4-5—Performance Indicators

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#1	*The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*	• Children • Adults	1st Quarter SFY 2019	PIHP
#2	*The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.*	• MI Adults • SED Children • IDD Adults • IDD Children • Medicaid SUD	1st Quarter SFY 2019	PIHP
#3	*The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.*	• MI Adults • SED Children • IDD Adults • IDD Children • Medicaid SUD	1st Quarter SFY 2019	PIHP
#4a	*The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.*	• SED and IDD Children • MI and IDD Adults	1st Quarter SFY 2019	PIHP

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#4b	*The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.*	• Consumers	1st Quarter SFY 2019	PIHP
#5	*The percent of Medicaid recipients having received PIHP managed services.*	• Medicaid Recipients	1st Quarter SFY 2019	MDHHS
#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 Recipients	1st Quarter SFY 2019	MDHHS
#8	*The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.*	• MI Adults • IDD Adults • MI/IDD Adults	SFY 2018	MDHHS
#9	*The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.*	• MI Adults • IDD Adults • MI/IDD Adults	SFY 2018	MDHHS
#10	*The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*	• MI and IDD Adults • SED and IDD Children	1st Quarter SFY 2019	PIHP
#13	*The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*	• IDD Adults	SFY 2018	MDHHS
#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 2018	MDHHS

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 non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction and to involve:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The EQR technical report must include information on the validation of PIPs required by the State and underway during the preceding 12 months.

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., study question, population, indicator[s], sampling techniques, 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 PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and 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, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related and can be directly 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 2018–2019, the PIHPs submitted baseline data on one of the 10 State-recommended PIP topics. HSAG conducted the validation on the PIP study Design (Steps I through VI) and Implementation (Step VII through VIII) stages of the selected PIP topic for each PIHP. The PIP topics chosen by PIHPs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services.

Technical Methods of Data Collection and Analysis

The methodology used to validate PIPs was based on CMS guidelines as outlined in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-3] Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each PIHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The CMS protocols identify 10 steps that should be validated for each PIP. For the 2018–2019 submissions, the PIHPs reported baseline data and were validated for Steps I through VII. Several PIHPs, although not required, also submitted improvement strategies; therefore, these PIHPs were scored on evaluation elements in Step VIII.

The 10 steps included in the PIP Validation Tool are listed below:

Step I.	Appropriate Study Topic
Step II.	Clearly Defined, Answerable Study Question(s)
Step III.	Correctly Identified Study Population
Step IV.	Clearly Defined Study Indicator(s)
Step V.	Valid Sampling Techniques (if sampling was used)
Step VI.	Accurate/Complete Data Collection
Step VII.	Sufficient Data Analysis and Interpretation
Step VIII.	Appropriate Improvement Strategies
Step IX.	Real Improvement Achieved
Step X.	Sustained Improvement Achieved

HSAG used the following methodology to evaluate PIPs conducted by the PIHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not*

[4-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: January 10, 2020.

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 *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

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

HSAG assessed the implications of the study'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 (shown as "Submission" scores in ***Section 6*** of this report), request additional technical assistance from HSAG, make any necessary corrections, and resubmit the PIP for final validation (shown as "Resubmission" scores in ***Section 6*** of this report). HSAG forwarded the completed validation tools to MDHHS and the PIHPs.

Description of Data Obtained and Related Time Period

For 2018–2019, the PIHPs submitted baseline data. The study indicator measurement period dates for the PIP are listed below.

Table 4-6—Measurement Period Dates

Data Obtained	Reporting Year (Measurement Period)
Baseline	HEDIS 2019 (calendar year 2018)
Remeasurement 1	HEDIS 2020 (calendar year 2019)
Remeasurement 2	HEDIS 2021 (calendar year 2020)

5. Assessment of PIHP Performance

Methodology for Aggregating and Analyzing EQR Activity Results

HSAG used findings across mandatory EQR activities conducted during the previous 12 months to evaluate the performance of Medicaid PIHPs on providing quality, timely, and accessible healthcare services to Michigan Medicaid managed care members.

To identify strengths and weaknesses and draw conclusions for each PIHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to behavioral health, IDD, and SUD services across the Michigan Medicaid managed care program. The composite findings for each PIHP were analyzed and aggregated to identify overarching conclusions and focus areas for the PIHP in alignment with the priorities of MDHHS, and specifically, BHDDA.

Region 1—NorthCare Network

To conduct the 2018–2019 EQR, HSAG reviewed **NorthCare Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **NorthCare Network**.

EQR Activity Results

Compliance Monitoring

NorthCare Network was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-1 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-1 also presents **NorthCare Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-1—Summary of 2018–2019 Compliance Monitoring Review Results for NorthCare Network

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	7	1	0	88%
Standard II—Quality Measurement and Improvement	8	6	2	0	75%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	11	5	0	69%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	67	15	0	82%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

NorthCare Network demonstrated compliance for 67 of 82 elements, with an overall compliance score of 82 percent. **NorthCare Network** demonstrated strong performance, scoring 90 percent or above in three standards, with all three of those standards achieving full compliance. These areas of strength include Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information.

Opportunities for improvement were identified in six of the nine standards, including deficiencies related to the following requirements:

- Quarterly analyses of data from the behavior treatment review committee (BTRC)
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Dissemination of clinical practice guidelines (CPGs) to all affected providers
- Content of the notices of adverse benefit determination (ABD)
- Providing notice of ABDs for the denial of payment at the time of an action affecting a claim
- Providing notice of ABDs for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Exceptions to providing an advance notice of ABD

- Providing members with written notice of a significant change at least 30 days before the intended effective date of the change
- Prohibit conditioning the provision of care based on whether or not a member has executed an advance directive
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions

NorthCare Network was required to develop and implement a corrective action plan (CAP) for each requirement in all standards scored *Not Met*. Refer to **NorthCare Network**'s *2018–2019 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan* for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **NorthCare Network** and to determine the extent to which performance indicators reported by **NorthCare Network** followed State specifications and reporting requirements.

HSAG evaluated **NorthCare Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 1—NorthCare Network* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **NorthCare Network**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **NorthCare Network** received and processed claims and encounter data for submission to MDHHS.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Based on demonstrations of three CMHSP's BH-TEDS data entry and submission processes (i.e., Hiawatha CMH, Northpointe CMH, and Pathways CMH), no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. HSAG recommends that **NorthCare Network** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **NorthCare Network** had appropriate oversight of its five affiliated CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **NorthCare Network** received an indicator designation of *Report* for all indicators, signifying that **NorthCare Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

Table 5-2 presents **NorthCare Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-2—Performance Measure Results for NorthCare Network

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	100.00%	95.00%
Adults	99.62%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	100.00%	95.00%
MI Adults	99.60%	95.00%
IDD Children	100.00%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	88.51%	95.00%
Total	95.13%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	98.20%	95.00%
MI Adults	98.86%	95.00%
IDD Children	100.00%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.70%	95.00%
Total	98.69%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	100.00%	95.00%
MI and IDD Adults	100.00%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.45%	—

Performance Indicator	Rate	MPS
#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.		
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.	99.20%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	17.80%	—
IDD Adults	7.34%	—
MI/IDD Adults	8.57%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	90.22%	—
IDD Adults	24.77%	—
MI/IDD Adults	30.51%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	4.17%	15.00%
MI and IDD Adults	10.10%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.15%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	55.34%	—

Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

NorthCare Network's performance exceeded the corresponding MPS for 18 of 19 measure indicators (94.7 percent), suggesting strength in these areas.

Although most of **NorthCare Network**'s rates were above the MPS, the rate for the Medicaid SUD population under indicator *#2* fell below the corresponding MPS, indicating an opportunity for improvement.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **NorthCare Network** provided baseline data on the PIP topic: *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*. The goal of this PIP is to increase follow-up visits with a mental health practitioner within seven days after an inpatient discharge for selected mental illness diagnoses.

Table 5-3 outlines the study indicators for the PIP.

Table 5-3—Study Indicators

PIP Topic	Study Indicators
Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older	1. The percentage of discharged enrollees ages 6 to 20 years, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge. 2. The percentage of discharged enrollees ages 21 and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge.

Table 5-4 and Table 5-5 show **NorthCare Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **NorthCare Network**.

Table 5-4—PIP Validation Results for NorthCare Network

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	75% (3/4)	25% (1/4)	0% (0/4)
Implementation Total			**86% (6/7)**	**14% (1/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**93% (14/15)**		

Table 5-5—2018–2019 PIP Validation Scores for NorthCare Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older	Submission	87%	100%	***Met***
	Resubmission	93%	100%	***Met***

NorthCare Network submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 93 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

NorthCare Network designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **NorthCare Network** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage (Steps VII and VIII), **NorthCare Network** accurately calculated and interpreted the baseline results for each study indicator. **NorthCare Network** progressed to completing a causal/barrier analysis using quality improvement tools and implementing interventions that have the potential to impact outcomes.

Strengths, Weaknesses, and Overall Conclusions

NorthCare Network demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **NorthCare Network** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **NorthCare Network** scored above 90 percent in the Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, and Credentialing standards, as demonstrated by moderate to low performance scores (88 percent, 75 percent, 75 percent, 69 percent, 85 percent, and 56 percent respectively), reflecting that additional focus is needed in these areas.

While 18 of the 19 performance measure rates were above the MDHHS-established MPS, indicating strength in these areas, **NorthCare Network**'s rate for indicator *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—Medicaid SUD fell below the established MPS, indicating an opportunity to improve this measure rate. **NorthCare Network**'s overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-6—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound study related to *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older* and accurately calculated and interpreted the baseline results for each study indicator. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 75 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 75 percent, indicating that not all providers received the PIHP's adopted CPGs. • Weakness: Credentialing was the lowest performing standard with a compliance score of 56 percent, indicating that some providers' credentials were not adequately being evaluated prior to joining the PIHP's network.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, and IDD Adults populations; receiving timely needed, ongoing services for SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; timely follow-up care following discharges from an inpatient psychiatric unit; and timely follow-up care following discharge from a substance abuse detox unit. • Weakness: The Utilization Management standard received a compliance score of 69 percent, suggesting that members are not receiving timely and comprehensive notices of ABDs. • Weakness: The MPS related to timely face-to-face assessments with a professional for new Medicaid beneficiaries in the Medicaid SUD population was not met. • Weakness: The PIHP documented interventions that began prior to the baseline measurement period for the PIHP. By initiating interventions prior to the baseline, the baseline performance should be interpreted with caution.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard achieved full compliance, indicating that the PIHP had adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **NorthCare Network**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **NorthCare Network**. The recommendations provided to **NorthCare Network** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-7 in addition to **NorthCare Network**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-7—Recommendations and NorthCare Network's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **NorthCare Network** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard X—Provider Network • Standard XII—Access and Availability • Standard XIV—Appeals • Standard XVII—Management Information Systems **NorthCare Network** should have included the following in each of its plans of action that were submitted to MDHHS: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
NorthCare Network's Response
Standard VI—Customer Service: NorthCare Network updated the member handbook to include specific time frames for grievances and appeals, all member rights and responsibilities specified in 42 CFR §438.100, and additional community resources and advocacy groups. This was completed on January 16, 2019. Additionally, **NorthCare Network** implemented a new process to obtain and feed the provider directory with all required elements for a directory. This new process also allows each CMHSP to utilize the same database to create their local provider directory with all required elements. The online provider directory can currently be searched and printed; however, search enhancements to improve upon 508 compliance and accessibility, and the ability to print the provider directory directly from the website are expected to be completed during second quarter two (Q2) of FY 2020. **NorthCare Network** will monitor both data quality and usability within the new provider directory structure and implement improvements to both the process and the end product as the need arises. Enhancements to the provider directory are targeted for the Q2 of FY 2020. **Standard VII—Grievance Process: NorthCare Network** updated the member handbook, grievance resolution letters, and all State-required templates to inform members of their right to request State fair hearing (SHF) and how to do so. The member handbook was updated on January 16, 2019 and the letter templates were deployed in **NorthCare Network**'s electronic medical record (EMR) on August 28, 2019.

Compliance Monitoring Review
Standard IX—Subcontracts and Delegation: The contract between **NorthCare Network** and the CMHSPs was updated to reflect the 10-year right to audit language in the MI Health Link (MHL) program attachment and inadvertently missed in the body of the contract. **NorthCare Network** is finalizing a new contract that will be effective January 1, 2020 with the correct 10-year right to audit language. **Standard X—Provider Network:** The **NorthCare Network**/CMHSP contract and **NorthCare Network**'s policy both indicate that the CMHSP will notify **NorthCare Network** within four days of any changes to the CMHSP provider network composition that may negatively affect access to care. This was completed on January 7, 2019. **Standard XII—Access and Availability:** SUD providers in **NorthCare Network**'s network continue to struggle with indicator *#2* (timely assessments with a professional for new Medicaid members within 14 days). **NorthCare Network** is in the process of adding outpatient providers in Marquette and Houghton counties. Additionally, the largest outpatient provider in Marquette County is updating its intake procedure so that some of the paperwork can be completed with support staff and not a therapist. This should help to streamline the process and allow the therapist(s) additional capacity to see members. This remains ongoing. **Standard XIV—Appeals:** Specific information has been added to **NorthCare Network**'s grievance and appeal policy. This includes the requirement that all oral appeal requests be followed up in writing, and if services were reduced, terminated, or suspended without an advance adverse benefit determination notice being sent, services will be reinstated to the level before the action. **NorthCare Network**'s region wide grievance and appeal training was also updated to reflect the fact that members have the right to examine their records free of charge and must be made aware of the limited time to do this sufficiently in advance to the resolution timeframe for the appeal. **NorthCare Network**'s regional EMR was updated and the State-required letter templates were deployed on August 28, 2019. **NorthCare Network** also included language in the member handbook to inform members that appeal resolution time frames may be extended and their rights pertaining to an extension. **Standard XVII—Management Information Systems:** **NorthCare Network** submitted the Uniform Data and Information Attestation for FY 2018 to MDHHS on February 29, 2018. This will be submitted annually by March 1st of each year.
HSAG's Assessment of the Degree to Which NorthCare Network Effectively Addressed the Recommendation
Based on **NorthCare Network**'s response, HSAG has determined that **NorthCare Network** has addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **NorthCare Network**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.

Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **NorthCare Network** to members, HSAG recommended that **NorthCare Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Ratings Below the MPS** • *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Adults and Medicaid SUD • *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults • *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* **Performance Declined >2 Percent From Previous Year** • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children **Increase in Readmissions >5 Percent From Previous Year** • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children **NorthCare Network** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **NorthCare Network** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented preceding, **NorthCare Network** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement

Performance Measures
Additionally, **NorthCare Network** should have defined data entry processes, including its documented processes for data quality and data completeness checks.
NorthCare Network's Response
NorthCare Network's internal quality management committee will be developing a formal quality improvement (QI) plan during its regularly scheduled meeting on February 20, 2020 and will ensure all elements noted above are reviewed/included to ensure compliance with all measures. The time frame noted below is from January 1, 2018 to June 30, 2019, the most recent six quarters. **Indicator *#2*:** • IDD Adults—**NorthCare Network** has met this quarter for the past five of six quarters. The one outlier occurred in Q4 of SFY 2018 where one out of 15 members did not receive a face-to-face assessment within 14 days of non-emergent request. • Medicaid SUD—**NorthCare Network** has been a consistent outlier for the SUD population for this indicator. Of note, **NorthCare Network** does not consider offering a referral list of other providers as being in compliance with this indicator as was done in the past. **NorthCare Network** recognizes the importance of ensuring a member has an appointment versus walking away with a list of other providers to call with no appointment scheduled. In most circumstances, members choose to wait for the provider they originally called or presented to, which results in appointments being scheduled outside the 14-day time frame. With SUD providers being fee-for-service (FFS), it is difficult for them to leave open appointment times "in case" someone requests an appointment. **NorthCare Network** continues discussions with SUD providers stressing the need to ensure all members receive a face-to-face appointment within the 14 calendar days. **NorthCare Network** continues to post a request for proposal (RFP) for additional providers on its website and are in the process of adding outpatient providers in Marquette and Houghton counties. Additionally, the largest outpatient provider in Marquette County is updating its intake procedure so that some of the paperwork can be completed with support staff and not a therapist. This should help to streamline the process and allow the therapist(s) additional capacity to see members. This remains ongoing. **Indicator *#4a*:** • Adults—**NorthCare Network** has met this indicator for five of six past quarters and continues to work with the region to ensure compliance every quarter. **NorthCare Network** also initiated a PIP to address follow-up within seven days of discharge using HEDIS standards which is more restrictive than the Michigan's Mission-Based Performance Indicator System (MMBPIS) standards. **Indicator *#4b*:** • SUD—**NorthCare Network** SUD providers have met this standard at 100 percent for the past six quarters. **NorthCare Network** will continue to monitor. **NorthCare Network** continues to work with providers to achieve full compliance and monitors performance indicators rates quarterly. This remains ongoing.

Performance Measures
HSAG's Assessment of the Degree to Which NorthCare Network Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **NorthCare Network** improved upon its rates for indicators *#2* (IDD Adults), *#4a*, and *#4b*; however, it did not meet the MPS for indicator *#2* (Medicaid SUD), indicating that **NorthCare Network** partially addressed the prior recommendations.
Performance Improvement Project
HSAG Recommendation
HSAG recommended that **NorthCare Network** take proactive steps to ensure a successful PIP. As the PIP progressed, **NorthCare Network** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
NorthCare Network's Response
NorthCare Network will ensure the above is addressed within the next reporting period and ongoing through the PIP by quarterly monitoring. Results will be reviewed with each CMHSP board quarterly to assess progress and adherence to **NorthCare Network**'s recommended interventions. Each review process will inform subsequent interventions to improve performance on inpatient psychiatric follow-up care. Improvement strategies in effect will be analyzed for effectiveness and continued interventions will be explored to ensure ongoing refinement of strategies to improve regional performance on this measure.
HSAG's Assessment of the Degree to Which NorthCare Network Effectively Addressed the Recommendation
In the 2018–2019 validation, **NorthCare Network** addressed all recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **NorthCare Network** to members, HSAG recommends that **NorthCare Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS

- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—Medicaid SUD

Increase in Readmissions >5 Percent From Previous Year

- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—MI and IDD Adults

NorthCare Network should include within its next annual review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **NorthCare Network** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **NorthCare Network** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

Additionally, **NorthCare Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **NorthCare Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing

NorthCare Network was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **NorthCare Network** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **NorthCare Network** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **NorthCare Network** should take proactive steps to ensure a successful PIP. **NorthCare Network** should address all *General Comments* in the *2018–2019 PIP Validation Report Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older for Region 1—NorthCare Network* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **NorthCare Network** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner.
- **NorthCare Network** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **NorthCare Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **NorthCare Network** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 2—Northern Michigan Regional Entity

To conduct the 2018–2019 EQR, HSAG reviewed **Northern Michigan Regional Entity**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity**.

EQR Activity Results

Compliance Monitoring

Northern Michigan Regional Entity was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-8 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-8 also presents **Northern Michigan Regional Entity**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-8—Summary of 2018–2019 Compliance Monitoring Review Results for Northern Michigan Regional Entity

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	6	4	0	60%
Total	82	57	25	0	70%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Northern Michigan Regional Entity demonstrated compliance for 57 of 82 elements, with an overall compliance score of 70 percent. **Northern Michigan Regional Entity** demonstrated strong performance, scoring 90 percent or above in two standards, with both of those standards achieving full compliance. These areas of strength include Staff Qualifications and Training, and Coordination of Care.

Opportunities for improvement were identified in seven of the nine standards, including deficiencies related to the following requirements:

- The Governing Body's responsibility to monitor and evaluate the QAPIP
- Quarterly analyses of data from the BTRC
- Annual effectiveness review of the QAPIP
- Time frames for determining if a critical incident is a sentinel event and initiating a root cause analysis (RCA)
- Credentials of persons reviewing sentinel events
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Dissemination of CPGs to all affected providers
- Oversight of delegated utilization management functions
- Providing notices of ABD in easily understood language
- Content of the notices of ABD
- Providing notices of ABD for the denial of payment at the time of an action affecting a claim
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Provisions prohibiting incentives for individuals to deny, limit, or discontinue medically necessary services
- Providing members with written notice of a significant change at least 30 days before the intended effective date of the change
- Annually providing a member with the estimated annual cost to the PIHP of each covered support and service received
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Maintaining documented processes for maintaining the confidentiality, security, and integrity of member information
- Maintaining documented processes with respect to PHI and SUD treatment information that the PIHP generates, receives, maintains, uses, discloses, or transmits in the performance of its functions
- Content of breach notification letters
- Substitute notice provisions for breaches

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Northern Michigan Regional Entity** and to determine the extent to which performance indicators reported by **Northern Michigan Regional Entity** followed State specifications and reporting requirements. HSAG evaluated **Northern Michigan Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 2—Northern Michigan Regional Entity* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Northern Michigan Regional Entity**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Northern Michigan Regional Entity** received and processed claims and encounter data for submission to MDHHS.
- BH-TEDS Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Northern Lakes CMH, North Country CMH, and Northeast CMH), no major concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. During HSAG's PSV activity, HSAG identified conflicting BH-TEDS value sets (e.g., unemployed, but listed as earning minimum wage or more) that were not validated for quality assurance before submission to MDHHS. HSAG recommends **Northern Michigan Regional Entity** and the CMHSPs employ more robust data quality and reasonability checks of the BH-TEDS records. HSAG also recommends that **Northern Michigan Regional Entity** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Northern Michigan Regional Entity** had sufficient oversight of its five affiliated CMHSPs but, as discussed in the BH-TEDS data production section above, areas for improvement still existed.
- In addition, during HSAG's PSV activity, issues were identified for indicators *#1* and *#2*, which suggests that the CMHSPs' measure calculations were not in alignment with the measure specifications and additional oversight was needed from **Northern Michigan Regional Entity**. Specifically, the CMHSPs used different times for the crisis assessment start time for indicator *#1* (e.g., the time when the CMHSP arrived to begin the assessment was erroneously used by one CMHSP), and the date of the original appointment offered was not documented for all cases that were categorized as exceptions for indicator *#2*. Additionally, some dates documented in the CMHSPs' reporting for indicator *#2* were not found in the CMHSPs' electronic health records (EHRs), which indicated that the dates used to report cases as compliant or exceptions may be erroneous. Therefore, indicators *#1* and *#2* received an indicator designation of *Not Reported* as a result of HSAG's PSV activity. HSAG recommends that **Northern Michigan Regional Entity** provide more comprehensive education and rigorous oversight to the CMHSPs for reporting accuracy to ensure that the CMHSPs appropriately follow the specifications and **Northern Michigan Regional Entity** submits valid and accurate data to MDHHS.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Northern Michigan Regional Entity** received an indicator designation of *Report* for 10 indicators, signifying that **Northern Michigan Regional Entity** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported. However, **Northern Michigan Regional Entity** received an indicator designation of *Not Reported* for the remaining two indicators, indicating that **Northern Michigan Regional Entity**/CMHSPs did not calculate these indicators in compliance with MDHHS Codebook specifications. HSAG identified issues in **Northern Michigan Regional Entity**'s process for validating the performance indicator data, which included issues regarding time parameters and exception criteria. Therefore, these reported rates were considered materially biased. Table 5-9 presents **Northern Michigan Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-9—Performance Measure Results for Northern Michigan Regional Entity Network

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	*NR*	95.00%
Adults	*NR*	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	*NR*	95.00%
MI Adults	*NR*	95.00%
IDD Children	*NR*	95.00%
IDD Adults	*NR*	95.00%
Medicaid SUD	*NR*	95.00%
Total	*NR*	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	95.86%	95.00%
MI Adults	100.00%	95.00%
IDD Children	93.33%	95.00%
IDD Adults	94.74%	95.00%
Medicaid SUD	95.23%	95.00%
Total	96.80%	95.00%

Performance Indicator	Rate	MPS
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	95.74%	95.00%
MI and IDD Adults	93.38%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	92.47%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	8.22%	—
#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.		
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.	97.36%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	18.49%	—
IDD Adults	11.09%	—
MI/IDD Adults	17.71%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	92.61%	—
IDD Adults	42.38%	—
MI/IDD Adults	66.24%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	8.33%	15.00%
MI and IDD Adults	13.21%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	22.68%	—

Performance Indicator	Rate	MPS
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	52.86%	—

Indicates that the reported rate was better than the MPS.

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

NR (*Not Reported*) indicates that the rate was determined "materially biased." Rates designated *NR* are not displayed because the PIHP's performance cannot be evaluated based on biased rates.

* A lower rate indicates better performance.

Northern Michigan Regional Entity's performance exceeded the corresponding MPS for seven of 11 reportable measure indicators (63.6 percent), suggesting strength in these areas.

Northern Michigan Regional Entity's rates for at least one population under indicators *#3*, *#4a*, and *#4b* fell below their corresponding MPS, indicating opportunities for improvement. Additionally, **Northern Michigan Regional Entity**'s rates were deemed *Not Reported* for eight out of the 19 measure indicators (42.1 percent) with an MPS.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Northern Michigan Regional Entity** provided baseline data on the PIP topic: *Follow-Up Care for Children Prescribed ADHD Medication*. The goal of this PIP is to increase the percentage of children, with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication, who have two follow-up care visits within a 10-month period—one within 30 days of when the first ADHD medication was dispensed.

Table 5-10 outlines the study indicators for the PIP.

Table 5-10—Study Indicators

PIP Topic	Study Indicators
Follow-Up Care for Children Prescribed ADHD Medication	1. The percentage of members 6–12 years of age as of the IPSD [Index Prescription Start Date] with an ambulatory prescription dispensed for ADHD medication, who had a follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Table 5-11 and Table 5-12 show **Northern Michigan Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Northern Michigan Regional Entity**.

Table 5-11—PIP Validation Results for Northern Michigan Regional Entity

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Table 5-12—2018–2019 PIP Validation Scores for Northern Michigan Regional Entity

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Follow-Up Care for Children Prescribed ADHD Medication	Submission	100%	100%	***Met***
	Resubmission	*NA*	*NA*	***NA***

Northern Michigan Regional Entity submitted the Design and Implementation stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* and a resubmission was not required. The PIP had not progressed to the Outcomes stage.

Northern Michigan Regional Entity designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes**. Northern Michigan Regional Entity** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Northern Michigan Regional Entity** accurately calculated and interpreted the baseline results for each study indicator. The PIHP has not progressed to conducting a causal/barrier analysis and implementing interventions.

