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# State Fiscal Year 2020 External Quality Review Technical Report *for* Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Executive Summary

## Purpose and Overview of Report

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

The Behavioral Health and Developmental Disabilities Administration (BHDDA) within MDHHS administers and oversees the Michigan Behavioral Health Managed Care program, which contracts with 10 prepaid inpatient health plans (PIHPs) in Michigan to provide Medicaid waiver benefits for people with intellectual and developmental disabilities (IDD), serious mental illness (SMI), and serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs).[1-1] The PIHPs contracted with MDHHS during state fiscal year (SFY) 2020 are displayed in Table 1-1.

**Table 1-1—PIHPs in Michigan**

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

[1-1] The PIHPs serve Medicaid members who require the Medicaid services included under the following: the 1115 Demonstration Waiver, 1915(i); those eligible for the 1115 Healthy Michigan Plan (HMP), the Flint 1115 Waiver, or Community Block Grant, who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW); those eligible for the 1915(c) Children Waivers (Serious Emotional Disturbance Waiver [SEDW] and Children's Waiver Program [CWP]), who are enrolled in program; or those whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHPs also serve individuals covered under the SUD Community Grant.

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

**Table 1-2—Member Populations**

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

## 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 EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-2] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate State efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2020 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each PIHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

**Table 1-3—EQR Activities**

| Activity | Description | CMS Protocol |
|---|---|---|
| Validation of Performance Improvement Projects (PIPs) | This activity verifies whether a PIP conducted by a PIHP used sound methodology in its design, implementation, analysis, and reporting. | Protocol 1. Validation of Performance Improvement Projects |
| Performance Measure Validation (PMV) | This activity assesses whether the performance measures calculated by a | Protocol 2. Validation of Performance Measures |

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 26, 2020.

| Activity | Description | CMS Protocol |
|---|---|---|
| | PIHP are accurate based on the measure specifications and state reporting requirements. | |
| Compliance Review | This activity determines the extent to which a PIHP is in compliance with federal standards and associated state-specific requirements, when applicable. | Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations |

## Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the PIHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each PIHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the PIHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all PIHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Behavioral Health Managed Care program managed by BHDDA. Table 1-4 highlights substantive findings and actionable state-specific recommendations, when applicable, for MDHHS, and specifically BHDDA, to further promote its goals and objectives in its quality strategy. Refer to Section 6 for more details.

**Table 1-4—Statewide Substantive Findings**

| Program Strengths |
|---|
| • Through their participation in state-mandated PIPs, the PIHPs are focusing efforts on specific quality outcomes, explicitly in areas with identified opportunities for improvement within each PIHP's program and the Behavioral Health Managed Care program overall. Although the PIPs have not demonstrated significant improvement in these areas to date, continued implementation of effective initiatives and ongoing evaluation of interventions and focus in these areas should increase the likelihood that there will be a positive impact on members' access to timely and quality services and improve the overall health outcomes of Behavioral Health Managed Care program members.<br>• The assessment of the PIHPs' eligibility and enrollment data systems; medical services data systems, including claims and encounters; Behavioral Health Treatment Episode Data Set (BH-TEDS) data production; and oversight of affiliated Community Mental Health Services Programs (CMHSPs), as applicable, confirmed in general that the PIHPs are collecting data and calculating MDHHS-developed performance indicators in accordance with the MDHHS Codebook specifications. Additionally, nine out of the 10 PIHPs were able to successfully report data for all indicators suggesting BHDDA and its PIHPs are able to accurately report on members' ability to access behavioral health and SUD services timely. Further, performance measure rates demonstrated statewide strengths in quality, timeliness, and access to care for many behavioral health and substance use treatment services as demonstrated by the statewide average for six of seven indicators meeting the MDHHS-established minimum performance standard (MPS).<br>• Results from the three-year compliance review cycle indicated all 10 PIHPs have the ability to appropriately manage and adhere to most of the expectations established for the Behavioral Health Managed Care program through State and federal requirements, as demonstrated by SFY 2018–2020 |

| Program Strengths |
|---|
| aggregated compliance review results scoring between 97 percent and 99 percent, and the majority of the previously identified deficiencies from the first two years in the review cycle being remediated. These high-performance scores indicate the PIHPs have strong foundations in place to provide medically necessary quality and accessible behavioral healthcare services to their members. |