Strengths, Weaknesses, and Overall Conclusions

Northern Michigan Regional Entity demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Northern Michigan Regional Entity** received a total compliance score of 70 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Northern Michigan Regional Entity** scored 90 percent or above in the Staff Qualifications and Training, and Coordination of Care standards, indicating strong performance in these areas; however, it did not perform as well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, Credentialing, and Confidentiality of Health Information standards as demonstrated by moderate to low performance scores (63 percent, 50 percent, 75 percent, 56 percent, 85 percent, 56 percent, and 60 percent, respectively), reflecting that additional focus is needed in these areas.

While seven of the 11 reportable performance measure rates were above the MDHHS-established MPS, indicating strengths in these areas, **Northern Michigan Regional Entity**'s rates for indicators *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children and IDD Adults; *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults; and *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* fell below their corresponding MPS, indicating opportunities to improve these measure rates. Additionally, **Northern Michigan Regional Entity** received an audit designation of *Not Reported* for indicators *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three*

hours, and *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service* because the rates were determined to be materially biased, indicating that **Northern Michigan Regional Entity** did not calculate the performance indicators in compliance with MDHHS Codebook specifications.

Northern Michigan Regional Entity's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-13—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound project related to *Follow-Up Care for Children Prescribed ADHD Medication*, supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP also accurately calculated and interpreted the baseline results for each study indicator. • Weakness: The QAPIP Plan and Structure standard received a compliance score of 63 percent, indicating multiple opportunities to improve adherence to program requirements and enhance quality improvement initiatives. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 50 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 75 percent, indicating that not all providers received the PIHP's adopted CPGs. • Weakness: The Credentialing standard received a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network.
Timeliness	• Strength: The MPS were met related to receiving timely needed, ongoing services for SED Children, MI Adults, and Medicaid SUD populations; and timely follow-up care following discharges from an inpatient psychiatric unit for SED and IDD Children. • Weakness: The Utilization Management standard received a compliance score of 56 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The MPS related to ongoing services for the IDD Children and IDD Adults populations, timely follow-up care following discharges from an inpatient psychiatric unit for adults, and timely follow up care following discharge from a substance abuse detox unit were not met.

Performance Area*	Overall Performance Impact
	• Weakness: The PIHP received *NR* audit designations for two indicators related to preadmissions screenings for psychiatric inpatient care for children and adults; and face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Weakness: The Confidentiality of Health Information standard received a compliance score of 60 percent, indicating that the PIHP did not maintain adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Northern Michigan Regional Entity**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Northern Michigan Regional Entity**. The recommendations provided to **Northern Michigan Regional Entity** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 5-14 in addition to **Northern Michigan Regional Entity**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-14—Recommendations and Northern Michigan Regional Entity's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Northern Michigan Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard X—Provider Network • Standard XII—Access and Availability • Standard XIV—Appeals • Standard XVII—Management Information Systems

Compliance Monitoring Review
Northern Michigan Regional Entity should have included the following in each of its plans of action that were submitted to MDHHS: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Northern Michigan Regional Entity's Response
Standard VI—Customer Service: Northern Michigan Regional Entity had a citation regarding the Guide to Services (member handbook). **Northern Michigan Regional Entity** updated the Guide to Services to correct the deficiencies that were listed in the 2018 report. Prior to HSAG leaving the on-site visit in 2018, many of the corrections had already been addressed; however, **Northern Michigan Regional Entity** had to wait until a new batch of Guide to Services were printed to correct the information. An insert was provided with the Guide to Services for any information that needed correction prior to the next printing date. The latest version of Guide to Services was printed in July 2019 and contained the new templates to maintain compliance with MDHHS/PIHP Contract Amendment #2. **Standard VII—Grievance Process: Northern Michigan Regional Entity** revised the Grievance and Appeal policy and the **Northern Michigan Regional Entity** Board approved it during the February 2019 Board meeting. Additionally, **Northern Michigan Regional Entity** staff traveled around the region providing grievance and appeal training to all SUD provider staff. **Northern Michigan Regional Entity** addressed the issue of ensuring written consent from the member when a grievance is filed by a provider or other authorized representative acting on the member's behalf during the training as well in the policy. **Northern Michigan Regional Entity** has continued with ongoing training to assure that the information is retained, and procedures continue to be followed. **Northern Michigan Regional Entity** also revised and redistributed an acknowledgement letter and a resolution letter and provided it to each CMHSP. It was recommended to the CMHSPs to enter the templates into their EHR for convenience. If they do not utilize the grievance and appeal Module, then they have been advised to still utilize the template letters. The letters have been entered into the EHR for **Northern Michigan Regional Entity** to monitor compliance through the electronic system. **Northern Michigan Regional Entity** is evaluating the ongoing delegation of this system. As of June 2019, based on the MDHHS mandate contained in Contract Amendment #2, **Northern Michigan Regional Entity** has switched over to utilizing the State-generated templates for grievances and appeals. CMHSPs have been instructed to use the State-generated templates as well. There is currently not a State-mandated grievance resolution template. **Standard IX—Subcontracts and Delegation:** Changes were made to the PIHP-CMHSP contract to state 10 years rather than four years. Revised contract templates were provided to MDHHS as evidence. **Standard XII—Access and Availability: Northern Michigan Regional Entity** struggled with meeting the access and availability standards during FY18. Upon analysis, it appears a key factor in the non-compliance is related to implementation of EHR systems across **Northern Michigan Regional Entity**'s region. Three of the five CMHSPs within in the region were implementing a new EHR. The process of implementation identified several areas that needed addressing. For example, the new system labeled areas different and CMHSP staff

Compliance Monitoring Review
were not entering the correct dates in the appropriate fields. Also, some staff were not documenting member cancellations in the EHR. **Northern Michigan Regional Entity** had one final CMHSP that did not switch EHRs until July 2019, which is the largest of the five CMHSPs. With the majority of the CMHSPs using the same product at this time, **Northern Michigan Regional Entity** has seen the standards return to their previous level of compliance prior to the new system implementation. **Northern Michigan Regional Entity** has continued to work with the CMHSPs regarding compliance with this element. • The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. Standard = 95% in 14 days: **Northern Michigan Regional Entity** reviewed all FY 2018 quarters and identified compliance in several quarters on these standards. MIC – Q1-4 were all in compliance, DDC showed compliance in Q1; however, when looking at the population size it identified only one to two members that did not meet the standard, and for DDA-Q2&4 were compliant with only one to two members not meeting the standard for the missed two quarters. **Northern Michigan Regional Entity** continues to work with CMHSPs on compliance; however, the low population size is not a true representation of the measure. • The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days: **Northern Michigan Regional Entity** met the standard for adults and children for quarters 2-4 in FY 18. • The percent of discharges from a detoxification unit who are seen for follow-up care within seven days: **Northern Michigan Regional Entity** met the standards for follow up from detox in FY 2018 quarter 4. **Northern Michigan Regional Entity** identified a new method of reporting findings to the SUD provider panel, which identified the data per SUD provider rather than just at **Northern Michigan Regional Entity**'s level which then did not provide the opportunity for any SUD provider to take responsibility for their portion of the results. This information is now being provided to the SUD providers by individual provider on a quarterly basis. FY 2019 results show three out of four quarters were in compliance. Q1 was just below 95 percent compliant with 92.47 percent results. **Standard XIV—Appeals:** **Northern Michigan Regional Entity** revised the policy and procedure to address all deficiencies. The **Northern Michigan Regional Entity** Board approved the changes in February 2019. As of June 2019, **Northern Michigan Regional Entity** and the CMHSPs are using the State-mandated templates.
HSAG's Assessment of the Degree to Which Northern Michigan Regional Entity Effectively Addressed the Recommendation
Based on **Northern Michigan Regional Entity**'s response, HSAG has determined that **Northern Michigan Regional Entity** has addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Northern Michigan Regional Entity**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.

Performance Measures
HSAG Recommendation

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity** to members, HSAG recommended that **Northern Michigan Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS

- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Adults and Medicaid SUD
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children

Increase in Readmissions >5 Percent From Previous Year

- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children

Northern Michigan Regional Entity should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Northern Michigan Regional Entity** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented preceding, **Northern Michigan Regional Entity** should have included the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

Performance Measures
Additionally, **Northern Michigan Regional Entity** should have defined data entry processes, including its documented processes for data quality and data completeness checks.
Northern Michigan Regional Entity's Response
Northern Michigan Regional Entity struggled with meeting the access and availability standards during FY18. Upon analysis, it appears a key factor in the non-compliance is related to implementation of EHR systems across **Northern Michigan Regional Entity**'s region. Three of the five CMHSPs within in the region were implementing a new EHR. The process of implementation identified several areas that needed addressing. For example, the new system labeled areas different and CMHSP staff were not entering the correct dates in the appropriate fields. Also, some staff were not documenting member cancellations in the EHR. **Northern Michigan Regional Entity** had one final CMHSP that did not switch EHRs until July 2019, which is the largest of the five CMHSPs. With the majority of the CMHSPs using the same product at this time, **Northern Michigan Regional Entity** has seen the standards return to their previous level of compliance prior to the new system implementation. **Northern Michigan Regional Entity** has continued to work with the CMHSPs regarding compliance with this element. • The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional. Standard = 95% in 14 days: **Northern Michigan Regional Entity** reviewed all FY 2018 quarters and identified compliance in several quarters on these standards. SED Children – Quarters 1-4 were all in compliance, IDD Children – showed compliance in quarter 1; however, when looking at the population size it identified only one to two members that did not meet the standard, and for IDD Adults– quarters 2 & 4 were compliant with only one to two members not meeting the standard for the missed two quarters. **Northern Michigan Regional Entity** continues to work with CMHSPs on compliance; however, the low population size is not a true representation of the measure. • The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. Standard = 95% in seven days: **Northern Michigan Regional Entity** met the standard for adults and children for quarters 2-4 in FY 18. • The percent of discharges from a detoxification unit who are seen for follow-up care within seven days. Standard = 95% in seven days: **Northern Michigan Regional Entity** met the standards for follow up from detox in FY 2018 quarter 4. **Northern Michigan Regional Entity** identified a new method of reporting findings to the SUD provider panel, which identified the data per SUD provider rather than just at **Northern Michigan Regional Entity**'s level which then did not provide the opportunity for any SUD provider to take responsibility for their portion of the results. This information is now being provided to the SUD providers by individual provider on a quarterly basis. FY 2019 results show three out of four quarters were in compliance. Quarter 1 was just below 95 percent compliant with 92.47 percent results.
HSAG's Assessment of the Degree to Which Northern Michigan Regional Entity Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Northern Michigan Regional Entity** improved upon its rates for indicators *#3* (IDD Adults), *#4a* (Children and Adults), *#4b*, and *#10* (Children); however, it still did not meet the MPS for indicator *#3* (IDD Adults), *#4a* (Adults), and *#4b*, as well as receiving an *NR* audit designation for indicator *#2* (IDD Children), indicating that **Northern Michigan Regional Entity** partially addressed the prior recommendations.

Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Northern Michigan Regional Entity** take proactive steps to ensure a successful PIP. As the PIP progressed, **Northern Michigan Regional Entity** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Northern Michigan Regional Entity's Response
Northern Michigan Regional Entity was in full compliance, and the FY 2019 PIP was 100 percent met as well.
HSAG's Assessment of the Degree to Which Northern Michigan Regional Entity Effectively Addressed the Recommendation
In the 2018–2019 validation, **Northern Michigan Regional Entity** addressed all recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity** to members, HSAG recommends that **Northern Michigan Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*
- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*

Ratings Below the MPS[5-1]

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children and IDD Adults
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—Medicaid SUD

HSAG also recommends that **Northern Michigan Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Northern Michigan Regional Entity was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Northern Michigan Regional Entity** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Northern Michigan Regional Entity** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

[5-1] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

Finally, **Northern Michigan Regional Entity** should take proactive steps to ensure a successful PIP. **Northern Michigan Regional Entity** should address all *General Comments* in the *2018–2019 PIP Validation Report Follow-Up Care for Children Prescribed ADHD Medication for Region 2—Northern Michigan Regional Entity* and the following recommendations:

- To impact Remeasurement 1 study indicator performance, **Northern Michigan Regional Entity** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 period may not likely have enough time to impact the study indicator outcomes.
- **Northern Michigan Regional Entity** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Northern Michigan Regional Entity** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Northern Michigan Regional Entity** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 3—Lakeshore Regional Entity

To conduct the 2018–2019 EQR, HSAG reviewed **Lakeshore Regional Entity**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity**.

EQR Activity Results

Compliance Monitoring

Lakeshore Regional Entity was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-15 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-15 also presents **Lakeshore Regional Entity**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-15—Summary of 2018–2019 Compliance Monitoring Review Results for Lakeshore Regional Entity

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	5	3	0	63%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	10	3	0	77%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	2	8	0	20%
Total	82	53	29	0	65%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Lakeshore Regional Entity demonstrated compliance for 53 of 82 elements, with an overall compliance score of 65 percent. **Lakeshore Regional Entity** demonstrated strong performance, scoring 90 percent or above in two standards, with both of those standards achieving full compliance. These areas of strength include Staff Qualifications and Training, and Coordination of Care.

Opportunities for improvement were identified in seven of the nine standards, including deficiencies related to the following requirements:

- The Governing Body's responsibility to monitor and evaluate the QAPIP
- Quarterly analyses of data from the BTRC
- Annual effectiveness review of the QAPIP
- Engaging in two PIPs
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Adoption of CPGs
- Maintaining a current written utilization management program
- Mechanisms to identify and correct under- and overutilization
- Content of the notices of ABD
- Providing notices of ABD for the denial of payment at the time of an action affecting a claim
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Exceptions to providing advance notices of ABD
- Maintaining written policies regarding member rights
- Providing written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice
- Prohibit conditioning the provision of care based on whether or not a member has executed an advance directive and informing members of their right to file a grievance concerning non-compliance with advance directive requirements
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Processes to notify members, or next of kin, of a breach of PHI
- Time frame requirements for sending notice of a breach of PHI
- Content and readability of breach notification letters
- Substitute notice provisions for breaches

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Lakeshore Regional Entity** and to determine the extent to which performance indicators reported by **Lakeshore Regional Entity** followed State specifications and reporting requirements. HSAG evaluated **Lakeshore Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 3—Lakeshore Regional Entity* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Lakeshore Regional Entity**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Lakeshore Regional Entity** received and processed claims and encounter data for submission to MDHHS.
- BH-TEDS Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Allegan CMH, HealthWest [Muskegon CMH], and Network180), no concerns were identified with **Lakeshore Regional Entity** or the CMHSPs' adherence to the State-specified submission requirements. However, during HSAG's PSV activity, HSAG identified conflicting BH-TEDS value sets (e.g., unemployed, but listed as earning minimum wage or more). Two of the CMHSPs at the time of the on-site visit, Network180 and HealthWest, indicated a new process was put in place to check for these types of errors. HSAG recommends that **Lakeshore Regional Entity** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Lakeshore Regional Entity** had sufficient oversight of its five affiliated CMHSPs but, as discussed in the BH-TEDS data production section preceding, areas for improvement still existed.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Lakeshore Regional Entity** received an indicator designation of *Report* for all indicators, signifying that **Lakeshore Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-16 presents **Lakeshore Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-16—Performance Measure Results for Lakeshore Regional Entity

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	92.66%	95.00%
Adults	93.73%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	97.84%	95.00%
MI Adults	98.46%	95.00%
IDD Children	97.92%	95.00%
IDD Adults	98.25%	95.00%
Medicaid SUD	94.42%	95.00%
Total	97.33%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	90.70%	95.00%
MI Adults	97.19%	95.00%
IDD Children	84.62%	95.00%
IDD Adults	95.65%	95.00%
Medicaid SUD	99.45%	95.00%
Total	95.16%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	90.67%	95.00%
MI and IDD Adults	91.92%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	91.03%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.01%	—

Performance Indicator	Rate	MPS
#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.		
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.	96.40%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	14.42%	—
IDD Adults	9.48%	—
MI/IDD Adults	10.24%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	82.91%	—
IDD Adults	66.21%	—
MI/IDD Adults	68.79%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	6.38%	15.00%
MI and IDD Adults	6.88%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	12.58%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.78%	—

Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

Lakeshore Regional Entity's performance exceeded the corresponding MPS for 11 of 19 measure indicators (57.9 percent), suggesting strength in these areas.

Although most of **Lakeshore Regional Entity**'s rates were above the MPS, the rates for at least one population under indicators *#1*, *#2*, *#3*, *#4a*, and *#4b* fell below their corresponding MPS, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Lakeshore Regional Entity** provided baseline data for the PIP topic: *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*. The goal of this PIP is to increase Hemoglobin A1c (HbA1c) and low-density lipoprotein cholesterol (LDL-C) testing among Medicaid members with diabetes and schizophrenia.

Table 5-17 outlines the study indicator for the PIP.

Table 5-17—Study Indicator

PIP Topic	Study Indicator
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Table 5-18 and Table 5-19 show **Lakeshore Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Lakeshore Regional Entity**.

Table 5-18—PIP Validation Results for Lakeshore Regional Entity

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (1/1)	0% (0/1)	0% (0/1)
Implementation Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (12/12)**		

Table 5-19—2018–2019 PIP Validation Scores for Lakeshore Regional Entity

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Submission	92%	100%	***Met***
	Resubmission	100%	100%	***Met***

Lakeshore Regional Entity submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 100 percent of all applicable evaluation elements received a score of *Met* after the resubmission. The PIP had not progressed to the Outcomes stage.

Lakeshore Regional Entity designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Lakeshore Regional Entity** indicated that it plans to include its entire eligible population to calculate the study indicator percentage. In the Implementation stage, **Lakeshore Regional Entity** accurately calculated and interpreted the baseline results. The PIHP initiated the causal/barrier analysis to identify barriers; however, had not progressed to implementing interventions.

Strengths, Weaknesses, and Overall Conclusions

Overall, **Lakeshore Regional Entity** demonstrated low to moderate performance based on the results of the 2018–2019 EQR activities. **Lakeshore Regional Entity** received a total compliance score of 65 percent across all standards reviewed during the 2018–2019 compliance monitoring review. While **Lakeshore Regional Entity** scored 90 percent or above in the Staff Qualifications and Training, and Coordination of Care standards, indicating strong performance in these areas, **Lakeshore Regional Entity** did not perform well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, Credentialing, and Confidentiality of Health Information standards as demonstrated by low performance scores (63 percent, 63 percent, 75 percent, 56 percent, 77 percent, 56 percent, and 20 percent, respectively), indicating that additional focus is needed in these areas.

While 11 of the 19 performance measure rates were above the MDHHS-established MPS, indicating strengths in these areas, **Lakeshore Regional Entity**'s rates for indicators *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults; *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—Medicaid SUD; *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children; *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children and MI and IDD Adults; and *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* fell below the established MPS, indicating opportunities to improve these measure rates.

Lakeshore Regional Entity's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-20—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound study related to *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*, supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP also accurately calculated and interpreted the baseline results for each study indicator.

Performance Area*	Overall Performance Impact
	• Weakness: The QAPIP Plan and Structure standard received a compliance score of 63 percent, indicating multiple opportunities to improve adherence to program requirements and enhance quality improvement initiatives. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 63 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 75 percent, indicating that the PIHP did not follow program requirements for the adoption of CPGs. • Weakness: The Credentialing standard received a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network.
Timeliness	• Strength: The MPS were met related to timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, and IDD Adults populations; and receiving timely needed, ongoing services for MI Adults, IDD Adults, and Medicaid SUD populations. • Weakness: The Utilization Management standard received a compliance score of 56 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The MPS related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the Medicaid SUD population; receiving timely needed, ongoing services for SED Children and IDD Children; timely follow-up care following discharges from an inpatient psychiatric unit for MI and IDD Adults and SED and IDD children; and timely follow-up care following discharge from a substance abuse detox unit were not met.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Weakness: The Confidentiality of Health Information was the PIHP's lowest performance standard with a compliance score of 20 percent, indicating that the PIHP did not maintain adequate processes, or provide members with appropriate notification, in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Lakeshore Regional Entity**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Lakeshore Regional Entity**. The recommendations provided to **Lakeshore Regional Entity** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-21 in addition to **Lakeshore Regional Entity**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-21—Recommendations and Lakeshore Regional Entity's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Lakeshore Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard IX—Subcontracts and Delegation • Standard X—Provider Network • Standard XII—Access and Availability • Standard XIV—Appeals • Standard XV—Disclosure of Ownership, Control, and Criminal Convictions • Standard XVII—Management Information Systems **Lakeshore Regional Entity** should have included the following in each of its plans of action, and the plans of action should have been provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Lakeshore Regional Entity's Response
Standard VI—Customer Service: Lakeshore Regional Entity revised the Guide to Service, which was submitted to MDHHS and approval was received on May 8, 2019. The provider directory is under development; however, efforts have recently stalled as limited resources have been given to other urgent matters.

Compliance Monitoring Review
The efforts expended to-date in **Lakeshore Regional Entity**'s region to centralize the provider information at the regional level have been extensive. Although all CMHSPs are reporting provider data to **Lakeshore Regional Entity**/Beacon Health Options, they are not all reporting it in the consistent formats that are required and some are not reporting complete data needed for the generation of the centralized and public facing regional provider directory. The **Lakeshore Regional Entity** Chief Information Officer (CIO) has worked extensively with CMHSPs to assist them with the consistent production and transmission of their provider extract file. However, there continue to be internal issues that prevent CMHSPs from providing the necessary information for the directory. **Lakeshore Regional Entity** will issue a plan of correction to the two CMHSPs that are deficient in submitting data with clear time frames for providing the necessary data to complete the directory. **Standard IX—Subcontracts and Delegation:** The **Lakeshore Regional Entity**/Beacon/CMHSP delegation grid was incorporated into the FY 2019 PIHP/CMHSP sub-contract as part of Amendment #2. The delegation grid is also included in the FY 2020 PIHP/CMHSP sub-contract. Updated record retention time frames were incorporated into the FY 2019 PIHP/CMHSP sub-contract as part of Amendment #2. **Standard X—Provider Network:** CMHSP site review standard was updated to include the following: "If the CMHSP declines to include individual providers or groups of providers in its network, it gives the affected providers written notice of the reason for its decision." **Standard XII—Access and Availability:** **Lakeshore Regional Entity**'s region continues to encounter difficulty in meeting the MMBPIS benchmarks for indicator *#3*. Workgroups continue to strategize ways to ensure that these benchmarks are met. There has been some improvement, but work continues to consistently meet these standards. **Standard XIV—Appeals:** The **Lakeshore Regional Entity** due process policy procedure was updated and approved by the **Lakeshore Regional Entity** Board on June 21, 2018. In February 2019, **Lakeshore Regional Entity** entered into a contract with Beacon Health Options. Appeals and State fair hearing (SFH) for the region are delegated to Beacon Health Options. **Lakeshore Regional Entity**'s policies and procedures are being updated to reflect these changes. **Standard XV—Disclosure of Ownership, Control, and Criminal Convictions:** **Lakeshore Regional Entity**, through its contract with Beacon Health Options, continues to monitor CMHSPs and providers to ensure compliance with monthly Office of Inspector General (OIG) exclusion database checks.
HSAG's Assessment of the Degree to Which Lakeshore Regional Entity Effectively Addressed the Recommendation
Based on **Lakeshore Regional Entity**'s response, HSAG has determined that **Lakeshore Regional Entity** has partially addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Lakeshore Regional Entity**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.

Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity** to members, HSAG recommended that **Lakeshore Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: ***Not Reported*** **Performance Measure Rates** • *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults • *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children, MI Adults, IDD Children, IDD Adults, Medicaid SUD, Total • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Children, IDD Adults, Medicaid SUD, Total • *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children and MI and IDD Adults • *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children and MI and IDD Adults **Lakeshore Regional Entity** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Lakeshore Regional Entity** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Lakeshore Regional Entity** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates

Performance Measures
• Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Lakeshore Regional Entity** should have defined data entry processes, including its documented processes for data quality and data completeness checks.
Lakeshore Regional Entity's Response
The HSAG performance measure validation (PMV) review of **Lakeshore Regional Entity** that was conducted in July 2019 and reported to **Lakeshore Regional Entity** in October 2019 indicates that all performance measures were reportable and validated. Regional efforts to meet validation measurements included: • CMHSP information technology (IT) systems were re-programmed to ensure accurate data were being provided. • **Lakeshore Regional Entity** has engaged in quarterly meetings with all CMHSPs to review data and ensure accuracy, and strategize about barriers CMHSPs have encountered in meeting standards during the quarter. • CAPs are required for any indicator where the 95 percent has not been met. • **Lakeshore Regional Entity** has implemented the requirement that CMHSPs collect proof documents for all cases that are out of compliance or considered an exception from all external providers. – CMHSPs provide quarterly data to **Lakeshore Regional Entity** by the 15th of the month in which it is due to MDHHS. – QI staff randomly select a specific number of cases for each CMHSP for each indicator. – CMHSP staff are required to upload proof documents within five work days for review and validation by QI staff for the indicators chosen. – Any issues are discussed with CMHSPs and fixed prior to submission to MDHHS on the last day of the month. – Data are reviewed and discussed at QI meetings prior to submission to MDHHS. • CMHSPs that have been out of compliance for five out of the previous nine quarters and monthly reporting is required.
HSAG's Assessment of the Degree to Which Lakeshore Regional Entity Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Lakeshore Regional Entity** was able to report a valid rate for indicators *#1*, *#2*, *#3*, *#4a*, *#4b*, and *#10*, indicating that **Lakeshore Regional Entity** addressed the prior recommendations.

Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Lakeshore Regional Entity** take proactive steps to ensure a successful PIP. As the PIP progressed, **Lakeshore Regional Entity** should have ensured doing the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Lakeshore Regional Entity's Response
The **Lakeshore Regional Entity** PIP that was submitted in July 2019 reported a 100 percent met value as indicated in the September 2019 validation report from HSAG. CMHSPs are provided reports monthly identifying cases that are out of compliance. CMHSPs follow up with these individuals to ensure necessary action is taken. The PIP is monitored by the QI committee and the PIP workgroup.
HSAG's Assessment of the Degree to Which Lakeshore Regional Entity Effectively Addressed the Recommendation
In the 2018–2019 validation, **Lakeshore Regional Entity** addressed all recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity** to members, HSAG recommends that **Lakeshore Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults
- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—Medicaid SUD
- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children and MI and IDD Adults
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

HSAG also recommends that **Lakeshore Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Lakeshore Regional Entity was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Lakeshore Regional Entity** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Lakeshore Regional Entity** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Lakeshore Regional Entity** should take proactive steps to ensure a successful PIP. **Lakeshore Regional Entity** should address all *General Comments* in the *2018–2019 PIP Validation Report Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) for Region 3—Lakeshore Regional Entity* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Lakeshore Regional Entity** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 period are not likely to impact the study indicator outcomes.
- **Lakeshore Regional Entity** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Lakeshore Regional Entity** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Lakeshore Regional Entity** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 4—Southwest Michigan Behavioral Health

To conduct the 2018–2019 EQR, HSAG reviewed **Southwest Michigan Behavioral Health**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health**.

EQR Activity Results

Compliance Monitoring

Southwest Michigan Behavioral Health was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-22 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-22 also presents **Southwest Michigan Behavioral Health**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-22—Summary of 2018–2019 Compliance Monitoring Review Results for Southwest Michigan Behavioral Health

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	7	1	0	88%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	74	8	0	90%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Southwest Michigan Behavioral Health demonstrated compliance for 74 of 82 elements, with an overall compliance score of 90 percent. **Southwest Michigan Behavioral Health** demonstrated strong performance, scoring 90 percent or above in six standards, with all six of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information.

Opportunities for improvement were identified in three of the nine standards, including deficiencies related to the following requirements:

- Quantitative and qualitative assessment of member experience with services
- Providing notices of ABD in easily understood language
- Content of the notices of ABD
- Providing notices of ABD for the denial of payment at the time of an action affecting a claim
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Southwest Michigan Behavioral Health** and to determine the extent to which performance indicators reported by **Southwest Michigan Behavioral Health** followed State specifications and reporting requirements. HSAG evaluated **Southwest Michigan Behavioral Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 4—Southwest Michigan Behavioral Health* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Southwest Michigan Behavioral Health**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Southwest Michigan Behavioral Health** received and processed claims and encounter data for submission to MDHHS.
- BH-TEDS Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Berrien CMH [DBA Riverwood], Summit Pointe CMH [CMHSP for Calhoun County], and Kalamazoo CMH), no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. HSAG recommended that **Southwest Michigan Behavioral Health** and the CMHSPs clearly define the processes for entering the data into the PIHP's EMR and perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.

- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Southwest Michigan Behavioral Health** had sufficient oversight of its eight affiliated CMHSPs but, as discussed in the BH-TEDS data production section above, areas for improvement still existed.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Southwest Michigan Behavioral Health** received an indicator designation of *Report* for all indicators, signifying that **Southwest Michigan Behavioral Health** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-23 presents **Southwest Michigan Behavioral Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-23—Performance Measure Results for Southwest Michigan Behavioral Health

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	98.93%	95.00%
Adults	99.36%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	99.35%	95.00%
MI Adults	99.21%	95.00%
IDD Children	96.77%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.39%	95.00%
Total	98.91%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	94.61%	95.00%
MI Adults	96.00%	95.00%
IDD Children	91.23%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	95.83%	95.00%
Total	95.59%	95.00%

Performance Indicator	Rate	MPS
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	100.00%	95.00%
MI and IDD Adults	98.62%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	93.98%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.08%	—
#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.		
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.	98.56%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	16.67%	—
IDD Adults	10.22%	—
MI/IDD Adults	8.13%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	92.85%	—
IDD Adults	70.36%	—
MI/IDD Adults	70.97%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	3.39%	15.00%
MI and IDD Adults	10.57%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	22.03%	—

Performance Indicator	Rate	MPS
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	51.30%	—

Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

Southwest Michigan Behavioral Health's performance exceeded the corresponding MPS for 16 of 19 measure indicators (84.2 percent), suggesting strength in these areas.

Although most of **Southwest Michigan Behavioral Health**'s rates were above the MPS, the rates for at least one population under indicators *#3* and *#4b* fell below their corresponding MPS, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Southwest Michigan Behavioral Health** provided baseline data for the PIP topic: *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*. The goal of this PIP is to improve the proportion of members with schizophrenia or bipolar disorder and taking an antipsychotic medication who are screened for diabetes.

Table 5-24 outlines the study indicator for the PIP.

Table 5-24—Study Indicator

PIP Topic	Study Indicator
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication	The proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period.

Table 5-25 and Table 5-26 show **Southwest Michigan Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Southwest Michigan Behavioral Health**.

Table 5-25—PIP Validation Results for Southwest Michigan Behavioral Health

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (1/1)	0% (0/1)	0% (0/1)
Implementation Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (12/12)**		

Table 5-26—2018–2019 PIP Validation Scores for Southwest Michigan Behavioral Health

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication	Submission	93%	100%	***Met***
	Resubmission	100%	100%	***Met***

Southwest Michigan Behavioral Health submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 100 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Southwest Michigan Behavioral Health designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Southwest Michigan Behavioral Health** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Southwest Michigan Behavioral Health** accurately calculated and interpreted the baseline results for the study indicator. **Southwest Michigan Behavioral Health** used appropriate quality improvement tools to conduct a casual/barrier analysis; however, the PIHP has not progressed to implementing interventions.

Strengths, Weaknesses, and Overall Conclusions

Southwest Michigan Behavioral Health demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Southwest Michigan Behavioral Health** received a total compliance score of 90 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Southwest Michigan Behavioral Health** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the Quality Measurement and Improvement, Utilization Management, and Credentialing standards, as demonstrated by moderate to low performance scores (88 percent, 81 percent, and 56 percent, respectively), reflecting that additional focus is needed in these areas.

While 16 of the 19 performance measure rates were above the MDHHS-established MPS, indicating strength in these areas, **Southwest Michigan Behavioral Health**'s rates for indicators *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children, and *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* fell below the established MPS, indicating opportunities to improve these measure rates.

Southwest Michigan Behavioral Health's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-27—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The QAPIP Plan and Structure standard achieved full compliance, indicating the PIHP maintained a comprehensive quality program. • Strength: The Practice Guidelines standard achieved full compliance, indicating the PIHP implemented processes for the adoption, development, implementation, monitoring, and evaluation of CPGs. • Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The Members' Rights and Protections standard achieved full compliance, suggesting the PIHP guaranteed, observed, and protected members' rights. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound project related to *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication* supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator. • Weakness: Credentialing was the lowest performing standard with a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; receiving timely needed, ongoing services for MI Adults, IDD Adults, and Medicaid SUD populations; and timely follow-up care following discharges from an inpatient psychiatric unit for MI and IDD Adults and SED and IDD Children. • Weakness: The MPS related to receiving timely needed, ongoing services in the SED Children and IDD Children populations; and timely follow-up care following discharge from a substance abuse detox unit were not met.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard achieved full compliance, indicating that the PIHP had adequate processes in place for generating, receiving,

Performance Area*	Overall Performance Impact
	maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Southwest Michigan Behavioral Health**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Southwest Michigan Behavioral Health**. The recommendations provided to **Southwest Michigan Behavioral Health** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-28 in addition to **Southwest Michigan Behavioral Health**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-28—Recommendations and Southwest Michigan Behavioral Health's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Southwest Michigan Behavioral Health** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard XII—Access and Availability • Standard XIV—Appeals **Southwest Michigan Behavioral Health** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Compliance Monitoring Review
Southwest Michigan Behavioral Health's Response

Standard VI—Customer Service

- **Customer Handbook:** **Southwest Michigan Behavioral Health** updated the member handbook to include all grievance and appeals processes template language. This includes language addressing the member's right to file an SFH if notice and timing requirements are not met and expedited authorization decisions made in 72 hours.
- **Provider Listing:** Changes to the provider directory were completed by a web design company, **Southwest Michigan Behavioral Health**'s website vendor, in February of 2019. **Southwest Michigan Behavioral Health** modified its Operating Policy 2.8 to require its participant CMHSPs to utilize a link to the **Southwest Michigan Behavioral Health** provider directory on each of their websites. **Southwest Michigan Behavioral Health** modified its credentialing form to add cultural competence, any non-English languages spoken, and accessibility for people with disabilities to the information collection and credentialing process for individual clinicians and organizational providers. The same fields have been added to the Access database that is used to manage **Southwest Michigan Behavioral Health**'s electronic provider directory. **Southwest Michigan Behavioral Health** worked with the web design company to publish these fields on the public website. To enhance oversight and monitoring of this requirement, **Southwest Michigan Behavioral Health** modified its annual Administrative and Delegated Functions Review for Fiscal Year 2019 to include: 1) verifying the CMHSP has a link to the **Southwest Michigan Behavioral Health** provider directory on its website; and 2) if the CMHSP elects to also have its own electronic provider directory, that its provider directory complies with the requirements of 42 CFR §438.10(h)(1-4).

Standard VII—Grievance Process

- **General:** The **Southwest Michigan Behavioral Health** authorized representative complaint form has been finalized and implemented through the region. As **Southwest Michigan Behavioral Health**'s policy indicates, **Southwest Michigan Behavioral Health** and its participant CMHSPs require written consent when anyone other than the member/guardian/parent of a minor child files a grievance on behalf of the member. At the time of the compliance monitoring review **Southwest Michigan Behavioral Health** and each CMHSP currently had individual processes addressing this requirement, including the use of letters and a form to obtain a signature from both the member and the proposed authorized representative. The regional committee has created a standard form to be used within the region.
- **PIHP Responsibility When Member Files a Grievance:** The acknowledgement letter template was implemented region wide as of July 1, 2019. Training with the regional representatives on the use of templates was provided on August 23, 2019. **Southwest Michigan Behavioral Health** and the participant CMHSPs document in the grievance and appeal database when a grievance is acknowledged orally instead of in writing. **Southwest Michigan Behavioral Health** has implemented standard templates for the region based on the MDHHS contract template requirements.
- **Format of Notice of Grievance Resolution:** All State-mandated templates including the grievance resolution template were implemented on July 1, 2019 with a training on the use and completion of the templates with the regional representatives completed on August 23, 2019. The training included samples of plain language and the content to be included.
- **Content of Notice of Grievance Resolution:** All State-mandated templates including the grievance resolution template were implemented on July 1, 2019 with a training on the use and completion of the

Compliance Monitoring Review

templates with the regional representatives on August 23, 2019. The training included examples of plain language and the content to be included.

Standard IX—Subcontracts and Delegation

- **Right to Audit:** The FY 2018 contract was amended to incorporate the required changes, and the required changes were carried forward into the FY 2019 contract boilerplate. This language continues to be included in the contract boilerplate. The second amendment to the FY 2018 CMHSP contracts was finalized and executed by all eight participant CMHSPs. This language was included in the boilerplate of the FY 2019 CMHSP contracts as well as the CMHSP-provider boilerplate, which the CMHSPs are required to use in contracting with their provider network.

Standard XII—Access and Availability

- **Access to Ongoing Services:** During the evaluation time period, **Southwest Michigan Behavioral Health** was in the process of implementing a new data collection strategy, to merge real-time data from its Peter Chang Enterprise (PCE) and Streamline information systems. Since the review period, **Southwest Michigan Behavioral Health** has improved processes by implementing a new data collection system and is recognizing CMHSPs on a monthly basis, during Board meetings for successfully achieving the benchmark for this indicator. These initiatives have helped **Southwest Michigan Behavioral Health** achieve this indicator, at the MDHHS indicated benchmark of 95percent for seven consecutive quarters. **Southwest Michigan Behavioral Health** also implemented a strategic CAP step program that puts CMHSPs at an increased level of scrutiny for poor performance and rewards CMHSPs for good performance. CMHSPs are also required to submit a CAP each time they fail to meet the MDHHS indicated benchmark for all indicators. **Southwest Michigan Behavioral Health** has continued to monitor the progress of the CMHSPs who fall below the State benchmark for the indicator that was not met along with all others as required by MDHHS. **Southwest Michigan Behavioral Health** has rejected CAPs that did not demonstrate systemic remediation and required CMHSPs to submit evidence that the particular population noted by HSAG does indeed start services within 14 days of receiving an assessment. **Southwest Michigan Behavioral Health** has noticed overall improvement; however, as the region prepares the EMR systems for the upcoming performance indicator update, it is important to note that future results do not have to meet the 95 percent standard per MDHHS.

Standard XIV—Appeals

- **Appeals Process:** **Southwest Michigan Behavioral Health** and participant CMHSPs have developed a form for members to sign and return to process the request for appeal. The form has been distributed to all delegated and contracted providers for ease of use and consistency. **Southwest Michigan Behavioral Health** has also allowed for electronic/email communication as a means to accept a written signed request for an appeal.
- **Medicaid Services Continuation or Reinstatement:** The **Southwest Michigan Behavioral Health** handbook and all appeals related documents have been updated to reflect the 10-day time frame. The State-mandated templates were implemented on July 1, 2019 throughout the region. This included the ABD form as well as appeal templates that include the information that a member can request a continuation of benefits within 10 days of receiving denial.
- **Individuals Making Decisions:** The two appeals reviewed that did not meet this requirement were from one CMHSP. This was also caught in the annual **Southwest Michigan Behavioral Health** site review for

Compliance Monitoring Review
2018 and the CMHSP has updated and reviewed its process for this. **Southwest Michigan Behavioral Health** will continue to monitor this through annual site review. This can be monitored through requests for SFHs and review of local appeals. Additionally, follow-up on this has been addressed at the August 23, 2019 region wide training. This was reviewed and monitored through the 2019 CMHSP site review. • **Standard Appeal Resolutions:** There had been staff turnover during the time the letters were sent out late. **Southwest Michigan Behavioral Health** has implemented standard templates for the region based on the MDHHS contract template requirements. Follow-up on this has been addressed at the August 23, 2019 region wide training. This was reviewed and monitored through the 2019 CMHSP site review. • **Appeal Resolution Notice Format: Southwest Michigan Behavioral Health** has implemented standard templates for the region based on the MDHHS contract template requirements. All State-mandated templates including the appeal approval and denial templates were implemented on July 1, 2019 with a training on the use and completion of the templates with the regional representatives on August 23, 2019. The training included examples of plain language and content to be included. • **Appeal Resolution Notice Content: Southwest Michigan Behavioral Health** has implemented standardized templates for the region based on the MDHHS contract template requirements. All State-mandated templates including the appeal approval and denial templates were implemented on July 1, 2019 with a training on the use and completion of the templates with the regional representatives on August 23, 2019. The training included examples of plain language and content to be included.
HSAG's Assessment of the Degree to Which Southwest Michigan Behavioral Health Effectively Addressed the Recommendation
Based on **Southwest Michigan Behavioral Health**'s response, HSAG has determined that **Southwest Michigan Behavioral Health** addressed the prior year's recommendations. A comprehensive review of **Southwest Michigan Behavioral Health**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health** to members, HSAG recommended that **Southwest Michigan Behavioral Health** develop a quality improvement strategy within the QAPIP to ensure that all performance indicators remain stable. **Southwest Michigan Behavioral Health** should have focused on the lowest-performing indicators with an MPS, and should include within its next annual QAPIP review the results of analyses for these performance indicators that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Southwest Michigan Behavioral Health** considering or has already implemented to improve rates and performance for each identified indicator?

Performance Measures
Based on the information presented above, **Southwest Michigan Behavioral Health** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Southwest Michigan Behavioral Health** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Southwest Michigan Behavioral Health's Response
During the evaluation time period, **Southwest Michigan Behavioral Health** was in the process of implementing a new data collection strategy, to merge real-time data from its PCE and Streamline information systems. Since the review period, **Southwest Michigan Behavioral Health** has improved processes by implementing a new data collection system and is recognizing CMHSPs on a monthly basis, during Board meetings for successfully achieving the benchmark for this indicator. These initiatives have helped **Southwest Michigan Behavioral Health** achieve this indicator, at the MDHHS indicated benchmark of 95 percent for seven consecutive quarters. **Southwest Michigan Behavioral Health** also implemented a strategic CAP step program that puts CMHSPs at an increased level of scrutiny for poor performance and rewards CMHSPs for good performance. CMHSPs are also required to submit a CAP each time they fail to meet the MDHHS indicated benchmark for all indicators. **Southwest Michigan Behavioral Health** has continued to monitor the progress of the CMHSPs who fall below the State benchmark for the indicator that was not met along with all others as required by MDHHS. **Southwest Michigan Behavioral Health** has rejected CAPs that did not demonstrate systemic remediation and required CMHSPs to submit evidence that the particular population noted by HSAG does indeed start services within 14 days of receiving an assessment. **Southwest Michigan Behavioral Health** has noticed overall improvement; however, as the region prepares the EMR systems for the upcoming performance indicator update, it is important to note that future results do not have to meet the 95 percent standard per MDHHS.
HSAG's Assessment of the Degree to Which Southwest Michigan Behavioral Health Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Southwest Michigan Behavioral Health**'s rates declined by more than 2 percentage points for indicators *#3* (IDD Children) and *#4b* to go from above the MPS in 2017–2018 to below the MPS for 2018–2019, indicating that **Southwest Michigan Behavioral Health** partially addressed the prior recommendations.

Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Southwest Michigan Behavioral Health** take proactive steps to ensure a successful PIP. As the PIP progressed, **Southwest Michigan Behavioral Health** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Southwest Michigan Behavioral Health's Response
During the 2017–2018 validation period, **Southwest Michigan Behavioral Health**'s PIP submission was a description of the study design, per MDHHS and HSAG direction. The baseline measurement, causal/barrier analysis, development of intervention steps, and process for evaluating each improvement measure was reported in the 2018–2019 PIP submission.
HSAG's Assessment of the Degree to Which Southwest Michigan Behavioral Health Effectively Addressed the Recommendation
In the 2018–2019 validation, **Southwest Michigan Behavioral Health** addressed all recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health** to members, HSAG recommends that **Southwest Michigan Behavioral Health** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-2]

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Performance Declined >2 Percent From Previous Year

- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Children

HSAG also recommends that **Southwest Michigan Behavioral Health** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard II—Quality Measurement and Improvement
- Standard V—Utilization Management
- Standard XI—Credentialing

Southwest Michigan Behavioral Health was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Southwest Michigan Behavioral Health** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Southwest Michigan Behavioral Health** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

[5-2] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

Finally, **Southwest Michigan Behavioral Health** should take proactive steps to ensure a successful PIP. **Southwest Michigan Behavioral Health** should address all *General Comments* in the *2018–2019 PIP Validation Report Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication for Region 4—Southwest Michigan Behavioral Health* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Southwest Michigan Behavioral Health** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the outcomes.
- **Southwest Michigan Behavioral Health** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Southwest Michigan Behavioral Health** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Southwest Michigan Behavioral Health** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 5—Mid-State Health Network

To conduct the 2018–2019 EQR, HSAG reviewed **Mid-State Health Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network**.

EQR Activity Results

Compliance Monitoring

Mid-State Health Network was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-29 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-29 also presents **Mid-State Health Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-29—Summary of 2018–2019 Compliance Monitoring Review Results for Mid-State Health Network

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	7	1	0	88%
Standard II—Quality Measurement and Improvement	8	6	2	0	75%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	12	4	0	75%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	71	11	0	87%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Mid-State Health Network demonstrated compliance for 71 of 82 elements, with an overall compliance score of 87 percent. **Mid-State Health Network** demonstrated strong performance, scoring 90 percent or above in five standards, with all five of those standards achieving full compliance. These areas of strength include Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information.

Opportunities for improvement were identified in four of the nine standards, including deficiencies related to the following requirements:

- Annual effectiveness review of the QAPIP
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Content of the notices of ABD
- Notices of ABD time frame standards
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Mid-State Health Network** and to determine the extent to which performance indicators reported by **Mid-State Health Network** followed State specifications and reporting requirements. HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 5—Mid-State Health Network* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Mid-State Health Network**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Mid-State Health Network** received and processed claims and encounter data for submission to MDHHS.
- BH-TEDS Data Production—Based on demonstrations of CMHSPs' BH-TEDS data entry and submission processes (i.e., CMH for Central MI, CEI CMH, Mid-State Health Network Substance Use Disorder), no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. HSAG recommends that **Mid-State Health Network** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Mid-State Health Network** had sufficient oversight of its 12 affiliated CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Mid-State Health Network** received an indicator designation of *Report* for all indicators, signifying that **Mid-State Health**

Network had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-30 presents **Mid-State Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-30—Performance Measure Results for Mid-State Health Network

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	98.42%	95.00%
Adults	98.45%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	98.16%	95.00%
MI Adults	98.54%	95.00%
IDD Children	99.01%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.15%	95.00%
Total	98.34%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	96.64%	95.00%
MI Adults	98.43%	95.00%
IDD Children	90.79%	95.00%
IDD Adults	96.72%	95.00%
Medicaid SUD	97.92%	95.00%
Total	97.63%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	98.08%	95.00%
MI and IDD Adults	94.52%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	95.59%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	8.41%	—

Performance Indicator	Rate	MPS
#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.		
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.	97.32%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	17.93%	—
IDD Adults	9.45%	—
MI/IDD Adults	8.65%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	92.27%	—
IDD Adults	44.50%	—
MI/IDD Adults	40.27%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	9.77%	15.00%
MI and IDD Adults	10.66%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	19.08%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	51.83%	—

Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

Mid-State Health Network's performance exceeded the corresponding MPS for 17 of 19 measure indicators (89.5 percent), suggesting strength in these areas.

Although most of **Mid-State Health Network**'s rates were above the MPS, the rates for at least one population under indicators *#3* and *#4a* fell below their corresponding MPS, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Mid-State Health Network** provided baseline data on the PIP topic: *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*. The goal of this PIP is to increase annual HbA1c and LDL-C testing among Medicaid members with diabetes and schizophrenia.

Table 5-31 outlines the study indicator for the PIP.

Table 5-31—Study Indicator

PIP Topic	Study Indicator
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Table 5-32 and Table 5-33 show **Mid-State Health Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Mid-State Health Network**.

Table 5-32—PIP Validation Results for Mid-State Health Network

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage		Step	Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (15/15)**		

Table 5-33—2018–2019 PIP Validation Scores for Mid-State Health Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Submission	100%	100%	***Met***
	Resubmission	NA	NA	***NA***

Mid-State Health Network submitted the Design and Implementation stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* on the initial validation and a resubmission was not required. The PIP had not progressed to the Outcomes stage.

Mid-State Health Network designed a scientifically sound project and the technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. **Mid-State Health Network** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Mid-State Health Network** accurately calculated and interpreted the baseline results. **Mid-State Health Network** progressed to completing a causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes.

Strengths, Weaknesses, and Overall Conclusions

Mid-State Health Network demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Mid-State Health Network** received a total compliance score of 87 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Mid-State Health Network** scored 90 percent or above in the Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Utilization Management, and Credentialing standards, as demonstrated by moderate to low performance scores (88 percent, 75 percent, 75 percent, and 56 percent, respectively), reflecting that additional focus is needed in these areas.

While 17 of the 19 performance measure rates were above the MDHHS-established MPS, indicating strength in these areas, **Mid-State Health Network**'s rates for indicators *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children, and *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults fell below the established MPS, indicating opportunities to improve these measure rates.

Mid-State Health Network's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-34—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The Practice Guidelines standard achieved full compliance, indicating the PIHP implemented processes for the adoption, development, implementation, monitoring, and evaluation of CPGs. • Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The Members' Rights and Protections standard achieved full compliance, suggesting the PIHP guaranteed, observed, and protected members' rights. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound project related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 75 percent, indicating that the PIHP lacked comprehensive

Performance Area*	Overall Performance Impact
	processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: Credentialing was the lowest performing standard with a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; receiving timely needed, ongoing services for SED Children, MI Adults, IDD Adults, and Medicaid SUD populations; timely follow-up care following discharges from an inpatient psychiatric unit for SED and IDD Children; and timely follow-up care following discharge from a substance abuse detox unit. • Weakness: The Utilization Management standard received a compliance score of 75 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The MPS related to receiving timely needed, ongoing services for IDD Children and timely follow-up care following discharges from an inpatient psychiatric unit for MI and IDD Adults were not met.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard achieved full compliance, indicating that the PIHP had adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact, was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Mid-State Health Network**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Mid-State Health Network**. The recommendations provided to **Mid-State Health Network** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-35 in addition to **Mid-State Health Network**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-35—Recommendations and Mid-State Health Network's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Mid-State Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard XII—Access and Availability • Standard XIV—Appeals **Mid-State Health Network** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Mid-State Health Network's Response
Standard VI—Customer Service: The required information identified by HSAG that included information regarding the member's right to use any hospital or other setting for emergency care and information on how to report suspected fraud and/or abuse has been added to the member handbook for FY 2019. **Mid-State Health Network** received approval from MDHHS for the FY 2019 handbook, including the addition of the missing elements. **Mid-State Health Network** also corrected the time frame for standard appeal decisions to reflect 30 days as identified in the MDHHS contract. This information was completed at the time **Mid-State Health Network** submitted the initial CAP response. The twelve CMHSPs under contract with **Mid-State Health Network** continue to upload their provider directory file to **Mid-State Health Network**'s managed care information system (REMI) in accordance with all content required by contract and 42 CFR §438.10(h) as indicated in **Mid-State Health Network**'s provider network directory policy and procedure. The combined file (of all CMHSPs) is then exported to a CSV file along with the **Mid-State Health Network** SUD network directory and uploaded to **Mid-State Health Network**'s website for a complete listing of providers, inclusive of independent person-centered planning (PCP) facilitators. The directory template used by CMHSPs to import CMHSP provider directory data includes a field 'Accepting New Enrollees' with an indicator of "Yes" or "No". This information is then displayed in the directory. Additionally, **Mid-State Health Network** collects this information when providers apply to the **Mid-State Health Network** provider network and maintains those data in REMI. Providers are required to submit a monthly waitlist report to **Mid-State Health Network** which would indicate they are at capacity and would trigger the system to be updated accordingly. Process improvement that is currently in progress includes

Compliance Monitoring Review
the development of data validations to ensure all data are consistent and the elimination/consolidation of duplicate provider records (i.e., when multiple CMHSPs have a contract with the same provider, the listing will include duplicates). **Standard VII—Grievance Process:** The **Mid-State Health Network** SUD treatment contracts state that providers are required to assist members with filing grievances and appeals, assessing the local dispute resolution processes, and coordinate, as appropriate, with the recipient rights advisor. **Mid-State Health Network** provides oversight and monitoring of this process during the annual site review of providers by reviewing the provider's grievance policies and procedures, along with reviewing a sample of grievances that have been completed to ensure compliance with all required standards. The grievance site review tool was updated for FY 2019 to ensure a review of the required elements. **Mid-State Health Network** also monitors grievances through quarterly reporting through the denial, grievance, appeals and second opinion report which was updated for FY 2019 to require the submission of grievance details for all grievances reported by the provider. All grievances reported directly to **Mid-State Health Network** are investigated through to resolution by the member service and rights specialist with follow up to the appropriate SUD provider. **Mid-State Health Network** developed a standardized grievance resolution notice template to be utilized by MSHN providers that is compliant with the 42 CFR §438.10. The grievance and appeal tool for the delegated managed care site review has been revised for FY 2019 to monitor that letters are written at fourth-grade reading level, when possible, and meet the needs of those with limited English proficiency and limited reading proficiency by answering the question "Resolution notice is easily understood? (length, language, grammar, reading level)". **Standard IX—Subcontracts and Delegation:** As identified in the plan of correction, the following language was added to the FY 2019 subcontract between **Mid-State Health Network** and the CMHSPs, and the SUD providers: "E. The parties hereto agree that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with42 CFR 438.230(c)(3)(iii)." **Standard XII—Access and Availability:** During the review period of the compliance monitoring review, **Mid-State Health Network** had the following CAPs related to indicator *#3* (The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional—IDD Children. • FY 2018 Q1—one CMHSP had corrective action. **Mid-State Health Network**'s performance was 83.05 percent. • FY 2018 Q2—one CMHSP had corrective action. **Mid-State Health Network**'s performance was 98.08 percent. • FY 2018 Q3—no CMHSPs had corrective action. **Mid-State Health Network**'s performance was 97.79 percent. • FY 2018 Q4—two CMHSPs had corrective action. **Mid-State Health Network**'s performance was 97.56 percent. **Mid-State Health Network** has demonstrated an increase in performance for those quarters identified below the standard which indicates that the corrective actions implemented were effective.