| Program Weaknesses |
|---|
| • **Access to Services and Barriers to Care**<br>– Although the PIHPs developed methodologically sound PIPs, the goal of demonstrating significant improvement was not achieved for eight of the 10 PIHPs during the first remeasurement, with a decrease in performance for seven of the PIP topics. The statewide performance across the PIPs indicate the quality improvement strategies do not appear to be targeting the appropriate barriers, or areas in need of improvement, to achieve the desired outcomes, and/or there may be barriers across the Medicaid program that are inhibiting the PIHPs from seeing real improvement in the identified focus areas.<br>– While most statewide average performance measure scores exceeded their MDHHS-established MPS, Indicator #4a for the adult population fell below the MPS. Additionally, the statewide average performance measure score for Indicator #4a for children decreased by more than 2 percentage points and adults decreased by more than 1 percentage point from the prior year. While Indicator #4a for the adult population fell below the MPS and decreased in percentage points from the prior year, the MDHHS Codebook methodology for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of PIHP performance and results. Further, although Indicator #10 met the MPS statewide, the percentage of readmissions for adults to an inpatient psychiatric unit have increased by more than 3 percentage points over the past year.<br>– Although the PIHPs demonstrated high performance across most compliance standards over the three-year compliance cycle, challenges remain in areas of the program related to utilization management (UM) functions, member appeals, and provider credentialing, potentially contributing to members' unawareness of certain member rights related to accessing services or accessing providers that have not been properly credentialed in accordance with program requirements, which could negatively impact the delivery of quality services. |

| Program Recommendations | |
|---|---|
| **Recommendation** | **Associated Quality Strategy Goals/Objectives** |
| • MDHHS BHDDA could consider conducting a program-wide survey/interview of members receiving PIHP services who have recently accessed psychiatric inpatient services to determine potential barriers members have to accessing timely care, both prior to being seen inpatient, while accessing inpatient services, and after being discharged from the hospital. | **Goal #1:** Ensure high quality and high levels of access to care.<br>**Goal #3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders.<br>**Goal #4:** Reduce racial and ethnic disparities in healthcare and health outcomes. |
| • MDHHS BHDDA could consider collaborating with the PIHPs to identify common barriers that exist amongst the PIHPs in ensuring adult | |

| Program Recommendations | |
|---|---|
| Medicaid members have timely access to follow-up care within seven days of discharge from a psychiatric inpatient unit. Upon identification of common barriers and the root cause of the common barriers, MDHHS could consider developing a general intervention to test within all PIHPs in order to improve adult Medicaid members' timely access to this follow-up care. | |
| • MDHHS BHDDA has indicated that the current methodology within the MDHHS Codebook for indicators #4a and #4b allows for a relatively large volume of exceptions based on the members who refuse and miss appointments, which has led to unclear interpretation of the PIHP performance and results. Based on this, HSAG recommends MDHHS BHDDA continue its efforts to restructure the methodology to disallow exceptions, which will allow for all members to be included in the indicators and provide a clear understanding of PIHP performance, ensuring consistency in PIHP reporting. | |
| • MDHHS could consider reviewing the MDHHS Codebook for opportunities to clarify performance indicator specifications to ensure the PIHPs and MDHHS are able to align primary data sources' documentation directly to the final performance indicator rates as reported to MDHHS and calculated by the PIHPs, CMHSPs, and MDHHS. | **Goal #1:** Ensure high quality and high levels of access to care.<br>• **Objective 1.3:** Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services. |
| • MDHHS could considering enhancing its statewide monitoring efforts in the areas of UM, appeals, and provider credentialing to support program improvement in these areas. | |

# 2. Overview of the Prepaid Inpatient Health Plans

## Managed Care in Michigan

In Michigan, management of the Medicaid program is spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services are managed by the Managed Care Plan Division in the Medical Services Administration (MSA). Long-term services and supports (LTSS) are implemented by three different MDHHS program areas including the Long-Term Care Services Division (MI Choice Program), the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly), and the BHDDA Quality Division. BHDDA also administers Medicaid waivers for people with IDD, SMI, and SED, and it administers prevention and treatment services for SUDs. Table 2-1 displays the Michigan managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program.

**Table 2-1—Michigan Managed Care Programs**

| Medicaid Managed Care Program | MCEs | MDHHS Division |
|---|---|---|
| Comprehensive Health Care Program (CHCP), including:<br>• Children's Health Insurance Program (CHIP)—MIChild<br>• Children's Special Health Care Services Program<br>• Healthy Michigan Plan (HMP) (Medicaid Expansion)<br>• Flint Medicaid Expansion Waiver | Medicaid Health Plans (MHPs) | MSA |
| Managed LTSS, including:<br>• MI Health Link Demonstration | Integrated Care Organizations (ICOs)<br>PIHPs | MSA |
| Dental Managed Care Programs, including:<br>• Healthy Kids Dental<br>• Pregnant Women Dental<br>• HMP Dental | Prepaid Ambulatory Health Plans (PAHPs) | MSA |
| Behavioral Health Managed Care | PIHPs | BHDDA |