Compliance Monitoring Review
Mid-State Health Network reviews the MMBPIS reports quarterly with the Quality Improvement Council (QIC) which consists of the QI representative from each of the 12 CMHSPs and one representative from the SUD program, who is a **Mid-State Health Network** staff working with the SUD providers in providing technical assistance and guidance. A CAP is completed for each indicator that falls below the standard each quarter. The action plan consists of common or special causal factors contributing to the low performing rates and the interventions with an implementation date and the date of full impact/benefit is identified. The plan is reviewed and approved by **Mid-State Health Network** staff. The effectiveness of the plan is demonstrated based on the performance of the organization during the upcoming measurement periods. Additionally, regional activity developed to improve this process includes additional training and development of documents to ensure consistency of reporting, definitions, and interpretations (frequently asked questions [FAQ]). The monitoring of the completion of corrective actions and validations of data reported is completed during the delegated managed care site reviews. The status of the process for monitoring the performance is completed; however, it is ongoing to ensure that all causes of low performance are continually reviewed and acted upon. **Standard XIV—Appeals:** The **Mid-State Health Network** appeals and grievances policy was revised to include the requirement for providers to be in compliance with 42 CFR §438 Subpart F, which includes the standard of requesting written follow-up after the acceptance of an oral request for an appeal. **Mid-State Health Network**'s appeal and grievance tool for the delegated managed care site review includes the review that if a request for an appeal was submitted orally, then it must be followed up in writing. During the annual review, **Mid-State Health Network** reviews the appeal process and a sample of appeals that have been completed to ensure compliance with the standards. The appeal requirements are monitored through the regional Customer Service Committee to ensure the standards are being implemented appropriately and consistently across the region. The **Mid-State Health Network** appeals and grievances policy was revised to include the requirement for providers to be in compliance with 42 CFR §438 Subpart F. **Mid-State Health Network** monitors the appeals time frame through a case record review during the delegated managed care site review process. **Mid-State Health Network** also monitors appeals through quarterly reporting of the denial, grievance, appeals and second opinion report which was updated for FY 2019 to require the submission of appeal details for all appeals reported by the provider. The report includes appeal time frame data to ensure that each appeal was completed within the required 30 calendar day time frame. The quarterly report requires that a CAP be submitted by any CMHSP or SUD provider that does not meet the 100 percent compliance requirement for providing appeals notices within the 30-day time frame. Currently two of the twelve CMHSPs are under corrective action for not meeting the standard of 100 percent. The grievance and appeal tool for the delegated managed care site review has been revised for FY 2019 to monitor that letters are written at a fourth-grade reading level, when possible, and meets the needs of those with limited English proficiency and limited reading proficiency by answering the question: "Resolution notice is easily understood? (length, language, grammar, reading level)". **Mid-State Health Network** also utilizes standardized appeal notice templates to ensure consistent information is provided throughout the region. The CAP was modified to include the use of the contract attached notice templates for grievance and appeals as required by MDHHS.

Compliance Monitoring Review
Mid-State Health Network revised the standard appeal approval and denial templates for FY 2019 to include the date the appeal was completed. The templates also provide a framework to include the required results of the resolution. The appeal tool for the delegated managed care site review had been revised for FY 2019. The following was added to the appeal site review tool: "Resolution notice is easily understood? (length, language, grammar, reading level)".
HSAG's Assessment of the Degree to Which Mid-State Health Network Effectively Addressed the Recommendation
Based on **Mid-State Health Network**'s response, HSAG has determined that **Mid-State Health Network** has partially addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Mid-State Health Network**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommended that **Mid-State Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Ratings Below the MPS** • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children **Performance Declined >2 Percent From Previous Year** • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children • *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* **Mid-State Health Network** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Mid-State Health Network** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Mid-State Health Network** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator

Performance Measures
• Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Mid-State Health Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Mid-State Health Network's Response
During this review period **Mid-State Health Network** had the following CAPs by different CMHSPs related to indicators *#3a*, *#3c*, and *#4b* completed. Only one CMHSP did not demonstrate improvement or reach the desired performance level after corrective action during the reporting periods below. • FY 2018 Q1—five CMHSPs were required to have a plan of correction. • FY 2018 Q2—five CMHSPs were required to have a plan of correction. • FY 2018 Q3—four CMHSPs were required to have a plan of correction. • FY 2018 Q4—two CMHSPs were required to have a plan of correction. **Mid-State Health Network** reviews the MMBPIS reports quarterly with the QIC which consists of the QI representative from each of the 12 CMHSPs and one representative from the SUD program, who is a **Mid-State Health Network** staff working with the SUD providers in providing technical assistance and guidance. A CAP is completed for each indicator that falls below the standard each quarter. The action plan consists of common or special causal factors contributing to the low performing rates and the interventions with an implementation date and the date of full impact/benefit is identified. The plan is reviewed and approved by **Mid-State Health Network** staff. The effectiveness of the plan is demonstrated based on the performance of the organization during the upcoming measurement periods. Additionally, regional activity developed to improve this process includes additional training and development of documents to ensure consistency of reporting, definitions, and interpretations (FAQ). The monitoring of the completion of corrective actions and validations of data reported is completed during the delegated managed care site reviews. The status of the process for monitoring the performance is completed; however, it is ongoing to ensure that all causes of low performance are continually reviewed and acted upon.
HSAG's Assessment of the Degree to Which Mid-State Health Network Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Mid-State Health Network** improved upon its rates for indicator *#3* (SED Children and IDD Children); however, it did not meet the MPS for indicator *#3* (IDD Children) and the rate for indicator *#4b* remains just above the MPS despite the rate continuing to decline, indicating that **Mid-State Health Network** partially addressed the prior recommendations.

Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Mid-State Health Network** take proactive steps to ensure a successful PIP. As the PIP progressed, **Mid-State Health Network** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Mid-State Health Network's Response
Mid-State Health Network followed the process as indicated in the PIP to determine baseline. After the baseline was obtained a causal analysis was completed by the QIC using a fishbone diagram. Interventions were identified to address each barrier or causal factor. The interventions were prioritized utilizing a prioritization matrix addressing the impact and effect of the interventions. The implementation of the interventions identified are reviewed quarterly by the QIC to determine effectiveness in improving the outcome. Any signals or variations of the data are investigated. If the identified interventions do not address the variations additional action steps are taken to improve or correct the process and ultimately impact the outcome of the study.
HSAG's Assessment of the Degree to Which Mid-State Health Network Effectively Addressed the Recommendation
In the 2018–2019 validation, **Mid-State Health Network** addressed all recommendations appropriate for the reporting of baseline data.

Recommendations for Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommends that **Mid-State Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-3]

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Adults
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

HSAG also recommends that **Mid-State Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard V—Utilization Management
- Standard XI—Credentialing

Mid-State Health Network was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Mid-State Health Network** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

[5-3] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

Once all plans of action are fully implemented, HSAG recommends that **Mid-State Health Network** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Mid-State Health Network** should take proactive steps to ensure a successful PIP. **Mid-State Health Network** should address all *General Comments* in the *2018–2019 PIP Validation Report Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test for Region 5—Mid-State Health Network* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Mid-State Health Network** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the study indicator outcomes.
- **Mid-State Health Network** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Mid-State Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Mid-State Health Network** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 6—Community Mental Health Partnership of Southeast Michigan

To conduct the 2018–2019 EQR, HSAG reviewed **Community Mental Health Partnership of Southeast Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Community Mental Health Partnership of Southeast Michigan**.

EQR Activity Results

Compliance Monitoring

Community Mental Health Partnership of Southeast Michigan was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-36 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-36 also presents **Community Mental Health Partnership of Southeast Michigan**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-36—Summary of 2018–2019 Compliance Monitoring Review Results for Community Mental Health Partnership of Southeast Michigan

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	2	1	0	67%
Standard V—Utilization Management	16	14	2	0	88%
Standard VIII—Members' Rights and Protections	13	10	3	0	77%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	9	1	0	90%
Total	82	63	19	0	77%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Community Mental Health Partnership of Southeast Michigan demonstrated compliance for 63 of 82 elements, with an overall compliance score of 77 percent. **Community Mental Health Partnership of Southeast Michigan** demonstrated strong performance, scoring 90 percent or above in two standards, with one of those standards achieving full compliance. These areas of strength include Coordination of Care and Confidentiality of Health Information.

Opportunities for improvement were identified in eight of the nine standards, including deficiencies related to the following requirements:

- The Governing Body's responsibility to monitor and evaluate the QAPIP
- Quarterly analyses of data from the BTRC
- Annual effectiveness review of the QAPIP
- Time frames for determining if a critical incident is a sentinel event and initiating an RCA
- Credentials of individuals reviewing sentinel events
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Adoption of CPGs
- Staff possessing the appropriate qualifications outlined in their job descriptions
- Content of the notices of ABD
- Extension of service authorization time frames and notice provisions
- Providing members with written notice of a significant change at least 30 days before the intended effective date of the change
- Prohibit conditioning the provision of care based on whether or not a member has executed an advance directive
- Annually providing a member the estimated annual cost to the PIHP of each covered support and service received
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Content of breach notification letters

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Community Mental Health Partnership of Southeast Michigan** and to determine the extent to which performance indicators reported by **Community Mental Health Partnership of Southeast Michigan** followed State specifications and reporting requirements. 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. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 6—Community Mental Health Partnership of Southeast Michigan* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Community Mental Health Partnership of Southeast Michigan**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no major concerns with how **Community Mental Health Partnership of Southeast Michigan** received and processed claims and encounter data for submission to MDHHS.
- BH-TEDS Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Washtenaw CMH, Monroe CMH, and Livingston CMH), no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Community Mental Health Partnership of Southeast Michigan** had sufficient oversight of its four affiliated CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Community Mental Health Partnership of Southeast Michigan** received an indicator designation of *Report* for 11 indicators, signifying that **Community Mental Health Partnership of Southeast Michigan** had calculated these indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Community Mental Health Partnership of Southeast Michigan** received an indicator designation of *Not Reported* for the remaining indicator, indicating that **Community Mental Health Partnership of Southeast Michigan**/CMHSPs did not calculate these indicators in compliance with MDHHS Codebook specifications.

HSAG identified issues during PSV in **Community Mental Health Partnership of Southeast Michigan**'s process for capturing data for indicator *#4b* for Quarter 1 of SFY 2019 and the data were considered *Not Reported*. **Community Mental Health Partnership of Southeast Michigan** had already identified and corrected these issues, but the corrections were not in place when reporting data for Quarter 1 of SFY 2019. Table 5-37 presents **Community Mental Health Partnership of Southeast Michigan**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-37—Performance Measure Results for Community Mental Health Partnership of Southeast Michigan

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	99.30%	95.00%
Adults	99.09%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	99.53%	95.00%
MI Adults	99.66%	95.00%
IDD Children	100.00%	95.00%
IDD Adults	96.30%	95.00%
Medicaid SUD	97.38%	95.00%
Total	98.61%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	95.60%	95.00%
MI Adults	89.44%	95.00%
IDD Children	93.33%	95.00%
IDD Adults	93.94%	95.00%
Medicaid SUD	97.13%	95.00%
Total	94.69%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	96.00%	95.00%
MI and IDD Adults	96.71%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	*NR*	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.04%	—

Performance Indicator	Rate	MPS
#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.		
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.	96.91%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	16.66%	—
IDD Adults	9.76%	—
MI/IDD Adults	8.66%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	91.64%	—
IDD Adults	51.31%	—
MI/IDD Adults	57.39%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	8.06%	15.00%
MI and IDD Adults	10.27%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	25.56%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	36.25%	—

Indicates that the reported rate was better than the MPS.

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

NR (*Not Reported*) indicates that the rate was determined "materially biased." Rates designated NR are not displayed because the PIHP's performance cannot be evaluated based on biased rates.

* A lower rate indicates better performance.

Community Mental Health Partnership of Southeast Michigan's performance exceeded the corresponding MPS for 14 of 18 reportable measure indicators (77.8 percent), suggesting strength in these areas.

Although most of **Community Mental Health Partnership of Southeast Michigan**'s rates were above the MPS, the rates for four populations (MI Adults, IDD Children, IDD Adults, and Total) under indicator *#3* fell below their corresponding MPS, indicating opportunities for improvement. Additionally, **Community Mental Health Partnership of Southeast Michigan**'s rate was deemed *Not Reported* for one of 19 measure indicators (5.3 percent) with an MPS.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Community Mental Health Partnership of Southeast Michigan** provided baseline data for the PIP topic: *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*. The goal of this PIP is to increase annual HbA1c and LDL-C testing among Medicaid members with diabetes and schizophrenia.

Table 5-38 outlines the study indicator for the PIP.

Table 5-38—Study Indicator

PIP Topic	Study Indicator
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members aged 18–64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year.

Table 5-39 and Table 5-40 show **Community Mental Health Partnership of Southeast Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Community Mental Health Partnership of Southeast Michigan**.

Table 5-39—PIP Validation Results for Community Mental Health Partnership of Southeast Michigan

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	50% (2/4)	50% (2/4)	0% (0/4)
Implementation Total			**71% (5/7)**	**29% (2/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**88% (14/16)**		

Table 5-40—2018–2019 PIP Validation Scores for Community Mental Health Partnership of Southeast Michigan

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Submission	75%	75%	***Partially Met***
	Resubmission	88%	88%	***Partially Met***

Community Mental Health Partnership of Southeast Michigan submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 88 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Community Mental Health Partnership of Southeast Michigan designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes.

Community Mental Health Partnership of Southeast Michigan indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Community Mental Health Partnership of Southeast Michigan** accurately calculated and interpreted the baseline results. **Community Mental Health Partnership of Southeast Michigan** progressed to completing causal/barrier analysis using quality improvement tools; however, it did not clearly identify barriers and implement interventions that were logically linked to those barriers.

Strengths, Weaknesses, and Overall Conclusions

Community Mental Health Partnership of Southeast Michigan demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Community Mental Health Partnership of Southeast Michigan** received a total compliance score of 77 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Community Mental Health Partnership of Southeast Michigan** scored 90 percent or above in the Coordination of Care and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Members' Rights and Protections, and Credentialing standards, as demonstrated by moderate to low performance scores (63 percent, 50 percent, 75 percent, 67 percent, 88 percent, 77 percent, and 56 percent, respectively), reflecting that additional focus is needed in these areas.

While 14 of the 18 reportable performance measure rates were above the MDHHS-established MPS, indicating strengths in these areas, **Community Mental Health Partnership of Southeast Michigan**'s rates for indicator *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—MI Adults, IDD Children, IDD Adults, and Total fell below their corresponding MPS, indicating opportunities to improve these measure rates. Additionally, **Community Mental Health Partnership of Southeast Michigan** received an audit designation of *Not Reported* for indicator *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* because the rate was determined to be materially biased, indicating that **Community Mental Health Partnership of Southeast Michigan** did not calculate the performance indicator in compliance with MDHHS Codebook specifications.

Community Mental Health Partnership of Southeast Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-41—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*. • Strength: The PIHP designed a scientifically sound project related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, supported by the use of key research principles, and accurately calculated and interpreted the baseline results. • Weakness: The QAPIP Plan and Structure standard received a compliance score of 63 percent, indicating the PIHP did not maintain a comprehensive quality program. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 50 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 75 percent, indicating that the PIHP did not follow program requirements for the adoption of CPGs. • Weakness: The Staff Qualifications and Training standard received a compliance score of 67 percent, suggesting the PIHP did not hire staff members who possessed the minimum qualifications required by the job descriptions. • Weakness: Credentialing was the lowest performing standard with a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network. • Weakness: The PIHP did not clearly identify barriers and implement interventions that were logically linked to the barriers and have the potential to impact the PIP study indicator outcomes.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; receiving timely needed, ongoing services for SED Children and Medicaid SUD; and timely follow-up care following discharges from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults. • Weakness: The MPS related to timely needed, ongoing services for MI Adults, IDD Children, and IDD Adults were not met. • Weakness: The PIHP received an *NR* audit designation for timely follow-up care following discharge from a substance abuse detox unit.

Performance Area*	Overall Performance Impact
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard received a compliance score of 90 percent, indicating that the PIHP had adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Community Mental Health Partnership of Southeast Michigan**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Community Mental Health Partnership of Southeast Michigan**. The recommendations provided to **Community Mental Health Partnership of Southeast Michigan** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 5-42 in addition to **Community Mental Health Partnership of Southeast Michigan**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-42—Recommendations and Community Mental Health Partnership of Southeast Michigan's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Community Mental Health Partnership of Southeast Michigan** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard IX—Subcontracts and Delegation • Standard X—Provider Network • Standard XII—Access and Availability • Standard XIV—Appeals **Community Mental Health Partnership of Southeast Michigan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency

Compliance Monitoring Review
• Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Community Mental Health Partnership of Southeast Michigan's Response
Community Mental Health Partnership of Southeast Michigan developed and implemented a CAP which was reviewed and approved by MDHHS. MDHHS reviewed **Community Mental Health Partnership of Southeast Michigan**'s CAP documentation which was determined to be in compliance.
HSAG's Assessment of the Degree to Which Community Mental Health Partnership of Southeast Michigan Effectively Addressed the Recommendation
Based on **Community Mental Health Partnership of Southeast Michigan**'s response, HSAG determined **Community Mental Health Partnership of Southeast Michigan**'s CAP included appropriate plans of action to effectively address the prior recommendations. A comprehensive review of **Community Mental Health Partnership of Southeast Michigan**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Community Mental Health Partnership of Southeast Michigan** to members, HSAG recommended that **Community Mental Health Partnership of Southeast Michigan** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Rating Below the MPS** • *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* **Increase in Readmissions >5 Percent From Previous Year** • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children **Community Mental Health Partnership of Southeast Michigan** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses?

Performance Measures
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Community Mental Health Partnership of Southeast Michigan** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Community Mental Health Partnership of Southeast Michigan** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Community Mental Health Partnership of Southeast Michigan** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Community Mental Health Partnership of Southeast Michigan's Response
Community Mental Health Partnership of Southeast Michigan implemented a new electronic health record which included a performance indicator module.
HSAG's Assessment of the Degree to Which Community Mental Health Partnership of Southeast Michigan Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Community Mental Health Partnership of Southeast Michigan** improved upon its rates for indicator *#10* (SED and IDD Children); however, it received an *NR* audit designation for indicator *#4b*, indicating that **Community Mental Health Partnership of Southeast Michigan** partially addressed the prior recommendations.
Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Community Mental Health Partnership of Southeast Michigan** take proactive steps to ensure a successful PIP. As the PIP progressed, **Community Mental Health Partnership of Southeast Michigan** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.

Performance Measures
• Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Community Mental Health Partnership of Southeast Michigan's Response
Community Mental Health Partnership of Southeast Michigan's PIP was discontinued and was transitioned to **Community Mental Health Partnership of Southeast Michigan**'s strategic plan.
HSAG's Assessment of the Degree to Which Community Mental Health Partnership of Southeast Michigan Effectively Addressed the Recommendation
In the 2018–2019 validation, **Community Mental Health Partnership of Southeast Michigan** addressed some but not all of the recommendations appropriate for the reporting of baseline data. The PIHP received recommendations last year that mimic this year's validation feedback for the improvement strategies.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Community Mental Health Partnership of Southeast Michigan** to members, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Ratings Below the MPS[5-4]

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—MI Adults, IDD Children, IDD Adults, and Total

[5-4] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

Performance Declined >2 Percent From Previous Year

- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Adults
- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children

HSAG also recommends that **Community Mental Health Partnership of Southeast Michigan** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard IV—Staff Qualifications and Training
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Community Mental Health Partnership of Southeast Michigan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** conduct an internal audit and/or an audit of CMHSPs of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Community Mental Health Partnership of Southeast Michigan** should take proactive steps to ensure a successful PIP. **Community Mental Health Partnership of Southeast Michigan** should address all *General Comments* in the *2018–2019 PIP Validation Report Patients With Schizophrenia*

and Diabetes Who Had an HbA1c and LDL-C Test for Region 6—Community Mental Health Partnership of Southeast Michigan and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Community Mental Health Partnership of Southeast Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the study indicator outcomes.
- **Community Mental Health Partnership of Southeast Michigan** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Community Mental Health Partnership of Southeast Michigan** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Community Mental Health Partnership of Southeast Michigan** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 7—Detroit Wayne Integrated Health Network

To conduct the 2018–2019 EQR, HSAG reviewed **Detroit Wayne Integrated Health Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Integrated Health Network**.

EQR Activity Results

Compliance Monitoring

Detroit Wayne Integrated Health Network was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-43 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-43 also presents **Detroit Wayne Integrated Health Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-43—Summary of 2018–2019 Compliance Monitoring Review Results for Detroit Wayne Integrated Health Network

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	6	2	0	75%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	2	1	0	67%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	12	1	0	92%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	5	5	0	50%
Total	82	65	17	0	79%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Detroit Wayne Integrated Health Network demonstrated compliance for 65 of 82 elements, with an overall compliance score of 79 percent. **Detroit Wayne Integrated Health Network** demonstrated strong performance, scoring 90 percent or above in three standards, with two of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care.

Opportunities for improvement were identified in seven of the nine standards, including deficiencies related to the following requirements:

- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Periodic review of CPGs
- Staff possessing the appropriate qualifications outlined in their job descriptions
- Providing notices of ABD for the denial of payment at the time of an action affecting a claim
- Extension of service authorization time frames and notice provisions
- Exceptions to providing advance notices of ABD
- Providing written notice to members of termination of a contracted provider within 15 days after receipt or issuance of the termination notice
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Maintaining documented processes with respect to PHI and SUD treatment information that the PIHP generates, receives, maintains, uses, discloses, or transmits in the performance of its functions
- Mailing of a written notification of a breach
- Substitute notice provisions for breaches

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Detroit Wayne Integrated Health Network** and to determine the extent to which performance indicators reported by **Detroit Wayne Integrated Health Network** followed State specifications and reporting requirements. HSAG evaluated **Detroit Wayne Integrated Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 7—Detroit Wayne Integrated Health Network* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Detroit Wayne Integrated Health Network**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Detroit Wayne Integrated Health Network** received and processed claims and encounter data for submission to MDHHS. During HSAG's PSV activity, HSAG identified inconsistencies with how **Detroit Wayne Integrated Health Network** captured the request date for indicator *#2*;

therefore, the reported rates were considered to be materially biased. HSAG identified multiple occurrences where the assessment and follow-up visit were on the same date when both occurrences were part of the assessment and not a separate same-day visit for indicator *#3*. Therefore, the reported rates were considered to be materially biased. This was a billing-related process that **Detroit Wayne Integrated Health Network** will need to review and correct. HSAG also identified multiple instances where the incorrect dates were extracted for measure data reporting for indicators *#4a* and *#4b*; therefore, the reported rates were considered to be materially biased. In addition, HSAG identified multiple instances where readmissions were being counted inaccurately for indicator *#10*. **Detroit Wayne Integrated Health Network** determined that multiple authorizations were generated by its finance department that led to inaccurate data being included for measure reporting. Due to the unavailability of the data, the reputed rates were considered to be materially biased.

- BH-TEDS Data Production—Based on demonstrations of **Detroit Wayne Integrated Health Network**'s BH-TEDS data entry and submission processes, no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. HSAG recommends that **Detroit Wayne Integrated Health Network** perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Detroit Wayne Integrated Health Network** had sufficient oversight of its one affiliated CMHSP. Effective October 1, 2018, **Detroit Wayne Integrated Health Network** ended contracts with three of its Managed Care Provider Networks (MCPNs). The PIHP continued to contract with Community Living Services (CLS), whose contract was extended through June 30, 2019.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Detroit Wayne Integrated Health Network** received an indicator designation of *Report* for seven indicators, signifying that **Detroit Wayne Integrated Health Network** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported. However, **Detroit Wayne Integrated Health Network** received an indicator designation of *Not Reported* for the remaining five indicators, indicating that **Detroit Wayne Integrated Health Network** did not calculate these indicators in compliance with MDHHS Codebook specifications. HSAG identified issues in **Detroit Wayne Integrated Health Network**'s process for documentation of outreach attempts as well as authorizations related to inpatient stay that did not allow for accurate capture of data needed for measure reporting. Therefore, these reported rates were considered materially biased. Table 5-44 presents **Detroit Wayne Integrated Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-44—Performance Measure Results for Detroit Wayne Integrated Health Network

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	94.47%	95.00%
Adults	95.77%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	*NR*	95.00%
MI Adults	*NR*	95.00%
IDD Children	*NR*	95.00%
IDD Adults	*NR*	95.00%
Medicaid SUD	*NR*	95.00%
Total	*NR*	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	*NR*	95.00%
MI Adults	*NR*	95.00%
IDD Children	*NR*	95.00%
IDD Adults	*NR*	95.00%
Medicaid SUD	*NR*	95.00%
Total	*NR*	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	*NR*	95.00%
MI and IDD Adults	*NR*	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	*NR*	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.15%	—

Performance Indicator	Rate	MPS
#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.		
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.	96.46%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	10.09%	—
IDD Adults	9.13%	—
MI/IDD Adults	5.66%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	88.88%	—
IDD Adults	43.40%	—
MI/IDD Adults	30.64%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	*NR*	15.00%
MI and IDD Adults	*NR*	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	22.27%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	36.04%	—

Indicates that the reported rate was better than the MPS.