## Behavioral Health Managed Care

Under approval granted by CMS, MDHHS operates an 1115 Behavioral Health Demonstration Waiver. Under this waiver, selected Medicaid State plan specialty services related to mental health and developmental disability services, as well as certain covered substance use services, have been carved out from Medicaid primary physical healthcare plans and arrangements. CMS also approved an 1115 Demonstration Waiver titled the HMP, which provides healthcare coverage for adults who become eligible for Medicaid under section 1902(2)(10)(A)(i)(VIII) of the Social Security Act. In Michigan, the 1115 Behavioral Health Demonstration Waiver and the HMP are managed on a shared risk basis by specialty PIHPs, selected through an Application for Participation process to manage the services included as part of the Behavioral Health Managed Care program. These services include treatment for people with SMI, SED, SUD and IDD. Mental health services include State plan and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, 1915(i) waiver services and 1915(c) waiver services (CWP, HSW, and SEDW). All substance abuse services are covered under the State plan (or alternative benefit plan) for the HMP population.

BHDDA within MDHHS administers and oversees the Behavioral Health Managed Care program. BHDDA services and supports in Michigan are delivered through county-based CMHSPs. Michigan uses a managed care delivery structure including 10 PIHPs who contract for service delivery with 46 CMHSPs and other not-for-profit providers to provide mental health, substance abuse prevention and treatment, and developmental disability services to eligible members. PIHPs are required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults, and family-driven and youth-guided services for children. Through a combination of different PIHP/CMHSP management and service delivery models, CMHSPs are normally contracted to directly provide or contract for the majority of direct services including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery.

## Overview of PIHPs

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

**Table 2-2—PIHP Profiles[2-1]**

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

## Quality Strategy

The 2020–2023 MDHHS Comprehensive Quality Strategy (CQS) provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, LTSS, dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. Michigan's CQS is organized around the three aims of the NQS—better care, healthy people and communities, and

[2-1] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration. *10 Region PIHP Directors & Affiliates.* Available at: https://www.michigan.gov/documents/PIHPDIRECTOR_97962_7.pdf. Accessed on: Nov 1, 2020.

affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

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

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

[2-2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Jan 28, 2021.

| Michigan CQS Managed Care Program Goals | MDHHS Strategic Priorities | Objectives |
|---|---|---|
| | | **Objective 2.5:** Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community. |
| **Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)** | | |
| **NQS Aim #1: Better Care**<br><br>MDHHS Pillar #3: Serve the whole person | Address food and nutrition, housing, and other social determinants of health<br><br>Integrate services, including physical and behavioral health, and medical care with long-term support services | **Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems. |
| | | **Objective 3.2:** Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations. |
| | | **Objective 3.3:** Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. |
| **Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes** | | |
| **NQS Aim #1: Better Care**<br><br>MDHHS Pillar #1: Give all kids a healthy start<br><br>MDHHS Pillar #3: Serve the whole person | Improve maternal-infant health and reduce outcome disparities<br><br>Address food and nutrition, housing, and other social determinants of health<br><br>Integrate services, including physical and behavioral health, and medical care with long-term support services | **Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible. |
| | | **Objective 4.2:** Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process. |
| | | **Objective 4.3:** Promote and ensure access to and participation in health equity training. |
| | | **Objective 4.4:** Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations. |
| | | **Objective 4.5:** Expand and share promising practices for reducing racial disparities. |
| | | **Objective 4.6:** Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities. |

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

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

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

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

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

## *Quality Initiatives and Interventions*

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

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or the Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can

access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.

- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring plans to coordinate behavioral health services and services for persons with disabilities with the CMHSPs/PIHPs. While contracted plans may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.
- **Value-based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. Managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.
- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.
- **National Core Indicators (NCI)® Adult Consumer Survey**—Michigan participates in the NCI survey, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with IDD. Performance indicators within the survey assess individual outcomes, health, welfare, and rights (e.g., safety and personal security, health and wellness, and protection of and respect for individual rights); and system performance (e.g., service coordination, family and individual participation in provider-level decisions, the utilization of and outlays for various types of services and supports, cultural competency, and access to services).

# 3. Assessment of PIHP Performance

## PIHP Methodology

HSAG used findings across mandatory EQR activities conducted during the SFY 2020 review period to evaluate the performance of the PIHPs on providing quality, timely, and accessible healthcare services to Behavioral Health Managed Care program 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 the provision of healthcare services across the Behavioral Health 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.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

### *Validation of Performance Improvement Projects*

For the SFY 2020 validation, the PIHPs continued their MDHHS-mandated PIP topics reporting Remeasurement 1 study indicator outcomes. The purpose of each PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. HSAG's PIP validation ensures that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the PIHP during the project.

Table 3-1 outlines the selected PIP topics and study indicator(s) for all PIHPs.

**Table 3-1—PIP Topic and Study Indicator(s)**

| PIHP | PIP Topic | Study Indicator(s) |
|---|---|---|
| NorthCare | *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 six (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 (7) days of discharge.<br>2. The percentage of discharged enrollees age 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 (7) days of discharge. |

| PIHP | PIP Topic | Study Indicator(s) |
|---|---|---|
| NMRE | *Follow-Up Care for Children Prescribed Attention/Hyperactivity Disorder (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 practitioner with prescribing authority during the 30-day Initiation Phase.<br>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. |
| LRE | *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. |
| SWMBH | *Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication* | The percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period. |
| MSHN | *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. |
| CMHPSM | *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test* | The percentage of members ages 18–64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year. |
| DWIHN | *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. |
| OCHN | *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* | The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication. |
| MCCMH | *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness (SMI)* | 30-day Hospital Readmission |
| Region 10 | *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. |

## Performance Measure Validation

The purpose of PMV is to assess the accuracy of performance measures reported by PIHPs and to determine the extent to which performance measures reported by the PIHPs follow reporting requirements. For the SFY 2020 PMV, HSAG validated the PIHPs' data collection and reporting processes used to calculate rates for a set of performance indicators that were developed and selected by MDHHS for validation. The data collection and reporting processes evaluated included the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, and the PIHP's oversight of affiliated CMHSPs. The PMV included a review of the PIHPs' data for the first quarter of SFY 2020.

Based on all validation methods used to collect information during the Michigan SFY 2020 PMV, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. The performance indicators developed and selected by MDHHS for the PMV, which included a readiness review of the three new indicators, are identified in Table 3-2.

**Table 3-2—Performance Indicators**

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

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

*New indicator for SFY 2020.

## Compliance Review

The PIHP compliance review consisted of an evaluation of each PIHP's performance in 17 program areas, called standards, identified in Table 3-3. These standards encompass all federally mandated requirements under 42 CFR §438.358(b)(iii) and state-specified contract requirements. HSAG reviewed half of the standards during the SFY 2018 review and the remaining half of the standards during the SFY 2019 review. At the conclusion of each year's review, MDHHS required the PIHPs to develop a corrective action plan (CAP) for each element that did not achieve full compliance. For the third year of the three-year compliance review cycle (SFY 2020 review period), MDHHS requested that HSAG conduct a comprehensive desk review of the completed SFY 2018 and SFY 2019 CAPs.

**Table 3-3—Compliance Review Standards**

| SFY 2018 | SFY 2019 |
|---|---|
| Standard VI—Customer Service | Standard I—QAPIP Plan and Structure |
| Standard VII—Grievance Process | Standard II—Quality 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 |

# EQR Activity Results

## *Region 1—NorthCare Network*

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-4 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goals for the PIP topic.

**Table 3-4—Overall Validation Rating for NorthCare Network**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older* | *Not Met* | 1. The percentage of discharged enrollees ages six (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 (7) days of discharge. | 65.5% | 61.5% ⇔ | | 75.3% |
| | | 2. The percentage of discharged enrollees age 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 (7) days of discharge. | 60.3% | 62.0% ⇔ | | 62.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **NorthCare Network** revised the baseline data results. The PIHP described that the baseline data submitted in the prior year incorrectly included hospital admissions resulting in an underreporting of results.

Table 3-5 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-5—Remeasurement 1 Interventions for NorthCare Network**

| Intervention Descriptions | |
|---|---|
| Developed electronic resources for clinicians to access when providing emergency services and discharge planning. | Addressed training needs through various committees and developed strategies to enhance providers' capabilities for co-occurring SUDs. |
| Sent discharge notifications for shared members to Upper Peninsula Health Plan upon discharge for follow-up appointments scheduled post discharge. | Provided members with discharge planning that included housing information, transportation assistance resources, and alternative means of follow-up. |
| Required the use of evidenced-based standards for determining levels of care relating to authorization for inpatient admissions. | Provided training on transition from inpatient psychiatric services policy requirements to the committees. |

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: NorthCare Network** designed a methodologically sound PIP.

**Strength: NorthCare Network** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

**Weaknesses**

**Weakness: NorthCare Network** demonstrated a decrease in the percentage of members ages 6 to 20 years receiving a follow-up visit with a mental health practitioner within seven days of a hospital discharge for mental illness.

**Why the weakness exists:** While it is unclear what led to the decrease in performance, **NorthCare Network** noted that several implemented interventions had an indirect impact on the study indicators and were difficult to evaluate for effectiveness.

**Recommendation:** HSAG recommends that **NorthCare Network** reassess barriers linked to members 6 to 20 years of age and develop active interventions that can be tracked and trended to determine the impact on the study indicator outcomes. The results should be used to guide decisions for quality improvement efforts.