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

NR (*Not Reported*) indicates that the rate was determined "materially biased." Rates designated NR are not displayed because the PIHP's performance cannot be evaluated based on biased rates.

* A lower rate indicates better performance.

Detroit Wayne Integrated Health Network's performance exceeded the corresponding MPS for one of two reportable measure indicators (50.0 percent), suggesting strength in that area.

Detroit Wayne Integrated Health Network's rate for the Children population under indicator *#1* fell below its corresponding MPS, indicating an opportunity for improvement. Additionally, **Detroit Wayne Integrated Health Network**'s rates were deemed *Not Reported* for 17 of 19 measure indicators (89.5 percent) with an MPS.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Detroit Wayne Integrated Health Network** provided baseline data on the PIP topic: *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*. The goal of this PIP is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications.

Table 5-45 outlines the study indicator for the PIP.

Table 5-45—Study Indicator

PIP Topic	Study Indicator
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.

Table 5-46 and Table 5-47 show **Detroit Wayne Integrated Health Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Detroit Wayne Integrated Health Network**.

Table 5-46—PIP Validation Results for Detroit Wayne Integrated Health Network

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (15/15)**		

Table 5-47—2018–2019 PIP Validation Scores for Detroit Wayne Integrated Health Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Submission	60%	50%	***Partially Met***
	Resubmission	100%	100%	***Met***

Detroit Wayne Integrated Health Network submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 100 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Detroit Wayne Integrated Health Network designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Detroit Wayne Integrated Health Network** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Detroit Wayne Integrated Health Network** accurately calculated and interpreted the baseline results for the study indicator. **Detroit Wayne Integrated Health Network** progressed to completing a causal/barrier analysis using quality improvement tools and implementing interventions that have the potential to impact outcomes.

Strengths, Weaknesses, and Overall Conclusions

Detroit Wayne Integrated Health Network demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Detroit Wayne Integrated Health Network** received a total compliance score of 79 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Detroit Wayne Integrated Health Network** scored 90 percent or above in the QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care standards, indicating strong performance in these areas; however, it did not perform as well in the Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Credentialing, and Confidentiality of Health Information standards, as demonstrated by moderate to low performance scores (75 percent, 75 percent, 67 percent, 81 percent, 56 percent, 50 percent, respectively), reflecting that additional focus is needed in these areas.

While one of the two reportable performance measure rates was above the MDHHS-established MPS, indicating strength in that area, **Detroit Wayne Integrated Health Network**'s rate for indicator *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children fell below its corresponding MPS, indicating an opportunity to improve that measure rate. Additionally, **Detroit Wayne Integrated Health Network** received an audit designation of *Not Reported* for indicators *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*; *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*; *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*; *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*; and *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge* because the rates were determined to be materially biased, indicating that **Detroit Wayne Integrated Health Network** did not calculate the performance indicators in compliance with MDHHS Codebook specifications.

Detroit Wayne Integrated Health Network's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-48—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The QAPIP Plan and Structure standard achieved full compliance, indicating the PIHP maintained a comprehensive quality program. • Strength: The PIHP designed a scientifically sound project related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 75 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 75 percent, indicating the PIHP had not implemented processes for reviewing and updating CPGs periodically. • Weakness: The Staff Qualifications and Training standard received a compliance score of 75 percent, suggesting the PIHP did not hire staff members who possessed the minimum qualifications required by the job descriptions. • Weakness: The Credentialing standard received a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network. • Weakness: The PIHP received *NR* audit designations for 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults. • Weakness: The MPS related to timely preadmissions screenings for psychiatric inpatient care for children was not met. • Weakness: The PIHP received *NR* audit designations for timely face-to-face assessments with a professional; receiving timely needed, ongoing services; timely follow-up care following discharges from an inpatient psychiatric unit; and timely follow-up care following discharge from a substance abuse detox unit.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Weakness: The Confidentiality of Health Information standard received a compliance score of 50 percent, indicating that the PIHP did not maintain adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Detroit Wayne Integrated Health Network**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Detroit Wayne Integrated Health Network**. The recommendations provided to **Detroit Wayne Integrated Health Network** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-49 in addition to **Detroit Wayne Integrated Health Network**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-49—Recommendations and Detroit Wayne Integrated Health Network's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Detroit Wayne Integrated Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard IX—Subcontracts and Delegation • Standard XII—Access and Availability • Standard XIV—Appeals • Standard XVII—Management Information Systems **Detroit Wayne Integrated Health Network** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Detroit Wayne Integrated Health Network's Response
Standard VI—Customer Service: Detroit Wayne Integrated Health Network revised and updated the grievance and appeals information to reflect all required language regarding payment for services and the reporting of fraud, waste and abuse. **Detroit Wayne Integrated Health Network**'s provider directory was also revised to include requirements specified in contract and federal regulations. **Standard IX—Subcontracts and Delegation: Detroit Wayne Integrated Health Network** dissolved all of the CMHSP contracts effective July 1, 2019. Currently, **Detroit Wayne Integrated Health Network** contracts

Compliance Monitoring Review
directly with the clinically responsible service providers, specialty providers, credentialing verification organization, and crisis vendors. **Standard XII—Access and Availability: Detroit Wayne Integrated Health Network**'s QI unit directly monitors providers no less than quarterly. Currently, **Detroit Wayne Integrated Health Network** is in full compliance with indicators *#1* and *#2*. Plan of corrections and/or root cause analyses are requested from the crisis vendors and service providers when applicable. **Standard XIV—Appeals: Detroit Wayne Integrated Health Network** revised the Customer Service Enrollee/Member Appeals policy to reflect the following: • Continuation of services within 10 calendar days and the reinstatement of services if approved within 72 hours. • Reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing and inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. • A process for denial of an expedited appeal. The Local Appeal Procedures for Members with Medicaid document has been updated to reflect both the resolution and the date of resolution. **Standard XVII—Management Information Systems: Detroit Wayne Integrated Health Network** is currently in full compliance with the annual financial audit and compliance exam. Additionally, **Detroit Wayne Integrated Health Network** implemented a new system that includes additional reporting on HEDIS and risk standards that allows providers to compare their scores against State and national reports.
HSAG's Assessment of the Degree to Which Detroit Wayne Integrated Health Network Effectively Addressed the Recommendation
Based on **Detroit Wayne Integrated Health Network**'s response, HSAG has determined that **Detroit Wayne Integrated Health Network** addressed the prior year's recommendations. A comprehensive review of **Detroit Wayne Integrated Health Network**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Integrated Health Network** to members, HSAG recommended that **Detroit Wayne Integrated Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: ***Not Reported* Performance Measure Rates** • *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults

Performance Measures
• *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children, MI Adults, IDD Children, IDD Adults, Medicaid SUD, and Total • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Children, IDD Adults, Medicaid SUD, and Total • *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children and MI and IDD Adults • *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children and MI and IDD Adults **Detroit Wayne Integrated Health Network** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Detroit Wayne Integrated Health Network** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Detroit Wayne Integrated Health Network** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Detroit Wayne Integrated Health Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Detroit Wayne Integrated Health Network's Response
To improve the indicator rates, **Detroit Wayne Integrated Health Network** implemented several QI processes. • Developed a Performance Indicator Provider Workgroup: The workgroup consists of **Detroit Wayne Integrated Health Network** quality staff and quality staff from the service providers. The purpose of the

Performance Measures
workgroup is to assess trending patterns, identify areas of deviation from the specifications, and ensure that the service provider system understands the processing steps related to data integration and performance measure reporting. • Data validation prior to submission: Data validation includes a review of the MMBPIS provider data submitted via the "MH_WIN" reporting module. A detailed report is generated in Excel which lists all members, compliance scores and responsible providers. The detailed report is then sorted by the service provider and submitted to the responsible service provider via secure email for review. This process will ensure that only accurate and valid data are used for rate calculation.
HSAG's Assessment of the Degree to Which Detroit Wayne Integrated Health Network Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Detroit Wayne Integrated Health Network** met the MPS for indicator *#1* (Children); however, it did not meet the MPS for indicator *#1* (Adults), and continued to receive an *NR* audit designation for indicators *#2*, *#3*, *#4a*, *#4b*, and *#10*, indicating that **Detroit Wayne Integrated Health Network** partially addressed the prior recommendations.
Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Detroit Wayne Integrated Health Network** take proactive steps to ensure a successful PIP. As the PIP progressed, **Detroit Wayne Integrated Health Network** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Detroit Wayne Integrated Health Network's Response
Detroit Wayne Integrated Health Network has implemented proactive steps to ensure a successful PIP. As a result of Year 2 of the PIP validation, **Detroit Wayne Integrated Health Network** received a score of 100 percent compliance.
HSAG's Assessment of the Degree to Which Detroit Wayne Integrated Health Network Effectively Addressed the Recommendation
In the 2018–2019 validation, **Detroit Wayne Integrated Health Network** addressed the recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Integrated Health Network** to members, HSAG recommends that **Detroit Wayne Integrated Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*
- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*
- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*

Ratings Below the MPS

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children

HSAG also recommends that **Detroit Wayne Integrated Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard IV—Staff Qualifications and Training
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Detroit Wayne Integrated Health Network was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Detroit Wayne Integrated Health Network** implement processes to periodically review the status of each plan of

action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Detroit Wayne Integrated Health Network** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Detroit Wayne Integrated Health Network** should take proactive steps to ensure a successful PIP. **Detroit Wayne Integrated Health Network** should address all *General Comments* in the *2018–2019 PIP Validation Report Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Who Are Using Antipsychotic Medications for Region 7—Detroit Wayne Mental Health Authority* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Detroit Wayne Integrated Health Network** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the study indicator rate.
- **Detroit Wayne Integrated Health Network** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Detroit Wayne Integrated Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Detroit Wayne Integrated Health Network** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 8—Oakland Community Health Network

To conduct the 2018–2019 EQR, HSAG reviewed **Oakland Community Health Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Oakland Community Health Network**.

EQR Activity Results

Compliance Monitoring

Oakland Community Health Network was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-50 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-50 also presents **Oakland Community Health Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-50—Summary of 2018–2019 Compliance Monitoring Review Results for Oakland Community Health Network

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	5	3	0	63%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	11	5	0	69%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	9	1	0	90%
Total	82	67	15	0	82%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Oakland Community Health Network demonstrated compliance for 67 of 82 elements, with an overall compliance score of 82 percent. **Oakland Community Health Network** demonstrated strong performance, scoring 90 percent or above in five standards, with four of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information.

Opportunities for improvement were identified in five of the nine standards, including deficiencies related to the following requirements:

- Time frames for determining if a critical incident is a sentinel event and initiating an RCA
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Content of the notices of ABD
- Providing notices of ABD for the denial of payment at the time of an action affecting a claim
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Exceptions to providing advance notices of ABD
- Providing members with written notice of a significant change at least 30 days before the intended effective date of the change
- Prohibit conditioning the provision of care based on whether or not a member has executed an advance directive
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Content of breach notification letters

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Oakland Community Health Network** and to determine the extent to which performance indicators reported by **Oakland Community Health Network** followed State specifications and reporting requirements. HSAG evaluated **Oakland Community Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 8—Oakland Community Health Network* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Oakland Community Health Network**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Oakland Community Health Network** received and processed claims and encounter data for submission to MDHHS.

- BH-TEDS Data Production—Based on demonstrations of **Oakland Community Health Network**'s BH-TEDS data entry and submission processes, no concerns were identified with the PIHP's adherence to the State-specified submission requirements. HSAG recommends that **Oakland Community Health Network** perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—**Oakland Community Health Network** is a stand-alone PIHP; therefore, this section is not applicable.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Oakland Community Health Network** received an indicator designation of *Report* for all indicators, signifying that **Oakland Community Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

However, **Oakland Community Health Network** reported less than the 95 percent standard for Children for performance indicator *#1* and SED Children for performance indicator *#2*. HSAG recommends that **Oakland Community Health Network** continue to work with related provider networks to improve reporting of the performance indicators, specifically training on completing clear documentation.

Table 5-51 presents **Oakland Community Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-51—Performance Measure Results for Oakland Community Health Network

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	94.06%	95.00%
Adults	96.34%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	93.37%	95.00%
MI Adults	97.80%	95.00%
IDD Children	100.00%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.81%	95.00%
Total	97.75%	95.00%

Performance Indicator	Rate	MPS
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	99.62%	95.00%
MI Adults	100.00%	95.00%
IDD Children	100.00%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	95.88%	95.00%
Total	98.26%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	100.00%	95.00%
MI and IDD Adults	95.34%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	98.56%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.98%	—
#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.		
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.	98.24%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	18.22%	—
IDD Adults	13.48%	—
MI/IDD Adults	8.19%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	92.23%	—
IDD Adults	52.82%	—
MI/IDD Adults	32.01%	—

Performance Indicator	Rate	MPS
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	6.06%	15.00%
MI and IDD Adults	16.09%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	19.35%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.96%	—

Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

Oakland Community Health Network's performance exceeded the corresponding MPS for 16 of 19 measure indicators (84.2 percent), suggesting strength in these areas.

Although most of **Oakland Community Health Network**'s rates were above the MPS, the rates for at least one population under indicators *#1*, *#2*, and *#10* fell below their corresponding MPS, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Oakland Community Health Network** provided baseline data for the PIP topic: *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*. The goal of this PIP is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications.

Table 5-52 outlines the study indicator for the PIP.

Table 5-52—Study Indicator

PIP Topic	Study Indicator
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.

Table 5-53 and Table 5-54 show **Oakland Community Health Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Oakland Community Health Network**.

Table 5-53—PIP Validation Results for Oakland Community Health Network

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Table 5-54—2018–2019 PIP Validation Scores for Oakland Community Health Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Submission	82%	67%	***Partially Met***
	Resubmission	100%	100%	***Met***

Oakland Community Health Network submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 100 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Oakland Community Health Network designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Oakland Community Health Network** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Oakland Community Health Network** accurately calculated and interpreted the baseline results for the study indicator. The PIHP has not progressed to conducting a causal/barrier analysis and implementing interventions that have the potential to have a positive impact on the study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Oakland Community Health Network demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Oakland Community Health Network** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Oakland Community Health Network** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the Quality Measurement and Improvement, Utilization Management, Members' Rights and Protections, and Credentialing standards, as demonstrated by moderate to low performance scores (63 percent, 69 percent, 85 percent, and 56 percent, respectively), reflecting that additional focus is needed in these areas.

While 16 of the 19 performance measure rates were above the MDHHS-established MPS, indicating strength in these areas, **Oakland Community Health Network**'s rates for indicators *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children; *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children; and *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of*

discharge—MI and IDD Adults fell below the established MPS, indicating opportunities to improve these measure rates.

Oakland Community Health Network's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-55—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The QAPIP Plan and Structure standard achieved full compliance, indicating the PIHP maintained a comprehensive quality program. • Strength: The Practice Guidelines standard achieved full compliance, indicating the PIHP implemented processes for the adoption, development, implementation, monitoring, and evaluation of CPGs. • Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The MPS was met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children. • Strength: The PIHP designed a scientifically sound project related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, supported by the use of key research principles, meeting all requirements in the Design stage. The PIHP accurately calculated and interpreted the baseline results for each study indicator. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 63 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Credentialing standard received a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network. • Weakness: The MPS related to 30-day readmissions after discharge from an inpatient psychiatric unit for MI and IDD Adults was not met.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; receiving timely needed, ongoing services for SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; timely follow-up care following discharges from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults; and timely follow-up care following discharge from a substance abuse detox unit.

Performance Area*	Overall Performance Impact
	• Weakness: The Utilization Management standard received a compliance score of 69 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The MPS related to timely preadmissions screenings for psychiatric inpatient care for children and timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children population were not met.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard received a compliance score of 90 percent, indicating that the PIHP had adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Oakland Community Health Network**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Oakland Community Health Network**. The recommendations provided to **Oakland Community Health Network** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plan*s are summarized in Table 5-56 in addition to **Oakland Community Health Network**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-56—Recommendations and Oakland Community Health Network's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Oakland Community Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard X—Provider Network • Standard XII—Access and Availability • Standard XIV—Appeals • Standard XVII—Management Information Systems

Compliance Monitoring Review
Oakland Community Health Network should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Oakland Community Health Network's Response
Standard VI—Customer Service • **Customer Handbook:** Each element identified during the HSAG review which required an update, revision, expansion, etc. to meet requirements has been incorporated into an updated version of the member handbook which was effective in March 2019. • **Provider Directory:** – Cultural and linguistic capabilities: The searchable **Oakland Community Health Network** provider directory includes languages spoken by providers. The provider directory also displays if providers were trained in cultural competency. Implementation date was prior to December 1, 2018. – Accepting new patients and Americans with Disabilities Act (ADA) accessibility: This information is included in the provider directory. Implementation date was prior to December 1, 2018. – Independent person-centered planning (PCP) facilitation: **Oakland Community Health Network** now directly contracts with staff to provide independent facilitation. This information is displayed in the provider directory. Implementation date was quarter three (Q3) SFY 2019. – Provider directory is inclusive of all contracted providers: **Oakland Community Health Network** has an electronic directory that is inclusive of all contracted providers. Implementation date was prior to December 1, 2018. – Provided annually to members: The member handbook is issued by hand initially upon service entry and offered annually via face-to-face contact with members. The member handbook includes information on the availability of the provider directory. Through this process, members are made aware of the opportunity to access the directory annually. Additionally, upon service entry, members are mailed a flyer that lists the availability of **Oakland Community Health Network** informational documents which includes the provider directory. This update was completed prior to December 1, 2018. – Available on website in a machine-readable format: The **Oakland Community Health Network** provider directory was enhanced to provide this feature effective April 2019. A "widget" appears in the upper left corner on **Oakland Community Health Network**'s website. Clicking on the "widget" activates the "reading tool" for all content on the webpage. – Standardized process for updates: **Oakland Community Health Network** has a documented process titled "Provider and Practitioner Directories" that outlines requirements for monthly updates and

Compliance Monitoring Review

updates within 30 days of any changes. This documented process was adopted May 2018. The most recent revision was October 2019.

- Providing paper copy to members within five days of request: **Oakland Community Health Network** internal procedure referenced above, "Provider and Practitioner Directories" addresses this requirement. This documented process was adopted May 2018. The most recent revision was October 2019.

Standard VII—Grievance Process

- **General:** The due process policy was updated to address all items noted in the CAP. The initial update was completed on July 30, 2018. Additional updates were made on October 30, 2019 and is reflective of all requirements.

Standard IX—Subcontracts and Delegation

- **Written Contract: Oakland Community Health Network**'s provider contracts have been rewritten and the approval process around the documents has been changed. The delegated functions are still an attachment but are now thoroughly vetted by our service network team who are managing the provider contract and network; and are reviewed, edited and approved through our purchase requisition process for each contract.
- **Right to Audit: Oakland Community Health Network** revised all boilerplate direct service contracts that includes the right to audit through 10 years and **Oakland Community Health Network** in the process of amending all agreements to include the language from the "final date of completion of any audit, whichever is later".

Standard X—Provider Network

- **Reason for Decision to Decline: Oakland Community Health Network** has formalized its practice of providing written notice of a decision of acceptance or rejection of providers bidding or applying for inclusion in the network by editing the procurement policy to include this practice. For organizational credentialing, this occurs via completion of the provider application. If a provider is not successful in meeting all requirements of the provider application, participation in the network is not granted. The provider is notified in writing of this decision. This process will be documented in **Oakland Community Health Network**'s internal procedure which is to be approved by January 31, 2020.
- **Network Changes: Oakland Community Health Network** has formalized the provider contract termination process via the promulgation of internal procedure title titled "Provider Contract Termination Procedure". This procedure has been reviewed and approved by **Oakland Community Health Network** executive leadership.

Standard XII—Access and Availability

- **Follow-up Care After Discharge/Inpatient (Adults):** As noted in **Oakland Community Health Network**'s CAP response, **Oakland Community Health Network** requires corrective action when performance falls below standards.
  - For three quarters in FY 2019, performance fell below the 95 percent compliance standard due to:
    - Alignment and transfer issues post discharge: members being aligned with one provider and requesting another. In these cases, the assigned provider met with the person within the seven-day

Compliance Monitoring Review

requirement; however, the transfer process to the new provider and appointment scheduling exceeded the seven-day standard. Per MDHHS' current standards, these situations are considered exceptions. However, for purposes of reporting **Oakland Community Health Network** did not consider these as exceptions for this indicator. This is in alignment with MDHHS' position to not allow any exceptions for rates.

- Office closed due to inclement weather causing scheduled appointments to be rescheduled.
- Providers lacking appointment documentation in EHR to prove appointment occurred.
- First post-hospital discharge appointment availability was greater than seven days.

– A total of four PIPs were issued to providers over the first three quarters of FY 2019. These PIPs focused on correcting alignment issues, scheduling delays, and certain providers lacking overall appointment documentation in their respective EHRs. These PIPs were issued any time a provider fell below the 95 percent compliance standard. Q4 FY 2019 was the first quarter in FY 2019 that the network reached the overall compliance standard, with only one provider receiving a PIP for falling below 95 percent.

- **Providers Required to Meet Access Standards:** As noted in **Oakland Community Health Network**'s CAP response, **Oakland Community Health Network** has developed a process for tracking performance following submission of CAPs. Implementation of this tool was in place at the start of FY 2019. This tool has been useful in tracking effectiveness of CAP implementation.

Standard XIV—Appeals

- **Medicaid Services Continuation or Reinstatement:** The due process policy has been updated to reflect all requirements. The policy was initially updated July 30, 2018 to reflect requirements. The most recent policy update was October 31, 2019. The policy addresses Medicaid services continuation or reinstatement requirements. The ABD notice has been submitted to an EMR vendor and is in the process of being updated as of December 16, 2019. The boilerplate language of the ABD notice also contains Medicaid services continuation or reinstatement requirements. The member handbook was also updated February 2019 to include these requirements. The grievance and appeal rights brochure was revised February 2019 and it includes information on the circumstances in which services can be continued and situations in which members may be required to pay back of the cost of those service. All these actions, with the exception of the ABD notice, have been completed and implemented.
- **Expedited Appeal Resolution:** The member handbook updated in February 2019 reflects this standard. The updated due process policy updated on October 31, 2019 also reflects this standard. The ABD notice has been submitted to an EMR vendor and is in the process of being updated as of December 16, 2019. The boilerplate language of the ABD notice also contains this requirement. All these actions, with the exception of the ABD notice, have been completed and implemented.
- **Extension of Timeframes:** The member handbook updated in February 2019 includes this standard. The due process local appeal 14-day extension letter was also updated on March 19, 2019 to reflect this standard. The ABD notice has been submitted to an EMR vendor and is in the process of being updated as of December 16, 2019. The boilerplate language of the ABD notice also contains this requirement. All these actions, with the exception of the ABD notice, have been completed and implemented.
- **Appeal Resolution Notice Format:** The due process policy updated October 31, 2019 includes this standard. The due process local appeal expedited letter has also been updated in May 2019 to reflect this standard. The corrective actions for these standards have been completed and implemented.

Compliance Monitoring Review
Standard XVII—Management Information Systems • **Uniform Data and Information:** Certification of Data Submitted: OCHN has amended the current certification document used for year-end financial reporting to include all data points within section 7.7.71 of the MDHHS contract. The document will then be reviewed and signed off by the CFO. OCHN also has an internal calendar that alerts required staff of reporting due dates. This certification will be completed for SFY 2019 submission.
HSAG's Assessment of the Degree to Which Oakland Community Health Network Effectively Addressed the Recommendation
Based on **Oakland Community Health Network**'s response, HSAG has determined that **Oakland Community Health Network** has addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Oakland Community Health Network**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.

Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Oakland Community Health Network** to members, HSAG recommended that **Oakland Community Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Ratings Below the MPS** • *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults **Performance Declined >2 Percent From Previous Year** • *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Children **Increase in Readmissions >5 Percent From Previous Year** • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children **Oakland Community Health Network** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses?

Performance Measures
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Oakland Community Health Network** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Oakland Community Health Network** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Oakland Community Health Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Oakland Community Health Network's Response
Oakland Community Health Network will address items "1-5" in the performance measures section of its QAPIP and will address on a quarterly basis. This practice is already in process. However, the specific items "1-5" were not listed specifically as action items in the QAPIP. This will be included in the FY 2020 QAPIP.
HSAG's Assessment of the Degree to Which Oakland Community Health Network Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Oakland Community Health Network** improved upon its rates for indicators *#1* (Children and Adults) and *#2* (IDD Children); however, it did not meet the MPS for indicator *#1* (Children) and performance declined for indicator *#10* (SED and IDD Children), indicating that **Oakland Community Health Network** partially addressed the prior recommendations.
Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Oakland Community Health Network** take proactive steps to ensure a successful PIP. As the PIP progressed, **Oakland Community Health Network** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.

Performance Improvement Project
• Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Oakland Community Health Network's Response
Oakland Community Health Network will ensure that the above action steps are incorporated into future **Oakland Community Health Network** submissions. Of note, **Oakland Community Health Network**'s most recent PIP submission was assessed at "met".
HSAG's Assessment of the Degree to Which Oakland Community Health Network Effectively Addressed the Recommendation
In the 2018–2019 validation, **Oakland Community Health Network** addressed the recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Oakland Community Health Network** to members, HSAG recommends that **Oakland Community Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-5]

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children
- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children
- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—MI and IDD Adults

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—Medicaid SUD

[5-5] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

HSAG also recommends that **Oakland Community Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard II—Quality Measurement and Improvement
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Oakland Community Health Network was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Oakland Community Health Network** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Oakland Community Health Network** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Oakland Community Health Network** should take proactive steps to ensure a successful PIP. **Oakland Community Health Network** should address all *General Comments* in the *2018–2019 PIP Validation Report Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications for Region 8—Oakland County CMH Authority* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Oakland Community Health Network** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the study indicator outcomes.
- **Oakland Community Health Network** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Oakland Community Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Oakland Community Health Network** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 9—Macomb County Community Mental Health

To conduct the 2018–2019 EQR, HSAG reviewed **Macomb County Community Mental Health**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Macomb County Community Mental Health**.