## Performance Measure Validation

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

**NorthCare Network** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **NorthCare Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

### *Performance Results*

Table 3-6 presents **NorthCare Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-6—Performance Measure Results for NorthCare Network**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 100.00% | 95.00% |
| *Adults* | 100.00% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *Children* | 100.00% | 95.00% |
| *Adults* | 100.00% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 100.00% | 95.00% |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 7.47% | — |
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 99.47% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 18.76% | — |
| *IDD Adults* | 9.40% | — |
| *MI/IDD Adults* | 9.98% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 97.00% | — |
| *IDD Adults* | 43.86% | — |
| *MI/IDD Adults* | 53.13% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 7.14% | 15.00% |
| *MI Adults and IDD Adults* | 9.71% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 16.49% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 55.41% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: NorthCare Network**'s performance exceeded the corresponding MPS for seven of seven measure indicators, suggesting child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** There were no identified weaknesses.

**Recommendation:** Although there were no identified weaknesses, during the SFY 2019 audit, the PIHP mentioned exploring the option of allowing institutional providers to enter claims directly into its electronic health record (EHR), which is not currently set up for 837 file uploads. HSAG recommends that **NorthCare Network** work toward allowing inpatient services to be directly entered by institutional providers into its EHR system in order to increase the completeness and accuracy of claims and encounter data. HSAG further recommends that **NorthCare Network** staff members continue to validate and ensure the accuracy of reported data for all performance indicators and provide sufficient oversight of its CMHSPs.

## Compliance Review

### *Performance Results*

Table 3-7 presents an overview of the combined results of the three-year cycle of compliance reviews for **NorthCare Network**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-7 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-7—Summary of Results for the Three-Year Cycle of Compliance Reviews for NorthCare Network**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 7 | 1 | 1 | 0 | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 6 | 2 | 2 | 0 | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **III** | Practice Guidelines | 4 | 3 | 1 | 1 | 0 | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 11 | 5 | 3 | 2 | **88%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 24 | 2 | 2 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 11 | 2 | 2 | 0 | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 10 | 1 | 1 | 0 | **100%** |
| **X** | Provider Network | 12 | 11 | 1 | 1 | 0 | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 4 | 0 | **100%** |
| **XII** | Access and Availability | 19 | 18 | 1 | 1 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 42 | 12 | 12 | 0 | **100%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 10 | 0 | NA | NA | **100%** |
| **XVII** | Management Information Systems | 12 | 10 | 2 | 2 | 0 | **100%** |
| | **Total** | **269** | **230** | **39** | **37** | **2** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: NorthCare Network**'s plans of action remediated 37 of 39 previously identified deficiencies. Overall, during the three-year compliance review cycle, 267 of 269 elements received a *Met* score, indicating that **NorthCare Network** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **NorthCare Network** initially struggled with operationalizing all appeal functions, through the CAP process, **NorthCare Network** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **NorthCare Network** also successfully addressed several deficiencies related to its analysis of Quality Assessment Performance Improvement Program (QAPIP) activities, member materials (member handbook and provider directory), and provider credentialing.

**Weaknesses**

**Weakness:** While **NorthCare Network** demonstrated a fair appeal process once an appeal was received, it did not consistently provide members with adequate information within the adverse benefit determinations (ABDs). Insufficient information via an ABD notice may be a barrier for members in making an informed decision on whether or not to file an appeal.

**Why the weakness exists: NorthCare Network**'s ABD notices did not include the policy or authority relied upon in making the determination that specifically related to the member's health status and service in question. **NorthCare Network** also did not include in the ABD notices the specific reason for the denial pertaining to the member's circumstance, but instead provided various potential reasons for the denial. Further, **NorthCare Network** did not provide members with an ABD notice with appeal rights when a denial of payment on a claim was made.

**Recommendation:** HSAG recommends that **NorthCare Network** revisit its procedures for generating ABD notices. UM staff members should be reeducated on the appropriate inclusion of the specific policy, authority, or criteria that supports the ABD. HSAG does not recommend that ABD notices include multiple citations or references, but instead, the ABD should include specific criteria used by UM staff that supports the denial of the service. HSAG also recommends that **NorthCare Network**'s UM and claims departments collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.

## Region 2—Northern Michigan Regional Entity

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-8 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goals for the PIP topic.

**Table 3-8—Overall Validation Rating for Northern Michigan Regional Entity**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Follow-Up Care for Children Prescribed Attention/Hyperactivity Disorder (ADHD) Medication* | *Not Met* | 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 practitioner with prescribing authority during the 30-day Initiation Phase. | 65.2% | 64.2% ⇔ | | 72.5% |
| | | 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. | 96.8% | 79.0% ↓ | | 96.8% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

The Remeasurement 1 plan-designated goal for the second study indicator was to maintain the baseline performance. Within the most recent submission, **Northern Michigan Regional Entity** revised the baseline data results. The PIHP described that the baseline data submitted in the prior year contained an error in the collection of member historical data used to determine eligibility for inclusion into the project.

Table 3-9 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-9—Remeasurement 1 Interventions for Northern Michigan Regional Entity**

| Intervention Descriptions | |
|---|---|
| Implemented a process for psychiatric clerical staff and an automated messaging system to make routine reminder calls to members regarding scheduled appointments. | Coordinated care with the primary care physician (PCP) who originally prescribed the medications to obtain records as needed for tracking purposes. |
| Provided education to school prevention workers and service staff on continued communication with the family regarding the importance of follow-up with PCPs. | Provided an informational packet to members regarding recommendations for follow-up care after being prescribed an ADHD medication. |
| Developed standard of care guidelines and implemented a procedure to meet the Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] measure. | Notified and educated psychiatrists to schedule the initial follow-up visit within 30 days. |
| CMHSP facilitated and participated in monthly care coordination meetings with community partners that are in the prescribing physicians' groups. | Conducted chart reviews. |
| CMHSP hired a full-time child psychiatrist to address the limited number of staff members available to achieve the procedure of scheduling an appointment within the initial 30 days. | |

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Northern Michigan Regional Entity** designed a methodologically sound PIP.

**Strength: Northern Michigan Regional Entity** utilized appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

**Weaknesses**

**Weakness: Northern Michigan Regional Entity** demonstrated a decrease in the percentage of members ages 6 to 12 years who were compliant for both study indicators.

**Why the weakness exists:** While it is unclear what led to the decrease in performance, **Northern Michigan Regional Entity** had opportunities for improvement in the collection and reporting of evaluation results for each intervention.

**Recommendation:** HSAG recommends that **Northern Michigan Regional Entity** develop evaluation methods for each intervention to demonstrate their effectiveness on the study indicator outcomes and guide decisions for quality improvement efforts. HSAG further recommends that **Northern Michigan Regional Entity** conduct a root cause analysis to identify the reasons for the decrease in performance rates.

[3-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## Performance Measure Validation

HSAG evaluated **Northern Michigan Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, BH-TEDS data production, and oversight of affiliated CMHSPs.

**Northern Michigan Regional Entity** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Northern Michigan Regional Entity** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported.

### *Performance Results*

Table 3-10 presents **Northern Michigan Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-10—Performance Measure Results for Northern Michigan Regional Entity**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 96.30% | 95.00% |
| *Adults* | 96.99% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 95.83% | 95.00% |
| *Adults* | 93.80% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 98.61% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 7.92% | — |
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.95% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 20.47% | — |
| *IDD Adults* | 12.13% | — |
| *MI/IDD Adults* | 18.81% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 99.16% | — |
| *IDD Adults* | 48.03% | — |
| *MI/IDD Adults* | 75.16% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 4.62% | 15.00% |
| *MI Adults and IDD Adults* | 9.77% | 15.00% |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 22.02% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 51.24% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Northern Michigan Regional Entity**'s performance exceeded the corresponding MPS for six of seven measure indicators, suggesting most child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Although the rate for Indicator #4a fell below the MPS, the methodology within the MDHHS Codebook for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Northern Michigan Regional Entity** consult with MDHHS to clarify the methodology specifically regarding the exceptions for this indicator.

**Weakness:** During primary source verification (PSV), HSAG noted SUD providers did not clearly document exception reasons for Indicator #4b, indicating there may be ambiguity in determining whether the exception reason was appropriate based on the MDHHS Codebook specifications.

**Why the weakness exists:** SUD providers are responsible for entering claims directly into the PIHP's EHR system and must clearly document the reasons for all exclusions for Indicator #4b according to the MDHHS Codebook specifications. This did not occur in all instances.

**Recommendation:** HSAG recommends that **Northern Michigan Regional Entity** implement additional training for SUD providers on clear documentation of exclusions

and exception reasons for Indicator #4b. HSAG also recommends that **Northern Michigan Regional Entity** complete additional validation checks on reported exceptions for Indicator #4b.