EQR Activity Results

Compliance Monitoring

Macomb County Community Mental Health was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-57 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-57 also presents **Macomb County Community Mental Health**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-57—Summary of 2018–2019 Compliance Monitoring Review Results for Macomb County Community Mental Health

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	6	2	0	75%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	2	2	0	50%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	10	6	0	63%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	8	4	4	1	50%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	81	63	18	1	78%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Macomb County Community Mental Health demonstrated compliance for 63 of 81 elements, with an overall compliance score of 78 percent. **Macomb County Community Mental Health** demonstrated strong performance, scoring 90 percent or above in four standards, with all four of those standards achieving full compliance. These areas of strength include Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information.

Opportunities for improvement were identified in five of the nine standards, including deficiencies related to the following requirements:

- The Governing Body's responsibility to monitor and evaluate the QAPIP
- Annual effectiveness review of the QAPIP
- Engaging in two PIPs
- Credentials of individuals reviewing sentinel events
- Quarterly analyses of critical incidents, sentinel events, and risk events
- Quantitative and qualitative assessment of member experience with services
- Periodic review of CPGs
- Dissemination of CPGs to all affected providers
- Content of the notices of ABD
- Notices of ABD time frame standards
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Advance notices of ABD
- Provisions prohibiting incentives for individuals to deny, limit, or discontinue medically necessary services
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Macomb County Community Mental Health** and to determine the extent to which performance indicators reported by **Macomb County Community Mental Health** followed State specifications and reporting requirements. HSAG evaluated **Macomb County Community Mental Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 9—Macomb County Community Mental Health* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Macomb County Community Mental Health**'s receipt and processing of eligibility data.

- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Macomb County Community Mental Health** received and processed claims and encounter data for submission to MDHHS. During the PSV, HSAG identified that **Macomb County Community Mental Health** submitted incorrect rates for performance indicator *#1*, resulting in a dramatically lower number from prior year data. Additionally, HSAG identified cases that were reported by **Macomb County Community Mental Health** as exclusions for performance indicator *#2* that did not meet the exclusion criteria. Therefore, the rates for performance indicators *#1* and *#2* were deemed *Not Reportable.* Based on these findings, HSAG recommends that the PIHP incorporate more stringent checks to compare its data year over year and ensure that exception criteria are followed.
- BH-TEDS Data Production—Based on demonstrations of **Macomb County Community Mental Health**'s BH-TEDS data entry and submission processes, no concerns were identified with the PIHPs' adherence to the State-specified submission requirements. HSAG recommends **Macomb County Community Mental Health** continue to focus on increasing the completeness and accuracy of the BH-TEDS data before entering them into FOCUS, the PIHP's electronic medical record (EMR) system, for MDHHS. HSAG recommends that **Macomb County Community Mental Health** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—**Macomb County Community Mental Health** is a stand-alone PIHP; therefore, this section is not applicable.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Macomb County Community Mental Health** received an indicator designation of *Report* for 10 performance indicators, signifying that **Macomb County Community Mental Health** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported. However, **Macomb County Community Mental Health** received an indicator designation of *Not Reported* for the remaining two indicators, indicating that **Macomb County Community Mental Health** did not calculate these indicators in compliance with MDHHS Codebook specifications. HSAG identified issues in **Macomb County Community Mental Health**'s process for validating the performance indicator data, which included issues regarding time parameters required by the specifications for the performance indicator. Therefore, these reported rates were considered materially biased. Table 5-58 presents **Macomb County Community Mental Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-58—Performance Measure Results for Macomb County Community Mental Health

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	*NR*	95.00%
Adults	*NR*	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	*NR*	95.00%
MI Adults	*NR*	95.00%
IDD Children	*NR*	95.00%
IDD Adults	*NR*	95.00%
Medicaid SUD	*NR*	95.00%
Total	*NR*	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	87.39%	95.00%
MI Adults	93.08%	95.00%
IDD Children	90.48%	95.00%
IDD Adults	88.57%	95.00%
Medicaid SUD	100.00%	95.00%
Total	96.65%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	100.00%	95.00%
MI and IDD Adults	86.96%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	99.43%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	5.64%	—

Performance Indicator	Rate	MPS
#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.		
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.	97.38%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	17.03%	—
IDD Adults	6.00%	—
MI/IDD Adults	6.36%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	94.26%	—
IDD Adults	32.28%	—
MI/IDD Adults	42.42%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	9.71%	15.00%
MI and IDD Adults	13.80%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	14.75%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	42.82%	—

Indicates that the reported rate was better than the MPS.

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

NR (*Not Reported*) indicates that the rate was determined "materially biased." Rates designated NR are not displayed because the PIHP's performance cannot be evaluated based on biased rates.

* A lower rate indicates better performance.

Macomb County Community Mental Health's performance exceeded the corresponding MPS for six of 11 reportable measure indicators (54.5 percent), suggesting strength in these areas.

Although most of **Macomb County Community Mental Health**'s reportable rates were above the MPS, the rates for at least one population under indicators *#3* and *#4a* fell below their corresponding MPS, indicating opportunities for improvement. Additionally, **Macomb County Community Mental Health**'s rates were deemed *Not Reported* for eight of 19 measure indicators (42.1 percent) with an MPS.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Macomb County Community Mental Health** provided baseline data on the PIP topic: *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness*. The goal of this PIP is to decrease members recidivating within 30 days post discharge to acute inpatient behavioral health services.

Table 5-59 outlines the study indicator for the PIP.

Table 5-59—Study Indicator

PIP Topic	Study Indicator
Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness	30-day Hospital Readmission

Table 5-60 and Table 5-61 show **Macomb County Community Mental Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Macomb County Community Mental Health**.

Table 5-60—PIP Validation Results for Macomb County Community Mental Health

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage		Step	Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	67%% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**86% (6/7)**	**14% (1/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**93% (14/15)**		

Table 5-61—2018–2019 PIP Validation Scores for Macomb County Community Mental Health

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness	Submission	60%	75%	***Partially Met***
	Resubmission	93%	100%	***Met***

Macomb County Community Mental Health submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 93 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Macomb County Community Mental Health designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Macomb County Community Mental Health** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Macomb County Community Mental Health** accurately calculated the baseline rate; however, the baseline rate and how the rate was calculated were not included in the narrative interpretation of findings. **Macomb County Community Mental Health** progressed to completing a causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes.

Strengths, Weaknesses, and Overall Conclusions

Macomb County Community Mental Health demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Macomb County Community Mental Health** received a total compliance score of 78 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Macomb County Community Mental Health** scored 90 percent or above in the Staff Qualifications and Training, Member's Rights and Protections, Coordination of Care, and Confidentiality of Health Information standards, indicating strong performance in these areas; however, it did not perform as well in the QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, and Credentialing standards, as demonstrated by moderate to low performance scores (75 percent, 50 percent, 50 percent, 63 percent, and 50 percent, respectively), reflecting that additional focus is needed in these areas.

While six of the 11 reportable performance measure rates were above the MDHHS-established MPS, indicating strengths in these areas, **Macomb County Community Mental Health**'s rates for indicator *#3*: *The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Children, and IDD Adults; and *#4a*: *The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults fell below their corresponding MPS, indicating opportunities to improve these measure rates. Additionally, **Macomb County Community Mental Health** received an audit designation of *Not Reported* for indicators *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*, and *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service* because the rates were determined to be materially biased, indicating that **Macomb County Community Mental Health** did not calculate the performance indicators in compliance with MDHHS Codebook specifications.

Macomb County Community Mental Health's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-62—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The Members' Rights and Protections standard achieved full compliance, suggesting the PIHP guaranteed, observed, and protected members' rights. • Strength: The MPS were met related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children and MI and IDD Adults, as demonstrated by performance of indicator *#10*.

Performance Area*	Overall Performance Impact
	• Strength: The PIHP designed a scientifically sound project related to *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness*, supported by the use of key research principles, meeting all requirements in the Design stage. • Weakness: The QAPIP Plan and Structure standard received a compliance score of 75 percent, indicating the PIHP did not maintain a comprehensive quality program. • Weakness: The Quality Measurement and Improvement standard received a compliance score of 50 percent, indicating that the PIHP lacked comprehensive processes to analyze and subsequently remediate trends and patterns pertaining to critical incidents and sentinel events, and areas of member dissatisfaction. • Weakness: The Practice Guidelines standard received a compliance score of 50 percent, indicating the PIHP did not implement comprehensive processes for the adoption, development, implementation, monitoring, and evaluation of CPGs. • Weakness: The Credentialing standard received a compliance score of 50 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network. • Weakness: The PIHP did not provide a complete narrative interpretation to include the baseline rate or a description of how the baseline rate for the PIP was calculated.
Timeliness	• Strength: The MPS were met related to receiving timely needed, ongoing services for the Medicaid SUD population; timely follow-up care following discharges from an inpatient psychiatric unit for SED and IDD Children; and timely follow-up care following discharge from a substance abuse detox unit. • Weakness: The Utilization Management standard received a compliance score of 63 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The MPS were not met related to receiving timely needed, ongoing services for the SED Children, MI Adults, IDD Children, and IDD Adults populations; and timely follow-up care following discharges from an inpatient psychiatric unit for MI and IDD Adults. • Weakness: The PIHP received *NR* audit designations related to timely preadmissions screenings for psychiatric inpatient care and timely face-to-face assessments with a professional for new Medicaid beneficiaries.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Strength: The Confidentiality of Health Information standard achieved full compliance, indicating that the PIHP had adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Macomb County Community Mental Health**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Macomb County Community Mental Health**. The recommendations provided to **Macomb County Community Mental Health** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 5-63 in addition to **Macomb County Community Mental Health**'s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-63—Recommendations and Macomb County Community Mental Health's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Macomb County Community Mental Health** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard IX—Subcontracts and Delegation • Standard XII—Access and Availability • Standard XIV—Appeals **Macomb County Community Mental Health** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Macomb County Community Mental Health's Response
Standard VI—Customer Service: Prior to the audit in July 2018, the member handbook was revised and included all required elements. The revised version is available in a printed version and on the website. The vendor list (provider directory) process is being followed; all changes are submitted to the Information Systems Division by the 29th of each month. The new list is modified by our Information System Division and changes are uploaded by the 1st of each month. The vendor list is a Word document and is machine readable. This was completed in December 2019.

Compliance Monitoring Review
Standard IX—Subcontracts and Delegation: Technical audits were completed over the summer of 2019 by Network Operations. Hospital audits were completed in January 2019 and August 2019 and will repeat in January 2020. Group Home audits began in September 2019 and are ongoing. Applied Behavioral Analysis (ABA) audits were completed in February 2019 and will repeat in February 2020. Clinical, technical, and credentialing training will begin in April and run through June 2020. The FY 2019 contract was updated which include all elements as required by 42 CFR §430.230(c). **Standard XII—Access and Availability:** Once a month, **Macomb County Community Mental Health** examines the monitor through the provider capacity workgroup as well as the utilization management committee. Indicator *#10* is monitored by our access department. If an appointment is not available, a supervisor is notified, and the provider is contacted. **Standard XIV—Appeals**: The appeals module has been in place since November 2018. Effective January 2019 it started to be utilized. Additionally, steps were taken to remove the legalistic language from the letters. Now, members receive the State-required notice of denial and appeal templates, which contain the State-approved language.
HSAG's Assessment of the Degree to Which Macomb County Community Mental Health Effectively Addressed the Recommendation
Based on **Macomb County Community Mental Health**'s response, HSAG has determined that **Macomb County Community Mental Health** has addressed the prior year's recommendations and continues to implement its plans of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Macomb County Community Mental Health**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Macomb County Community Mental Health** to members, HSAG recommended that **Macomb County Community Mental Health** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Ratings Below the MPS** • *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children, IDD Children, and IDD Adults • *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children • *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children and MI and IDD Adults • *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—MI and IDD Adults **Macomb County Community Mental Health** should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

Performance Measures
1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Macomb County Community Mental Health** considering or has already implemented to improve rates and performance for each identified indicator? Based on the information presented above, **Macomb County Community Mental Health** should have included the following within its quality improvement plan: • Measurable goals and benchmarks for each indicator • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Macomb County Community Mental Health** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Macomb County Community Mental Health's Response
Macomb County Community Mental Health incorporated the PCE performance module. There is also ongoing network training on performance indicator documentation in the EMR that is provided at our quality provider meetings. Additionally, **Macomb County Community Mental Health** completed its annual QAPIP, which included the analysis of the performance indicators. Lastly, **Macomb County Community Mental Health** is working on providing individual performance indicators reports with their own data to providers.
HSAG's Assessment of the Degree to Which Macomb County Community Mental Health Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Macomb County Community Mental Health** improved upon its rates for indicators *#4a* (Children) and *#10* (Adults); however, it did not meet the MPS for indicator *#3* (IDD Children) or *#4a* (Adults), and also received a *Not Reported* audit designation for indicator *#2*, indicating that **Macomb County Community Mental Health** partially addressed the prior recommendations.

Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Macomb County Community Mental Health** take proactive steps to ensure a successful PIP. As the PIP progressed, **Macomb County Community Mental Health** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Macomb County Community Mental Health's Response
Macomb County Community Mental Health requested HSAG consultation on the first year PIP submission. Validation was obtained. The committee meets to discuss ongoing implementation of interventions.
HSAG's Assessment of the Degree to Which Macomb County Community Mental Health Effectively Addressed the Recommendation
In the 2018–2019 validation, **Macomb County Community Mental Health** addressed the recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Macomb County Community Mental Health** to members, HSAG recommends that **Macomb County Community Mental Health** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*
- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*

Ratings Below the MPS[5-6]

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Children, and IDD Adults
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—Total

HSAG also recommends that **Macomb County Community Mental Health** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard V—Utilization Management
- Standard XI—Credentialing

Macomb County Community Mental Health was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Macomb County Community Mental Health** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Macomb County Community Mental Health** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Macomb County Community Mental Health** should take proactive steps to ensure a successful PIP. **Macomb County Community Mental Health** should address all *General Comments* in the *2018–2019 PIP Validation Report Reducing Acute Inpatient Recidivism for Adults with Serious*

[5-6] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

Mental Illness (SMI) for Region 9—Macomb County Community Mental Health and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Macomb County Community Mental Health** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have enough time to impact the study indicator outcomes.
- **Macomb County Community Mental Health** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Macomb County Community Mental Health** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Macomb County Community Mental Health** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

Region 10 PIHP

To conduct the 2018–2019 EQR, HSAG reviewed **Region 10 PIHP**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP**.

EQR Activity Results

Compliance Monitoring

Region 10 PIHP was evaluated in nine Medicaid managed care program areas referred to as "standards." Table 5-64 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 5-64 also presents **Region 10 PIHP**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

Table 5-64—Summary of 2018–2019 Compliance Monitoring Review Results for Region 10 PIHP

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	7	1	0	88%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	12	4	0	75%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	4	6	0	40%
Total	82	67	15	0	82%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Region 10 PIHP demonstrated compliance for 67 of 82 elements, with an overall compliance score of 82 percent. **Region 10 PIHP** demonstrated strong performance, scoring 90 percent or above in five standards, with all five of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, and Coordination of Care.

Opportunities for improvement were identified in four of the nine standards, including deficiencies related to the following requirements:

- Quantitative and qualitative assessment of member experience with services
- Content of the notices of ABD
- Notices of ABD time frame standards
- Providing notices of ABD for service authorizations not reached within applicable time frame standards
- Extension of service authorization time frames and notice provisions
- Oversight of delegated credentialing functions
- Initial credentialing, recredentialing, and organizational credentialing provisions
- Processes to notify members, or next of kin, of a breach of PHI
- Time frame requirements for sending notice of a breach of PHI
- Mailing of a written notification of a breach
- Substitute notice provisions for breaches

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Region 10 PIHP** and to determine the extent to which performance indicators reported by **Region 10 PIHP** followed State specifications and reporting requirements. HSAG evaluated **Region 10 PIHP**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to the *State Fiscal Year 2019 Validation of Performance Measures for Region 10—Region 10 PIHP* report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Region 10 PIHP**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no major concerns with how **Region 10 PIHP** received and processed claims and encounter data for submission to MDHHS. During HSAG's PSV activity, HSAG found instances in which cases identified as exceptions did not have the necessary documentation to meet the exclusion criteria. For example, cases were categorized as exceptions, but there were no notes to indicate that the consumer requested an appointment outside of seven days or refused an appointment that would have occurred within seven days. Therefore, performance indicator *#4b* was deemed *Not Reportable*. Each CMHSP was responsible for identifying cases for inclusion in each data element (e.g., denominator, numerator,

exceptions) based on the measure specifications provided in the MDHHS Codebook. Member-level detail files, along with summary rate files, were submitted to **Region 10 PIHP** via a secure file transfer protocol (FTP) site for review and verification prior to submission to MDHHS. Based on these findings, HSAG recommends that **Region 10 PIHP** incorporate more stringent checks to ensure that exception criteria are followed.

- BH-TEDS Data Production—Based on discussion of **Region 10 PIHP**'s add, change, and deletion process as well as a demonstration of one CMHSP's BH-TEDS data entry and submission processes (i.e., Lapeer CMH), no concerns were identified with the CMHSP's adherence to the State-specified submission requirements. HSAG recommends that **Region 10 PIHP** and the CMHSPs perform additional checks beyond the State-specified requirements before data are submitted to the State as an added level of validation in support of BH-TEDS data quality and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Region 10 PIHP** had sufficient oversight of its four affiliated CMHSPs but, as discussed in the Medical Services Data System (Claims and Encounters) Findings section preceding, areas for improvement still existed.

Based on all validation methods used to collect information during the Michigan SFY 2019 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Region 10 PIHP** received an indicator designation of *Report* for 11 performance indicators, signifying that **Region 10 PIHP** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported. However, **Region 10 PIHP** received an indicator designation of *Not Reported* for the remaining one indicator, indicating that **Region 10 PIHP** did not calculate this indicator in compliance with MDHHS Codebook specifications. HSAG also identified issues during PSV in **Region 10 PIHP**'s process for validating the performance indicator data, which included issues regarding time parameters required by the specifications for the performance indicator. Therefore, these reported rates were considered materially biased. Table 5-65 presents **Region 10 PIHP**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-65—Performance Measure Results for Region 10 PIHP

Performance Indicator	Rate	MPS
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	99.75%	95.00%
Adults	99.91%	95.00%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	100.00%	95.00%
MI Adults	99.78%	95.00%
IDD Children	99.04%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.59%	95.00%
Total	99.20%	95.00%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	99.58%	95.00%
MI Adults	99.37%	95.00%
IDD Children	99.08%	95.00%
IDD Adults	100.00%	95.00%
Medicaid SUD	98.20%	95.00%
Total	98.85%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	100.00%	95.00%
MI and IDD Adults	96.73%	95.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	*NR*	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.33%	—

Performance Indicator	Rate	MPS
#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.		
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.	98.29%	—
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	10.96%	—
IDD Adults	6.15%	—
MI/IDD Adults	6.29%	—
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	92.44%	—
IDD Adults	31.76%	—
MI/IDD Adults	42.28%	—
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	15.11%	15.00%
MI and IDD Adults	9.58%	15.00%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	15.52%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	48.87%	—

Indicates that the reported rate was better than the MPS.

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

NR (*Not Reported*) indicates that the rate was determined "materially biased." Rates designated NR are not displayed because the PIHP's performance cannot be evaluated based on biased rates.

* A lower rate indicates better performance.

Region 10 PIHP's performance exceeded the corresponding MPS for 17 of 18 reportable measure indicators (94.4 percent), suggesting strength in these areas.

Although most of **Region 10 PIHP**'s rates were above the MPS, the rate for the Children population under indicator *#10* fell below the corresponding MPS, indicating an opportunity for improvement. Additionally, **Region 10 PIHP**'s rate was deemed *Not Reported* for one of 19 measure indicators (5.3 percent) with an MPS.

Validation of Performance Improvement Projects

For the 2018–2019 validation, **Region 10 PIHP** provided baseline data for the PIP topic: *Medical Assistance for Tobacco Use Cessation*. The goal of this PIP is to improve the medical assistance services pertaining to tobacco use cessation for **Region 10 PIHP** members with serious mental illness and who have been identified as tobacco users. Medical assistance for this PIP is defined as a medical prescription to assist with tobacco cessation.

Table 5-66 outlines the study indicator for the PIP.

Table 5-66—Study Indicator

PIP Topic	Study Indicator
Medical Assistance for Tobacco Use Cessation	The proportion of adult Medicaid beneficiaries with serious mental illness (SMI) identified by the PIHP as tobacco users who have at least one medical assistance service event pertaining to tobacco use cessation during the measurement year.

Table 5-67 and Table 5-68 show **Region 10 PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2018–2019 PIP validation report for **Region 10 PIHP**.

Table 5-67—PIP Validation Results for Region 10 PIHP

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	50% (1/2)	50% (1/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**94% (15/16)**		

Table 5-68—2018–2019 PIP Validation Scores for Region 10 PIHP

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Medical Assistance for Tobacco Use Cessation	Submission	81%	75%	***Partially Met***
	Resubmission	94%	88%	***Partially Met***

Region 10 PIHP submitted the Design and Implementation stages of the PIP for this year's validation. For the final validation, overall, 94 percent of all applicable evaluation elements received a score of *Met*. The PIP had not progressed to the Outcomes stage.

Region 10 PIHP designed a scientifically sound project and the technical design of the PIP was sufficient to measure and monitor PIP outcomes. However, the PIHP did not include plan-specific data supporting the selection of the topic. **Region 10 PIHP** indicated that it plans to include its entire eligible population for this PIP. In the Implementation stage, **Region 10 PIHP** accurately calculated and interpreted the baseline results. **Region 10 PIHP** progressed to completing causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes.

Strengths, Weaknesses, and Overall Conclusions

Region 10 PIHP demonstrated both strengths and weaknesses based on the results of the 2018–2019 EQR activities. **Region 10 PIHP** received a total compliance score of 82 percent across all standards reviewed during the 2018–2019 compliance monitoring review. **Region 10 PIHP** scored 90 percent or above in the QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, and Coordination of Care standards, indicating strong performance in these areas; however, it did not perform as well in the Quality Measurement and Improvement, Utilization Management, Credentialing, and Confidentiality of Health Information standards, as demonstrated by moderate to low performance scores (88 percent, 75 percent, 56 percent, and 40 percent, respectively), reflecting that additional focus is needed in these areas.

While 17 of the 18 reportable performance measure rates were above the MDHHS-established MPS, indicating strengths in these areas, **Region 10 PIHP**'s rate for indicator *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children fell below the corresponding MPS, indicating opportunities to improve this measure rate. Additionally, **Region 10 PIHP** received an audit designation of *Not Reported* for indicator *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* because the rate was determined to be materially biased, indicating that **Region 10 PIHP** did not calculate the performance indicator in compliance with MDHHS Codebook specifications.

Region 10 PIHP's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-69—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: The QAPIP Plan and Structure standard achieved full compliance, indicating the PIHP maintained a comprehensive quality program. • Strength: The Practice Guidelines standard achieved full compliance, indicating the PIHP implemented processes for the adoption, development, implementation, monitoring, and evaluation of CPGs. • Strength: The Staff Qualifications and Training standard achieved full compliance, suggesting the PIHP hired qualified staff members and provided adequate new hire and ongoing training to its staff members. • Strength: The Members' Rights and Protections standard achieved full compliance, suggesting the PIHP guaranteed, observed, and protected members' rights. • Strength: The MPS was met related to 30-day readmissions after discharge from an inpatient psychiatric unit for MI and IDD Adults. • Strength: The PIHP designed a scientifically sound project related to *Medical Assistance for Tobacco Use Cessation*, supported by the use of key research principles.

Performance Area*	Overall Performance Impact
	The technical design of the PIP was sufficient to measure and monitor PIP outcomes. The PIHP accurately calculated and interpreted the baseline results. • Weakness: The Credentialing standard received a compliance score of 56 percent, indicating that some providers' credentials are not adequately being evaluated prior to joining the PIHP's network. • Weakness: The MPS related to 30-day readmissions after discharge from an inpatient psychiatric unit for SED and IDD Children was not met. • Weakness: The PIHP did not provide plan-specific data to support the PIP study topic selection. The study topic should be selected based on data that identify an opportunity for improvement.
Timeliness	• Strength: The MPS were met related to timely preadmissions screenings for psychiatric inpatient care for adults and children; timely face-to-face assessments with a professional for new Medicaid beneficiaries in the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; receiving timely needed, ongoing services for the SED Children, MI Adults, IDD Children, IDD Adults, and Medicaid SUD populations; and timely follow-up care following discharges from an inpatient psychiatric unit for MI and IDD Adults and SED and IDD Children. • Weakness: The Utilization Management standard received a compliance score of 75 percent, suggesting that members are not receiving timely and comprehensive notices of ABD. • Weakness: The PIHP received an *NR* audit designation related to timely follow-up care following discharge from a substance abuse detox unit.
Access	• Strength: The Coordination of Care standard achieved full compliance, indicating the PIHP had the necessary policies and procedures in place to provide members with access to care management, appropriate assessments, and service plans. • Weakness: The Confidentiality of Health Information standard received a compliance score of 40 percent, indicating the PIHP did not maintain adequate processes in place for generating, receiving, maintaining, using, and disclosing PHI in addition to providing members with appropriate notification in the event of a breach.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report, impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

From the assessment of results of **Region 10 PIHP**'s performance of EQR activities conducted in the 2017–2018 review year, HSAG made recommendations for improving the quality of healthcare services furnished to members by **Region 10 PIHP**. The recommendations provided to **Region 10 PIHP** for each activity in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plans* are summarized in Table 5-70 in addition to **Region 10 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.

Table 5-70—Recommendations and Region 10 PIHP's Responses

Compliance Monitoring Review
HSAG Recommendation
HSAG recommended that **Region 10 PIHP** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service • Standard VII—Grievance Process • Standard IX—Subcontracts and Delegation • Standard XIV—Appeals • Standard XVII—Management Information Systems **Region 10 PIHP** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Region 10 PIHP's Response
As written in the 2017–2018 Compliance Monitoring Review Final Report and CAP template, **Region 10 PIHP** was asked to identify the interventions intended to assist in achieving compliance with the requirement(s), the individual(s) responsible, and the timeline for each element requiring correction. **Region 10 PIHP** utilized the provided template to provide CAPs in response to the elements and required actions included. To monitor the status of the submitted CAPs, **Region 10 PIHP** added a goal to the FY 2019 QAPIP workplan. Assigned leads for each standard requiring corrective action were required to provide monthly status updates on the QAPIP workplan for the CAPs. Additionally, the QAPIP workplan was reviewed and discussed monthly during Quality Improvement Committee (QIC) meetings. As of December 17, 2019, **Region 10 PIHP** has completed 18 of the 19 CAPs submitted. The one outstanding CAP is for Standard VI – Customer Service, Requirement 5: Provider Listing. Required actions listed on the CAP template stated **Region 10 PIHP** must ensure its provider directory and the CMHSP provider directories include all required content and comply with provider directory requirements. The **Region 10 PIHP** provider directory has been completed and activities to ensure compliance continue. **Region 10 PIHP** has assigned plans of corrections to all CMHSPs to address the provider directories. The plans of correction are monitored quarterly by **Region 10 PIHP**'s Provider Network Management department. Additionally, continued monitoring of this CAP occurs via **Region 10 PIHP**'s Provider Network Committee (PNC) as a goal and standing agenda item at quarterly PNC meetings. Additionally, the PNC chairperson

Compliance Monitoring Review
provides monthly status updates on the FY 2020 QAPIP workplan for the provider directory goal. These status updates are also presented monthly during QIC meetings.
HSAG's Assessment of the Degree to Which Region 10 PIHP Effectively Addressed the Recommendation
Based on **Region 10 PIHP**'s response, HSAG has determined that **Region 10 PIHP** has addressed the prior year's recommendations and continues to implement its remaining plan of action to address the deficiencies identified during the 2017–2018 compliance monitoring activity. A comprehensive review of **Region 10 PIHP**'s CAPs will be completed during the 2019–2020 compliance monitoring activity.
Performance Measures
HSAG Recommendation

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP** to members, HSAG recommended that **Region 10 PIHP** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS

- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—MI and IDD Adults

Performance Declined >2 Percent From Previous Year

- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children

Region 10 PIHP should have included within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Region 10 PIHP** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Region 10 PIHP** should have included the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement

Performance Measures
• Ongoing analysis to identify factors that impact adequacy of rates • Quality improvement interventions that address the root cause of the deficiency • A plan to monitor the quality improvement interventions to detect whether they effect improvement Additionally, **Region 10 PIHP** should have defined data entry processes, including documented processes for data quality and data completeness checks.
Region 10 PIHP's Response
Region 10 PIHP responded that the *State Fiscal Year 2018 Validation of Performance Measures for Region 10 PIHP* report did not identify any areas requiring corrective actions and that the above recommendations were not previously provided to **Region 10 PIHP**.
HSAG's Assessment of the Degree to Which Region 10 PIHP Effectively Addressed the Recommendation
Based upon results of the 2018–2019 validation, **Region 10 PIHP** improved upon its rates for indicators *#3a* (Children) and *#10* (Adults) and both measures met their respective MPS, suggesting **Region 10 PIHP** incorporated improvement efforts in its QAPIP. However, **Region 10 PIHP** responded that it was not made aware of the recommendations identified in the *2017–2018 External Quality Review Technical Report for Prepaid Inpatient Health Plans*. In accordance with 42 CFR §438.364, MDHHS must produce an annual detailed technical report that summarizes the EQR results including recommendations for improving the quality of healthcare services furnished by each PIHP. The FY 2006 to 2018 annual EQR technical reports are available on MDHHS' website and are posted to the website by April 30th of each year as required by 42 CFR 438.364(c)(2)(i). Additionally, MDHHS distributed copies of the annual EQR Technical Report to each of the PIHPs.
Performance Improvement Project
HSAG Recommendation
HSAG recommended that **Region 10 PIHP** take proactive steps to ensure a successful PIP. As the PIP progressed, **Region 10 PIHP** should have ensured the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Performance Improvement Project
Region 10 PIHP's Response
The above recommendations align with the recommendations provided in the *2017–2018 PIP Validation Report Medical Assistance for Tobacco Use Cessation for Region 10—PIHP*. Recommendations were addressed as the PIP continued in FY 2019.
HSAG's Assessment of the Degree to Which Region 10 PIHP Effectively Addressed the Recommendation
In the 2018–2019 validation, **Region 10 PIHP** addressed the recommendations appropriate for the reporting of baseline data.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP** to members, HSAG recommends that **Region 10 PIHP** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Ratings Below the MPS

- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children

HSAG also recommends that **Region 10 PIHP** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard II—Quality Measurement and Improvement
- Standard V—Utilization Management
- Standard XI—Credentialing
- Standard XVI—Confidentiality of Health Information

Region 10 PIHP was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance monitoring report. Once the CAPs have been approved for implementation, HSAG recommends that **Region 10 PIHP** implement processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.

- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Region 10 PIHP** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

Finally, **Region 10 PIHP** should take proactive steps to ensure a successful PIP. **PIHP** should address all *General Comments* in the *2018–2019 PIP Validation Report Medical Assistance for Tobacco Use Cessation for Region 10—PIHP* and the following recommendations:

- To impact the Remeasurement 1 study indicator performance, **Region 10 PIHP** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not be in place long enough to impact the study indicator outcomes.
- **Region 10 PIHP** should document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Region 10 PIHP** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.
- **Region 10 PIHP** should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven.

6. PIHP Comparative Information With Recommendations for MDHHS

In addition to performing a comprehensive assessment of the performance of each PIHP, HSAG compared the findings and conclusions established for each PIHP to assess the Michigan Medicaid managed care program as a whole. The overall findings of the 10 PIHPs were used to identify the overall strengths and weaknesses of the Michigan Medicaid managed care program and to identify areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the 10 PIHPs.

Compliance Monitoring

Table 6-1 presents a summary of performance results for the Medicaid programs of the PIHPs as well as statewide aggregated performance. The percentage of requirements met for each of the nine compliance standards reviewed during the 2018–2019 compliance monitoring review are provided.

Table 6-1—Compliance Monitoring Comparative Results

Standard	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	88%	63%	63%	100%	88%	63%	100%	100%	75%	100%	**84%**
II	75%	50%	63%	88%	75%	50%	75%	63%	50%	88%	**68%**
III	75%	75%	75%	100%	100%	75%	75%	100%	50%	100%	**83%**
IV	100%	100%	100%	100%	100%	67%	67%	100%	100%	100%	**93%**
V	69%	56%	56%	81%	75%	88%	81%	69%	63%	75%	**71%**
VIII	85%	85%	77%	100%	100%	77%	92%	85%	100%	100%	**90%**
XI	56%	56%	56%	56%	56%	56%	56%	56%	50%	56%	**55%**
XIII	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
XVI	100%	60%	20%	100%	100%	90%	50%	90%	100%	40%	**75%**
Total	**82%**	**70%**	**65%**	**90%**	**87%**	**77%**	**79%**	**82%**	**78%**	**82%**	**79%**

Standard I—QAPIP Plan and Structure
Standard II—Quality Measurement and Improvement
Standard III—Practice Guidelines
Standard IV—Staff Qualifications and Training
Standard V—Utilization Management
Standard VIII—Members' Rights and Protections
Standard XI—Credentialing
Standard XIII—Coordination of Care
Standard XVI—Confidentiality of Health Information

The Michigan Medicaid managed care program under BHDDA received an average total performance score across the 10 PIHPs of 79 percent. The program as a whole demonstrated strong performance, scoring 90 percent or above in three standards. These areas of strength include Staff Qualifications and Training, Members' Rights and Protections, and Coordination of Care. All 10 PIHPs achieved full compliance in the Coordination of Care standard. Additionally, eight PIHPs scored 100 percent compliance in the Staff Qualifications and Training standard.

Opportunities for improvement were identified in eight of the nine standards. While four PIHPs achieved full compliance for the QAPIP Plan and Structure standard, the six remaining PIHPs scored less than 90 percent, with scores ranging from 63 to 88 percent. Additionally, while four PIHPs achieved full compliance for the Practice Guidelines standard, the remaining six PIHPs scored less than 90 percent, with scores ranging from 50 to 75 percent.

The areas of the program with the greatest opportunities include Quality Measurement and Improvement, Utilization Management, Credentialing, and Confidentiality of Health Information. The Quality Measurement and Improvement, and Utilization Management standards demonstrated overall low performance. The statewide averages were 68 and 71 percent, respectively. All PIHPs scored less than 90 percent for both of these standards, with scores ranging from 50 to 88 percent.

The Credentialing standard was the lowest performing program area, as demonstrated by the PIHPs receiving an aggregated score of 55 percent. The standard that demonstrated the greatest variance in scores across all PIHPs was Confidentiality of Health Information. Six PIHPs demonstrated strong performance, scoring 90 percent or higher, with four plans achieving full compliance. However, four PIHPs demonstrated low performance, with compliance scores ranging between 20 and 60 percent.

Performance Measures

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). This calculation excluded all rates with *Not Reported (NR)* audit designations.

Table 6-2 displays the statewide scores and the lowest and highest scores among the PIHPs for validated performance measure indicators.

Table 6-2—Performance Measure Indicator Scores

Performance Indicator	Statewide Score	MPS	PIHP Low Score	PIHP High Score
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.				
Children	96.53%	95.00%	92.66%	100.00%
Adults	97.28%	95.00%	93.73%	99.91%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.				
SED Children	98.36%	95.00%	93.37%	100.00%
MI Adults	98.83%	95.00%	97.80%	99.78%
IDD Children	98.63%	95.00%	96.77%	100.00%
IDD Adults	99.31%	95.00%	96.30%	100.00%
Medicaid SUD	97.38%	95.00%	88.51%	98.81%
Total	98.19%	95.00%	95.13%	99.20%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.				
SED Children	95.47%	95.00%	87.39%	99.62%
MI Adults	97.63%	95.00%	89.44%	100.00%
IDD Children	93.94%	95.00%	84.62%	100.00%
IDD Adults	96.52%	95.00%	88.57%	100.00%
Medicaid SUD	97.66%	95.00%	95.23%	100.00%
Total	97.08%	95.00%	94.69%	98.85%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.				
SED and IDD Children	97.66%	95.00%	90.67%	100.00%
MI and IDD Adults	94.49%	95.00%	86.96%	100.00%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.				
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	96.13%	95.00%	91.03%	100.00%
#5: The percent of Medicaid recipients having received PIHP managed services.				
The percent of Medicaid recipients having received PIHP managed services.	6.96%	—	5.64%	8.41%

Performance Indicator	Statewide Score	MPS	PIHP Low Score	PIHP High Score
#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.				
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.	97.48%	—	96.40%	99.20%
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.				
MI Adults	14.96%	—	10.09%	18.49%
IDD Adults	9.51%	—	6.00%	13.48%
MI/IDD Adults	8.20%	—	5.66%	17.71%
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.				
MI Adults	91.24%	—	82.91%	94.26%
IDD Adults	45.82%	—	24.77%	70.36%
MI/IDD Adults	43.53%	—	30.51%	70.97%
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*				
SED and IDD Children	9.12%	15.00%	15.11%	3.39%
MI and IDD Adults	11.23%	15.00%	16.09%	6.88%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).				
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	19.56%	—	12.58%	25.56%
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).				
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	44.82%	—	34.96%	55.34%

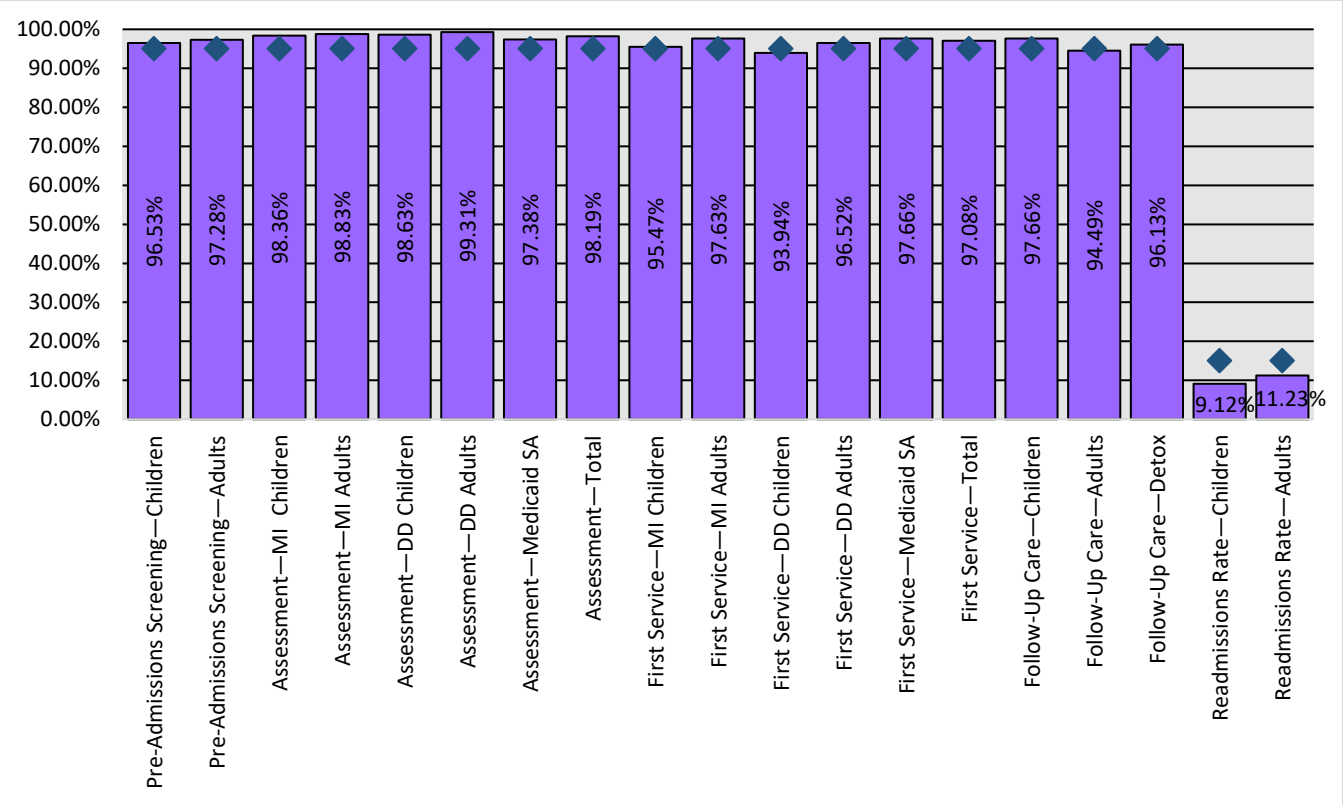
Indicates that the reported rate was better than the MPS.

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

* A lower rate indicates better performance.

MDHHS does not specify an MPS for all performance indicators, as demonstrated in Table 6-2. Statewide performance exceeded the MDHHS-established MPS for 17 of 19 indicators (89.5 percent) with specified standards, as shown in Figure 6-1.

Figure 6-1—Statewide Rates for Performance Measures



Timeliness of care and access to care are demonstrated as statewide strengths for the PIHPs. The statewide scores exceeded their corresponding MPS for each of the following indicators:

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*—Children and Adults
- *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—SED Children, MI Adults, IDD Children, IDD Adults, Medicaid SUD, and Total
- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Adults, Medicaid SUD, and Total

The statewide scores for the following performance indicators also exceeded their corresponding MPS, indicating statewide strengths in quality, timeliness, and access:

- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Performance on the following statewide scores exceeded their corresponding MPS, as lower rates for these measures indicate better performance, demonstrating statewide strengths in quality of care:

- *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*—SED and IDD Children and MI and IDD Adults

As displayed in Table 6-3, continued strong performance resulted in statewide rates for 17 of 19 indicators (89.5 percent) exceeding the MDHHS-established MPS. One PIHP, **NorthCare Network**, exceeded the established MPS for all but one indicator.

Indicator *#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service*—IDD Adults showed the highest statewide rate at 99.31 percent. Indicator *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge* represented another statewide area of strength, with statewide performance exceeding the MPS of 15 percent for both SED and IDD Children and MI and IDD Adults.

Compared to performance in the prior validation cycle, most statewide rates for indicators with an MDHHS-established MPS remained essentially unchanged, with all rates changing by less than 3 percentage points each. Refer to Appendix A, Table A-2. Indicator *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—SED and IDD Children achieved the largest statewide improvement in performance, improving by 2.08 percentage points from the prior year, which may indicate a statewide strength.

Two statewide measure rates were below the established MPS, indicators *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*—IDD Children, and *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults. Additionally, for every measure with an MDHHS-established MPS, at least one PIHP either did not meet the MPS or received a *Not Reported (NR)* audit designation for reporting a rate that was materially biased, indicating opportunities for improvement for those individual PIHPs. Additionally, three various PIHPs with a reportable rate did not meet the MPS for at least one population under each of the following indicators, indicating the most prevalent opportunities for improvement statewide:

- *#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*

- *#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional*
- *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*
- *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*

Performance Improvement Project

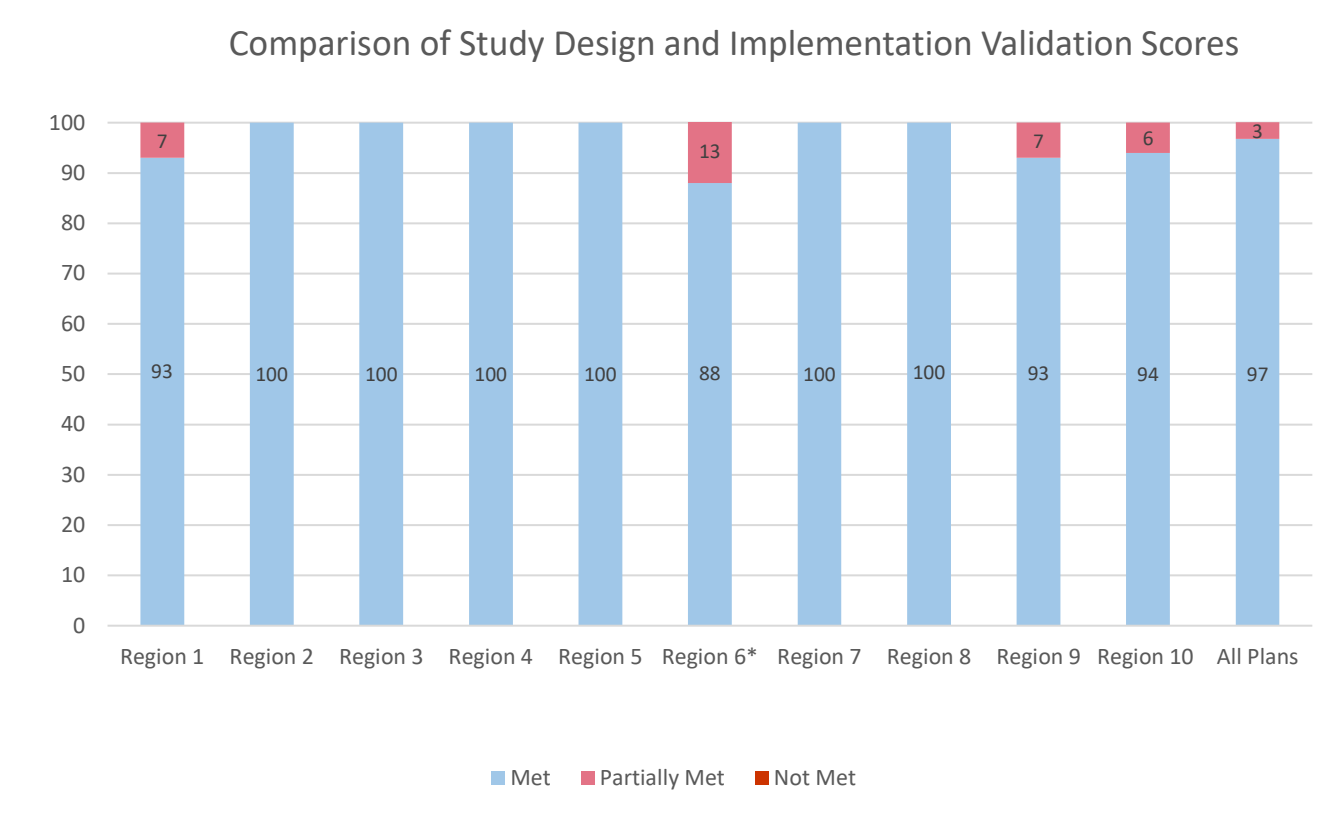
For 2018–2019 validation, the PIHPs provided baseline data for their PIP topic. Table 6-3 presents a list of the selected PIP topics by each PIHP.

Table 6-3—PIHP PIP Topics

PIHP	PIP Topic
Region 1—NorthCare Network	*Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*
Region 2—Northern Michigan Regional Entity	*Follow-Up Care for Children Prescribed ADHD Medication*
Region 3—Lakeshore Regional Entity	*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*
Region 4—Southwest Michigan Behavioral Health	*Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*
Region 5—Mid-State Health Network	*Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*
Region 6—Community Mental Health Partnership of Southeast Michigan	*Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*
Region 7—Detroit Wayne Integrated Health Network	*Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
Region 8—Oakland Community Health Network	*Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
Region 9—Macomb County Community Mental Health	*Reducing Acute Inpatient Recidivism for Adults with Serious Mental Illness*
Region 10 PIHP	*Medical Assistance for Tobacco Use Cessation*

For this year's validation, the PIHPs were required to include information on the PIP study Design (Steps I through VI) and Implementation (Steps VII) stages; however, several PIHPs also included their Improvement Strategies (Step VIII), which were reviewed and validated. The PIHPs reported baseline data in this year's annual PIP submission. Figure 6-2 and Table 6-4 provide a comparison of the validation scores and overall PIP validation status, by PIHP.

Figure 6-2—Comparison of Study Design and Implementation Validation Scores



*Percentage totals may not equal 100 due to rounding.

Table 6-4 presents a comparison of PIP validation results by each PIHP, showing how many of the PIPs reviewed for each activity received *Met* scores for all applicable evaluation or critical elements.

Table 6-4—Comparison of PIP Validation Status

PIHP	Percentage of All Applicable Evaluation Elements *Met*	Percentage of Critical Elements *Met*	Validation Status
Region 1—NorthCare Network	93%	100%	***Met***
Region 2—Northern Michigan Regional Entity	100%	100%	***Met***
Region 3—Lakeshore Regional Entity	100%	100%	***Met***
Region 4—Southwest Michigan Behavioral Health	100%	100%	***Met***
Region 5—Mid-State Health Network	100%	100%	***Met***
Region 6—Community Mental Health Partnership of Southeast Michigan	88%	88%	***Partially Met***
Region 7—Detroit Wayne Integrated Health Network	100%	100%	***Met***
Region 8—Oakland Community Health Network	100%	100%	***Met***
Region 9—Macomb County Community Mental Health	93%	100%	***Met***
Region 10 PIHP	94%	88%	***Partially Met***

The results from the 2018–2019 validation reflected strong performance in the Design stage (Steps I through VI) and Implementation stage (Steps VII through VIII) of the PIPs. Eight PIHPs received an overall *Met* validation status, with six of those PIHPs receiving a score of 100 percent in all applicable evaluation elements in Steps I through VII (or Steps I through VIII, as appropriate). However, two PIHPs received an overall *Partially Met* validation status. **Community Mental Health Partnership of Southeast Michigan** did not clearly identify barriers and implement interventions that were logically linked to those barriers and have the potential to impact the study indicator outcomes. **Region 10 PIHP** did not include plan-specific data supporting the selection of the PIP topic.

Summary, Conclusions, and Recommendations

HSAG performed a comprehensive assessment of the performance of each PIHP and of the overall strengths and weaknesses of the Michigan Medicaid managed care program related to behavioral health, IDD, and SUD services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise BHDDA under the Michigan Medicaid managed care program.

Strengths and Associated Conclusions

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

Compliance Monitoring

Through the 2018–2019 compliance monitoring review, overall, BHDDA under the Michigan Medicaid managed care program demonstrated areas of moderate strength in managing and adhering to expectations established for the Medicaid program through State and federal requirements as demonstrated by a statewide aggregated score of 79 percent. Most of the State and federal requirements assessed relate to or impact the quality of, timeliness of, and access to care and services provided by each PIHP to their members. The highest-performing plans were **Southwest Michigan Behavioral Health** and **Mid-State Health Network**, with an overall average performance score of 90 percent and 87 percent, respectively. Additionally, statewide average scores in each of the following standards were at 90 percent or above, demonstrating strong performance:

- Staff Qualifications and Training—the PIHPs had effective systems in place for providing new hire and ongoing training to their staff members.
- Members' Rights and Protections—the PIHPs maintained adequate processes for guaranteeing member rights and providing member communications in a language and format that was easily understood and readily accessible.
- Coordination of Care—the PIHPs had documented policies for completing appropriate assessments, developing person-centered service plans, and creating joint management care plans with MHPs for members with complex behavioral and physical health needs.

Performance Measures

The individual PIHPs were evaluated against State benchmarks for measures related to the quality of, access to, and timeliness of services. When the individual PIHP scores were aggregated, statewide average scores exceeded all corresponding MDHHS-established performance standards. On a statewide average, more than 95 percent of adult and child members were each able to:

- Receive a preadmission screening for psychiatric inpatient care, for those for whom the disposition was completed within three hours.

- Receive a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.
- Be seen for follow-up care within seven days of being discharged from a substance abuse detox unit.

Additionally, the percentage of SED and IDD Children and MI and IDD Adults being readmitted to inpatient psychiatric units within 30 days of discharge was under the 15 percent performance standard threshold, which may indicate that PIHPs are quickly and effectively coordinating care for members after discharge.

Performance Improvement Project

Through their participation in the PIP, the PIHPs will focus their efforts on specific quality outcomes—particularly quality and access to care and services—which should result in better health outcomes for Michigan Medicaid members.

During the 2018–2019 review period, all 10 PIHPs completed the Design stage of the PIP by successfully identifying an appropriate study topic, defining study questions, identifying the study population, defining study indicators to measure improvement over time, and collecting valid and reliable data on selected study indicators in order to effectively measure and monitor PIP outcomes. Additionally, nine of the 10 PIHPs accurately calculated and interpreted the baseline results for each study indicator.

As the PIPs progress, the PIHPs will establish and implement interventions to improve the health of their identified populations by:

- Increasing the prevalence of follow-up visits with a mental health practitioner within seven days after an inpatient discharge for members with selected mental health diagnoses. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce risk of repeat hospitalization.
- Increasing the percentage of child members, with newly prescribed ADHD medication, who have two follow-up care visits within a 10 month-period, one within 30 days of when the first ADHD medication was dispensed. Follow-up care visits are important in continuity of care to ensure that children's medications are prescribed and managed correctly.
- Increasing HbA1c and LDL-C testing among Medicaid members with diabetes and schizophrenia. Monitoring these test results can assist in controlling diabetes; prevent serious health complications such as blindness, kidney disease, and amputations; and lead to improvement in health and functional outcomes of members.
- Improving the proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes. Individuals with a mental health illness are at increased risk for developing diabetes. Uncontrolled diabetes can lead to adverse health problems.
- Decreasing members recidivating within 30 days post discharge to acute inpatient behavioral health services. Timely follow-up care after inpatient stay and adequate treatment after discharge can help

to identify risk factors for readmission and monitor risks, reducing the need for additional hospital services.