## Compliance Review

### *Performance Results*

Table 3-11 presents an overview of the combined results of the three-year cycle of compliance reviews for **Northern Michigan Regional Entity**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-11 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-11—Summary of Results for the Three-Year Cycle of Compliance Reviews for Northern Michigan Regional Entity**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 5 | 3 | 1 | 2 | **75%** |
| **II** | Quality Measurement and Improvement | 8 | 4 | 4 | 3 | 1 | **88%** |
| **III** | Practice Guidelines | 4 | 3 | 1 | 0 | 1 | **75%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 9 | 7 | 4 | 3 | **81%** |
| **VI** | Customer Service | 39 | 35 | 4 | 4 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 21 | 5 | 5 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 11 | 2 | 2 | 0 | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 10 | 1 | 1 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 4 | 0 | **100%** |
| **XII** | Access and Availability | 19 | 12 | 7 | 7 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **XIV** | Appeals | 54 | 44 | 10 | 10 | 0 | **100%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 6 | 4 | 4 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 12 | 0 | NA | NA | **100%** |
| | **Total** | **269** | **217** | **52** | **45** | **7** | **97%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Northern Michigan Regional Entity**'s plans of action remediated 45 of 52 identified deficiencies. Overall, 262 of 269 elements received a *Met* score, indicating that **Northern Michigan Regional Entity** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Northern Michigan Regional Entity** initially struggled with operationalizing all appeal functions, through the CAP process, **Northern Michigan Regional Entity** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **Northern Michigan Regional Entity** also successfully addressed several requirements related to critical incident (CI) procedures, member materials (member handbook and provider directory), the grievance process, provider credentialing, performance indicators, and the use and disclosure of protected health information (PHI) procedures.

**Weaknesses**

**Weakness:** While **Northern Michigan Regional Entity** demonstrated a fair appeal process once an appeal was received, it did not consistently provide members with adequate information within the ABDs. Insufficient information via an ABD notice may be a barrier for members in making an informed choice on whether or not to file an appeal.

**Why the weakness exists:** **Northern Michigan Regional Entity**'s ABD notices did not include the policy or authority relied upon in making the determination that specifically related to the member's health status and service in question and instead included various references or citations. While notices explained that members did not meet clinical eligibility criteria for services, they did not specifically inform the members of the reason why the services were not medically necessary. Some notices included outdated and inaccurate information or included confusing language. Further, **Northern Michigan Regional Entity** did not provide members with an ABD notice with appeal rights when a denial of payment on a claim was made.

**Recommendation:** HSAG recommends that **Northern Michigan Regional Entity** revisit its procedures for generating ABD notices. UM staff should be reeducated on the appropriate inclusion of the specific policy, authority, or criteria that supports the ABD and the inclusion of the specific reason why a member did not meet criteria. HSAG does not recommend that ABD notices include multiple citations or references, but instead, the specific criteria used by UM staff that supports the denial of the service. Additionally, HSAG recommends that **Northern Michigan Regional Entity** prioritize the review of the CMHSP that had outdated and inaccurate information in its notice and take action as appropriate. HSAG also recommends that **Northern Michigan Regional Entity**'s UM and claims departments collaborate to develop a process to generate an ABD notice when a payment on a claim is denied.

**Weakness:** **Northern Michigan Regional Entity** did not complete a meaningful analysis of certain activities of it QAPIP; specifically, an analysis of data from the Behavior Treatment Committee (BTC) including the length of time interventions were used, and an analysis of CIs, sentinel events (SEs), and risk events (REs). A comprehensive analysis of activities is needed to prevent, detect, and remediate concerns, and assure the health and welfare of members.

**Why the weakness exists:** **Northern Michigan Regional Entity** self-identified challenges in its current processes of aggregating data such as inconsistent reporting between CMHSPs and the usability of the data that are being reported.

**Recommendation:** HSAG recommends that the **Northern Michigan Regional Entity** develop a standardized template for CIs, SEs and REs, and data from the BTC; and mandate their use across all reporting entities (i.e., CMHSPs, SUD providers, etc.). Further, HSAG recommends that **Northern Michigan Regional Entity**'s analysis and subsequent interventions focus on data elements that have the greatest potential to impact member care and outcomes. The results of the analyses and any subsequent actions should be included in **Northern Michigan Regional Entity**'s committee meeting minutes.

**Weakness:** The **Northern Michigan Regional Entity** annual QAPIP review was limited and did not demonstrate a comprehensive evaluation of its QAPIP. A comprehensive evaluation is needed to identify trends and opportunities for improvement, and subsequently implement improvement action plans and drive improvement.

**Why the weakness exists:** The annual QAPIP did not include a summary of all activities required to be included in the QAPIP. It also lacked measurable goals for most activities, which are needed in determining the effectiveness of **Northern Michigan Regional Entity**'s QAPIP.

**Recommendation:** HSAG recommends that **Northern Michigan Regional Entity** review contract and federal regulations for all activities that are required to be included in a QAPIP. **Northern Michigan Regional Entity** should develop a comprehensive work plan that identifies measurable goals and objectives, interventions, time frames, and the responsible person or department for each activity. Each activity should be addressed in the annual effectiveness review of the QAPIP and include an evaluation of **Northern Michigan Regional Entity**'s progress on meeting its performance goals.