- Improving the medical assistance services (e.g., prescriptions) pertaining to tobacco use cessation for members with serious mental illness and who have been identified as tobacco users. Promoting tobacco cessation is expected to reduce smoking-related health hazards in members and improve members' health, functional status, satisfaction, and overall well-being.

Weaknesses and Associated Conclusions

HSAG's comprehensive assessment of the PIHPs and BHDDA under the Michigan Medicaid managed care program also identified areas of focus that represent significant opportunities for improvement within the program. These primary areas of focus are the QAPIP, management and adherence to managed care requirements, and the establishment of documented processes to support the use and disclosure of PHI.

Quality Assessment and Performance Improvement Program

The 2018–2019 compliance monitoring review revealed an opportunity to improve upon the PIHPs' QAPIP, and specifically the analyses of critical incidents and sentinel events, and the assessment of member experience with services. These requirements are addressed in the Quality Measurement and Improvement standard, which received a statewide aggregated score of 68 percent. While all PIHPs implemented processes to collect data on critical incidents and sentinel events, the analysis of the data was primarily focused on a quantitative review of incidents or events per category type and per CMHSP/provider. Only two PIHPs demonstrated a comprehensive qualitative review that included a review of commonalities between events and a discussion on trends or patterns. Overall, most PIHPs did not implement comprehensive processes to conduct a periodic quantitative and qualitative analysis that included meaningful discussion on trends. Without a comprehensive analysis, the PIHPs will lack the ability to successfully develop targeted actions to remediate a negative trend or pattern and prevent reoccurrence of additional incidents and events. Additionally, while all PIHPs completed activities (primarily member surveys) to assess member experience with services, most PIHPs did not link specific systemic actions to address areas of dissatisfaction or subsequently evaluate the impact of those actions taken. In some instances, activity findings suggested members were generally satisfied with services or met a PIHP's established standards; however, acceptance of member satisfaction based on consistent achievement of performance standards does not drive quality improvement.

Although most statewide average performance measure scores exceeded their MDHHS-established MPS, two indicators, *#3* for the IDD Children population and *#4a* for adults, fell below the MPS, suggesting that some members are not starting ongoing services timely, and some members are not receiving timely follow-up care after a discharge from an inpatient psychiatric unit. Additionally, the statewide average performance measure score for indicator *#4a* for adults decreased by more than 2 percentage points from the prior year.

Management and Adherence to Managed Care Requirements

The 2018–2019 compliance monitoring review included a review of individual case files; specifically, utilization management (service denials) and provider credentialing records. The statewide aggregated score for the Utilization Management standard was 71 percent, with PIHP scores ranging from 56 percent to 88 percent. The service denial file review identified gaps in each PIHP's ability to operationalize prior authorization program requirements and provide comprehensive advance and/or adequate notices of ABD to members. The credentialing file review also identified statewide challenges to adequately evaluate each licensed staff member's or contracted provider's (both individual or organizational) qualifications and credentials prior to joining a PIHP's network as evidenced by an overall low statewide performance score of 55 percent. All PIHPs received a compliance score at or under 56 percent due to varying non-adherence to initial and recredentialing program requirements. Further, most PIHPs did not conduct a file review of delegated utilization management and credentialing functions, indicating a significant statewide gap in the oversight of delegated managed care functions.

Processes for the Use and Disclosure of PHI

The 2018–2019 compliance monitoring review was the first year HSAG conducted a review of the Confidentiality of Health Information standard. Performance across the PIHPs varied with performance scores ranging from 20 percent to 100 percent. For the six PIHPs that did not achieve full compliance, HSAG noted several deficiencies related to the lack of documented comprehensive processes for generating, receiving, maintaining, using, and disclosing PHI and SUD treatment information, and for complying with notification requirements following the discovery of a breach of unsecured PHI.

Quality Strategy Recommendations for Michigan

Based on a comprehensive assessment of the PIHPs' performance in providing quality, timely, and accessible behavioral healthcare and SUD services to Michigan's Medicaid managed care members, HSAG concludes that the following prevalent areas of the program demonstrate the most opportunities for improvement:

- QAPIP
- Management and adherence to managed care requirements
- Processes for the use and disclosure of PHI

Michigan's Quality Strategy is designed to improve the health outcomes of its Medicaid members, including children and adults receiving behavioral health and SUD services, by measuring access, efficiency, and outcomes through standardized performance indicators; initiating PIPs that can be expected to have a positive effect on health outcomes and member satisfaction; and close monitoring of provider networks, affiliates, and subcontractors to ensure that quality healthcare and services are being provided to Michigan residents receiving Medicaid benefits. In consideration of the goals of the quality strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific areas of opportunity.

Quality Assessment and Performance Improvement Program

One way to gauge the effectiveness of a Medicaid managed care program is to determine whether it provides members access to medically necessary and high-quality healthcare services in a timely manner. MDHHS, as a State Medicaid agency, is required to monitor access to care. Through its MMBPIS, MDHHS has a mechanism to assess access to care and quality of the service delivery system statewide for behavioral health and SUD services. Additionally, MDHHS, through its contracts with the PIHPs, must establish and implement an ongoing comprehensive QAPIP for the services it furnishes to its members, and at least annually, review the impact and effectiveness of each PIHP's quality program.

1. To further assess member access to and availability of services, HSAG recommends that MDHHS consider requiring each PIHP incorporate efforts for improvement as part of its quality improvement strategy within the QAPIP to address any performance areas not meeting MDHHS, federal, and/or PIHP-specific standards. The quality improvement program description and work plan should be provided to MDHHS at least annually at an MDHHS-designated time frame, and should include the following:
   - Measurable goals and benchmarks for each indicator/performance area
   - Mechanisms to measure performance
   - Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates or goals
   - Identified opportunities for improvement
   - Ongoing analysis to identify factors that impact adequacy of rates or other performance thresholds
   - Quality improvement interventions that address the root cause of the deficiency
   - A plan to monitor the quality improvement interventions to detect whether they effect improvement
2. HSAG further recommends that MDHHS conduct a comprehensive evaluation of each submitted PIHP QAPIP work plan for completeness and to ensure the documented interventions have the ability to positively impact performance improvement.
3. At the end of each fiscal year, by an MDHHS-designated time frame, the PIHPs should provide MDHHS with an annual evaluation of their QAPIPs that include an analysis of the interventions and the effectiveness of those interventions on each of the PIHP's established goals and objectives. In alignment with 42 CFR 438.330(e), MDHHS could review the:
   - Impact and effectiveness of each PIHP's performance on indicators.
   - Outcomes and trended results of each PIHP's PIPs.
   - Results of any efforts made by the PIHPs to support community integration for members using long-term services and supports.

4. As statewide average performance scores consistently meet the minimum standards and based on guidance from CMS, MDHHS has revised the specifications for access to care indicators *#2* and *#3* as of January 1, 2020, with a required implementation date in quarter three of the 2019–2020 contract year. The goal of calculating rates for these new indicators is to better understand Michigan's performance in regard to timeliness of access to care to behavioral health services. Baseline data will be used to establish a future MPS for these indicators. In addition to the revisions of indicators *#2* and *#3*, MDHHS could also consider reviewing and revising the specifications for the remaining indicators that consistently meet the MPS to further promote quality improvement.
5. Additionally, to strengthen the statewide QAPIP, HSAG recommends that MDHHS:
    - Require PIHPs to complete an annual formal report on the analyses of critical incidents, sentinel events, and risk events. MDHHS could consider requiring the PIHPs to include as part of the report:
        - Quantitative and qualitative analyses.
        - Review of the details of and commonalities between events.
        - Member-specific, provider-specific, and systemic trends.
        - Events related to SUD providers and members receiving SUD services.
        - A review of data per 1,000 members (per event type, category, provider, CMHSP, etc.) that would allow MDHHS to conduct a comparative analysis between PIHPs. A review of PIHPs who consistently report minimal to low number of incidents and events should be conducted.
        - Activities and initiatives to be implemented to address negative patterns or trends.
        - An evaluation of the effectiveness of activities implemented to address patterns or trends identified during the prior year.
    - Require PIHPs to complete an annual formal report on the assessment of member experience with services. The report could include:
        - A summary of the data collected through all activities used to assess member satisfaction (member surveys, focus groups, feedback directly from members received through member services, member interviews and the advisory committees, grievances, etc.)
        - A quantitative and qualitative analysis of the results of each activity.
        - Identification of an area (or areas) of focus to address areas of member dissatisfaction, decrease in member satisfaction from prior years, lowest performing areas of member satisfaction, etc.
        - Identification of specific actions to increase member satisfaction in target areas.
        - An evaluation of the effectiveness of actions implemented to address the targeted areas of member dissatisfaction during the prior year.

Management and Adherence to Managed Care Requirements

CMS, through the CFR, has established provisions to ensure members receive timely access to quality care and services from its managed care entities. Part of these provisions were developed to ensure members receive their care from qualified providers and have access to information pertaining to denied service requests and medical necessity decisions. HSAG recommends that MDHHS ensure compliance with these provisions by considering the following:

1. As some PIHPs expressed concern over the complex or confusing language in letter templates used for utilization decisions (notices of ABD, denial of expedited authorization requests, extension of time frame requirements, etc.), convene a workgroup inclusive of MDHHS and PIHP participants to develop and/or update State-specific letter templates.
2. Establish uniform delegation oversight monitoring criteria that PIHPs must follow that, at a minimum, address oversight of each delegate's credentialing and utilization management functions. These monitoring criteria should require a comprehensive auditing plan to ensure implementation of program requirements.
3. Mandate that PIHPs follow established NCQA credentialing requirements. PIHPs that were either NCQA accredited or followed NCQA credentialing requirements generally performed better than the PIHPs that were not following NCQA guidelines.
4. Mandate a time frame standard in which PIHPs must complete the credentialing process. HSAG recommends that MDHHS consider a 90-calendar day time frame calculated from the day the PIHP receives a completed application from a provider to the day written notice of the credentialing decision is sent to the provider.

Processes for the Use and Disclosure of PHI

The U.S. Department of Health and Human Services (HHS), within its Summary of the HIPAA [Health Insurance Portability and Accountability Act of 1996] Privacy Rule,[6-1] addresses the use and disclosure of members' health information by covered entities subject to the Privacy Rule, as well as standards for members' privacy rights to understand and control how their health information is used. HHS also stipulates that covered entities, including PIHPs, must develop and implement policies and procedures that address all provisions within the Privacy Rule, as well as breach notification reporting requirements. Through the compliance monitoring review, HSAG discovered that some PIHPs did not have comprehensive written policies and procedures in place pertaining to all requirements under the HIPAA Privacy Rule. HSAG recommends that MDHHS consider the following:

1. Mandatory PIHP reporting of all breaches to MDHHS within a specified time period. PIHPs should also require all delegates, including CMHSPs, to report all unauthorized disclosures to the PIHP for review and submission to MDHHS when the unauthorized disclosure has been deemed to be a breach.
2. Develop a standardized breach reporting log for the PIHPs to submit to MDHHS at least annually. The log should include date of discovery, date of the incident, summary of incident details, the number of members impacted by each breach, date notification sent to members, date of mandatory reporting to HHS, etc.

[6-1] https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents current-year and prior-year results for compliance monitoring, performance measure validation, and PIP validation.

Results for Compliance Monitoring

As MDHHS' 17 standards were reviewed over a two-year period, Table A-1 presents the combined results for each PIHP and statewide aggregated performance across all standards.

Table A-1—2017–2018 and 2018–2019 Statewide Compliance Scores

Standard	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	88%	63%	63%	100%	88%	63%	100%	100%	75%	100%	**84%**
II	75%	50%	63%	88%	75%	50%	75%	63%	50%	88%	**68%**
III	75%	75%	75%	100%	100%	75%	75%	100%	50%	100%	**83%**
IV	100%	100%	100%	100%	100%	67%	67%	100%	100%	100%	**93%**
V	69%	56%	56%	81%	75%	88%	81%	69%	63%	75%	**71%**
VI	87%	90%	85%	87%	87%	87%	87%	82%	87%	87%	**87%**
VII	92%	81%	100%	81%	92%	100%	100%	88%	100%	77%	**91%**
VIII	85%	85%	77%	100%	100%	77%	92%	85%	100%	100%	**90%**
IX	91%	91%	82%	91%	91%	91%	82%	82%	55%	82%	**84%**
X	92%	100%	92%	100%	100%	83%	100%	83%	100%	100%	**95%**
XI	56%	56%	56%	56%	56%	56%	56%	56%	50%	56%	**55%**
XII	95%	63%	63%	89%	95%	89%	89%	89%	84%	100%	**86%**
XIII	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
XIV	78%	81%	61%	87%	93%	87%	83%	85%	98%	43%	**80%**
XV	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	**99%**
XVI	100%	60%	20%	100%	100%	90%	50%	90%	100%	40%	**75%**
XVII	83%	100%	83%	100%	100%	100%	75%	83%	100%	83%	**91%**
Total	**86%**	**81%**	**74%**	**90%**	**91%**	**87%**	**86%**	**85%**	**88%**	**77%**	**84%**

Standard I—QAPIP Plan and Structure
Standard II—Quality Measurement and Improvement
Standard III—Practice Guidelines
Standard IV—Staff Qualifications and Training
Standard V—Utilization Management
Standard VI—Customer Service
Standard VII—Grievance Process
Standard VIII—Members' Rights and Protections
Standard IX—Subcontracts and Delegation
Standard X—Provider Network
Standard XI—Credentialing
Standard XII—Access and Availability
Standard XIII—Coordination of Care
Standard XIV—Appeals
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions
Standard XVI—Confidentiality of Health Information
Standard XVII—Management Information Systems

Results for Validation of Performance Measures

Table A-2 presents the 2017–2018 and 2018–2019 statewide results for the validated performance indicators.

Table A-2—2017–2018 and 2018–2019 Statewide Performance Measure Rates

Performance Indicator	2017–2018 Rate	2018–2019 Rate
#1: The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	98.90%	96.53%
Adults	98.24%	97.28%
#2: The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.		
SED Children	97.98%	98.36%
MI Adults	98.92%	98.83%
IDD Children	97.77%	98.63%
IDD Adults	98.49%	99.31%
Medicaid SUD	97.53%	97.38%
Total	98.13%	98.19%
#3: The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.		
SED Children	96.82%	95.47%
MI Adults	98.26%	97.63%
IDD Children	95.39%	93.94%
IDD Adults	98.44%	96.52%
Medicaid SUD	98.25%	97.66%
Total	97.89%	97.08%
#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
SED and IDD Children	95.58%	97.66%
MI and IDD Adults	96.70%	94.49%
#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		
The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	95.95%	96.13%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.75%	6.96%

Performance Indicator	2017–2018 Rate	2018–2019 Rate
#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.		
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.	96.04%	97.48%
#8: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who are in competitive employment.		
MI Adults	12.50%	14.96%
IDD Adults	8.96%	9.51%
MIIDD Adults	8.35%	8.20%
#9: The percent of adults with mental illness, the percent of adults with intellectual and developmental disabilities, and the percent of dual MI/IDD adults served by the CMHSP/PIHP who earn minimum wage or more from employment activities.		
MI Adults	81.02%	91.24%
IDD Adults	36.34%	45.82%
MI/IDD Adults	38.68%	43.53%
#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge.*		
SED and IDD Children	10.10%	9.12%
MI and IDD Adults	11.88%	11.23%
#13: The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with intellectual and developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	19.45%	19.56%
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	40.05%	44.82%

* A lower rate indicates better performance.

Table A-3 and Table A-4 present a two-year comparison of the PIHP-specific results for the validated performance indicators.

Table A-3—Current Year (CY) and Prior Year (PY) PIHP-Specific Performance Measure Rate Percentages (Performance Indicators #1–4b)

PIHP		#1—Children	#1—Adults	#2—SED Children	#2—MI Adults	#2—IDD Children	#2—IDD Adults	#2—Medicaid SUD	#2—Total	#3—SED Children	#3—MI Adults	#3—IDD Children	#3—IDD Adults	#3—Medicaid SUD	#3—Total	#4a—SED and IDD Children	#4a—MI and IDD Adults	#4b
Region 1—NorthCare	CY	100.00	99.62	100.00	99.60	100.00	100.00	88.51	95.13	98.20	98.86	100.00	100.00	98.70	98.69	100.00	100.00	100.00
	PY	100.00	99.54	98.80	99.52	100.00	93.33	91.24	95.86	96.80	100.00	100.00	100.00	99.68	99.17	100.00	94.00	86.67
Region 2—NMRE	CY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	95.86	100.00	93.33	94.74	95.23	96.80	95.74	93.38	92.47
	PY	97.14	96.71	96.93	98.36	93.94	100.00	98.12	97.91	96.74	97.20	96.43	90.00	98.17	97.20	82.14	94.07	76.19
Region 3—LRE	CY	92.66	93.73	97.84	98.46	97.92	98.25	94.42	97.33	90.70	97.19	84.62	95.65	99.45	95.16	90.67	91.92	91.03
	PY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
Region 4—SWMBH	CY	98.93	99.36	99.35	99.21	96.77	100.00	98.39	98.91	94.61	96.00	91.23	100.00	95.83	95.59	100.00	98.62	93.98
	PY	97.94	97.88	97.43	99.52	100.00	100.00	97.04	98.09	95.67	96.06	100.00	100.00	95.21	95.70	96.55	99.25	97.24
Region 5—MSHN	CY	98.42	98.45	98.16	98.54	99.01	100.00	98.15	98.34	96.64	98.43	90.79	96.72	97.92	97.63	98.08	94.52	95.59
	PY	99.72	99.31	98.77	99.10	100.00	100.00	98.65	98.92	95.55	97.90	83.05	100.00	99.80	97.68	100.00	97.17	97.90

PIHP		#1—Children	#1—Adults	#2—SED Children	#2—MI Adults	#2—IDD Children	#2—IDD Adults	#2—Medicaid SUD	#2—Total	#3—SED Children	#3—MI Adults	#3—IDD Children	#3—IDD Adults	#3—Medicaid SUD	#3—Total	#4a—SED and IDD Children	#4a—MI and IDD Adults	#4b
Region 6—CMHPSM	CY	99.30	99.09	99.53	99.66	100.00	96.30	97.38	98.61	95.60	89.44	93.33	93.94	97.13	94.69	96.00	96.71	*NR*
	PY	100.00	99.63	99.37	99.65	100.00	100.00	97.58	98.75	97.94	97.55	96.77	96.30	95.15	96.30	100.00	97.79	92.13
Region 7—DWIHN	CY	94.47	95.77	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
	PY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
Region 8—OCHN	CY	94.06	96.34	93.37	97.80	100.00	100.00	98.81	97.75	99.62	100.00	100.00	100.00	95.88	98.26	100.00	95.34	98.56
	PY	92.76	90.98	96.50	98.26	96.15	96.00	99.45	98.35	100.00	99.67	100.00	100.00	98.73	99.43	97.14	95.26	100.00
Region 9—MCCMH	CY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	87.39	93.08	90.48	88.57	100	96.65	100.00	86.96	99.43
	PY	100.00	99.82	91.61	95.65	89.58	94.59	97.82	96.31	97.71	100.00	93.02	100.00	99.89	99.47	86.30	94.75	99.34
Region 10 PIHP	CY	99.75	99.91	100.00	99.78	99.04	100.00	98.59	99.20	99.58	99.37	99.08	100.00	98.20	98.85	100.00	96.73	*NR*
	PY	99.51	99.83	100.00	100.00	100.00	100.00	96.64	98.47	98.05	99.37	98.81	96.61	99.38	98.94	97.35	97.63	100.00

NR (Not Reported) indicates that the rate was determined "materially biased."

Table A-4—Current Year (CY) and Prior Year (PY) PIHP-Specific Performance Measure Rate Percentages (Performance Indicators #5–14)

PIHP		#5	#6	#8—MI Adults	#8—IDD Adults	#8—MI/IDD Adults	#9—MI Adults	#9—IDD Adults	#9—MI/IDD Adults	#10—SED and IDD Children*	#10—MI and IDD Adults*	#13	#14
Region 1—NorthCare	CY	7.45	99.20	17.80	7.34	8.57	90.22	24.77	30.51	4.17	10.10	16.15	55.34
	PY	7.08	98.66	15.93	5.18	7.05	92.09	92.11	90.91	5.26	4.71	16.05	50.56
Region 2—NMRE	CY	8.22	97.36	18.49	11.09	17.71	92.61	42.38	66.24	8.33	13.21	22.68	52.86
	PY	7.90	96.78	15.25	12.18	13.73	90.60	50.29	82.35	14.71	9.89	25.82	55.29
Region 3—LRE	CY	6.01	96.40	14.42	9.48	10.24	82.91	66.21	68.79	6.38	6.88	12.58	49.78
	PY	5.27	98.05	13.21	11.87	12.60	80.24	65.73	55.43	*NR*	*NR*	14.40	51.40
Region 4—SWMBH	CY	7.08	98.56	16.67	10.22	8.13	92.85	70.36	70.97	3.39	10.57	22.03	51.30
	PY	6.94	81.03	15.32	9.01	7.80	91.63	68.75	73.13	0.00	10.14	22.18	48.66
Region 5—MSHN	CY	8.41	97.32	17.93	9.45	8.65	92.27	44.50	40.27	9.77	10.66	19.08	51.83
	PY	7.99	96.51	15.37	9.02	8.60	91.84	79.90	80.89	10.12	9.09	19.98	50.48
Region 6—CMHPSM	CY	7.04	96.91	16.66	9.76	8.66	91.64	51.31	57.39	8.06	10.27	25.56	36.25
	PY	6.59	96.86	14.40	9.20	9.31	89.41	60.96	68.64	12.20	9.38	26.00	29.81

PIHP		#5	#6	#8—MI Adults	#8—IDD Adults	#8—MI/IDD Adults	#9—MI Adults	#9—IDD Adults	#9—MI/IDD Adults	#10—SED and IDD Children*	#10—MI and IDD Adults*	#13	#14
Region 7—DWIHN	CY	6.15	96.46	10.09	9.13	5.66	88.88	43.40	30.64	*NR*	*NR*	22.27	36.04
	PY	6.42	98.43	9.84	8.45	6.02	86.43	83.96	77.65	*NR*	*NR*	19.13	30.80
Region 8—OCHN	CY	7.98	98.24	18.22	13.48	8.19	92.23	52.82	32.01	6.06	16.09	19.35	34.96
	PY	7.31	97.80	15.46	11.03	10.49	86.51	41.88	81.82	5.88	14.25	21.29	33.71
Region 9—MCCMH	CY	5.64	97.38	17.03	6.00	6.36	94.26	32.28	42.42	9.71	13.80	14.75	42.82
	PY	5.48	97.68	14.43	5.99	5.86	91.16	98.06	90.14	11.90	15.23	12.18	31.58
Region 10 PIHP	CY	7.33	98.29	10.96	6.15	6.29	92.44	31.76	42.28	15.11	9.58	15.52	48.87
	PY	7.17	98.13	9.82	5.99	6.28	90.03	75.26	71.21	12.00	15.22	16.42	45.50

NR (Not Reported) indicates that the rate was determined "materially biased."

* A lower rate indicates better performance.

Results for Validation of Performance Improvement Projects

In 2017–2018, the PIHPs implemented a new PIP on one of the 10 State-recommended PIP topics. In 2018–2019, the PIHPs provided baseline data for those PIP topics and HSAG performed validation activities on the Design and Implementation stages for each PIHP as appropriate.

Table A-5 presents a two-year comparison of the PIHPs' PIP validation status.

Table A-5—Comparison of PIHPs' PIP Validation Status

Validation Status	Number of PIPs	
	2017–2018	2018–2019
Met	10	8
Partially Met	0	2
Not Met	0	0

Table A-6 presents a two-year comparison of statewide PIP validation results, showing how many of the PIPs reviewed for each activity received *Met* scores for all evaluation or critical elements.

Table A-6—Summary of Data from Validation of Performance Improvement Projects

Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
		2017–2018	2018–2019	2017–2018	2018–2019
I.	Appropriate Study Topic	10/10	9/10	10/10	9/10
II.	Clearly Defined, Answerable Study Question(s)	10/10	10/10	10/10	10/10
III.	Correctly Identified Study Population	10/10	10/10	10/10	10/10
IV.	Clearly Defined Indicator(s)	10/10	10/10	10/10	10/10
V.	Valid Sampling Techniques*	*NA*	*NA*	*NA*	*NA*
VI.	Accurate/Complete Data Collection	10/10	10/10	10/10	10/10
VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*	9/10	*Not Assessed*	10/10
VIII.	Appropriate Improvement Strategies	*Not Assessed*	6/8	*Not Assessed*	7/8
IX.	Real Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*

*All the PIHPs included the entire eligible population in the PIP. HSAG scored all elements for Activity V as *Not Applicable (NA)* for all PIPs.

Table A-7 presents a two-year comparison of PIP validation scores for each PIHP.

Table A-7—Comparison of PIHP PIP Validation Scores

PIHP	Percent of All Evaluation Elements Met		Percent of Critical Elements Met		Validation Status	
	2017–2018	2018–2019	2017–2018	2018–2019	2017–2018	2018–2019
	Activities I–VI	Activities I–VIII	Activities I–VI	Activities I–VIII	Activities I–VI	Activities I–VIII
Region 1—NorthCare*	100%	93%	100%	100%	*Met*	***Met***
Region 2—NMRE	100%	100%	100%	100%	*Met*	***Met***
Region 3—LRE*	100%	100%	100%	100%	*Met*	***Met***
Region 4—SWMBH*	100%	100%	100%	100%	*Met*	***Met***
Region 5—MSHN*	100%	100%	100%	100%	*Met*	***Met***
Region 6—CMHPSM*	100%	88%	100%	88%	*Met*	***Partially Met***
Region 7—DWIHN*	100%	100%	100%	100%	*Met*	***Met***
Region 8—OCHN	100%	100%	100%	100%	*Met*	***Met***
Region 9—MCCMH*	100%	93%	100%	100%	*Met*	***Met***
Region 10 PIHP*	100%	94%	100%	88%	*Met*	***Partially Met***

*Please note that, for the 2018–2019 validation, the PIHP's PIP was validated for Activities I through VIII.