## Region 3—Lakeshore Regional Entity

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-12 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-12—Overall Validation Rating for Lakeshore Regional Entity**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)* | *Met* | The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period. | 32.4% | 37.9% ↑ | | 50.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Lakeshore Regional Entity** revised the baseline data results. The PIHP described that the baseline data submitted in the prior year contained a programming logic that incorrectly captured members receiving either the HbA1c or the LDL-C rather than members who received both tests.

Table 3-13 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-13—Remeasurement 1 Interventions for Lakeshore Regional Entity**

| Intervention Descriptions | |
|---|---|
| Provided education to each of the CMHSP leadership, conducted staff meetings, convened the quality improvement Regional Operations Advisory Team (ROAT), and conducted PIHP leadership and physicians' meetings on the purpose of and importance of the PIP. | Developed a new Integrated Care Data Platform (ICDP) report for each CMHSP that includes members with dual Medicare/Medicaid enrollment and from which CMHSP services are received. Four of the five CMHSPs and plan staff members have access to the system housing Medicare claims to review receipt of HbA1c and LDL-C testing. |
| Developed a reminder card/note to give to members at the time of services to inform them it is time for their annual HbA1c and LDL-C lab test that provides instructions to contact their PCP to schedule their lab test. | Generated a monthly report for each of the CMHSPs. The report included the names of members who have not had their HbA1c and LDL-C testing completed. |

### *Strengths, Weaknesses, and Recommendations*

| | |
|---|---|
| **Strengths** | **Strength: Lakeshore Regional Entity** met 100 percent of the requirements for data analysis and implementation of improvement strategies. |
| | **Strength: Lakeshore Regional Entity** achieved the goal of statistically significant improvement over the baseline rate for the first remeasurement period. |
| **Weaknesses** | **Weakness:** There were no identified weaknesses. |
| | **Recommendation:** Although there were no identified weaknesses, HSAG recommends, as **Lakeshore Regional Entity** progresses into the second remeasurement, the PIHP revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps. |

## Performance Measure Validation

HSAG evaluated **Lakeshore Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, and oversight of the five affiliated CMHSPs; however, an issue was discovered during PSV of member records that resulted in a *Do Not Report* designation for one indicator.

**Lakeshore Regional Entity** received an indicator designation of *Reportable* for nine indicators, signifying that **Lakeshore Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Lakeshore Regional Entity** received an indicator designation of *Do Not Report* for Indicator #4a, indicating that **Lakeshore Regional Entity** did not calculate that indicator in compliance with MDHHS Codebook specifications. Additionally, the new indicators for SFY 2020, in which data were not available, received an indicator designation of *Not Applicable*.

### *Performance Results*

Table 3-14 presents **Lakeshore Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-14—Performance Measure Results for Lakeshore Regional Entity**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 98.85% | 95.00% |
| *Adults* | 95.71% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.*** | | |
| *Children* | DNR | 95.00% |
| *Adults* | DNR | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***+ | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 98.50% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 6.13% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.17% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 16.20% | — |
| *IDD Adults* | 9.80% | — |
| *MI/IDD Adults* | 10.02% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 98.46% | — |
| *IDD Adults* | 64.87% | — |
| *MI/IDD Adults* | 71.19% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 8.16% | 15.00% |
| *MI Adults and IDD Adults* | 9.36% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 14.44% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 48.12% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

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

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Lakeshore Regional Entity**'s performance exceeded the corresponding MPS for five of seven measure indicators, suggesting many child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness: Lakeshore Regional Entity** received an indicator designation of *Do Not Report* for Indicator #4a, indicating insufficient and inconsistent processes were in place to assure accuracy of its reported data for this indicator.

**Why the weakness exists:** A CMHSP's manual process for updating discharge dates to align with hospital documentation created a risk for inaccurately documenting dates within the EHR system. During PSV, HSAG identified one out of five records (20 percent) reviewed contained an incorrect date. **Lakeshore Regional Entity** was unable to provide evidence of consistent use of a defined field for the CMHSP's reporting of data related to this indicator.

**Recommendation:** While **Lakeshore Regional Entity** took immediate corrective action with the CMHSP to mitigate future reporting issues, HSAG recommends **Lakeshore Regional Entity** oversee the successful implementation of required CMHSP corrective action to ensure complete and accurate performance indicator data in the future. This oversight process should ensure appropriate data entry controls are in place to prevent inaccurate manual entry of dates that are used for performance indicator reporting.

**Weakness:** HSAG reviewed the final BH-TEDS data submitted by MDHHS and identified five member records with discrepant non-competitive workforce and minimum wage status BH-TEDS data.

**Why the weakness exists:** While the PIHP and all of the CMHSPs noted processes in place to check for BH-TEDS data entry discrepancies (e.g., categorizing the member as having "Full-time Competitive Integrated Employment" versus "Unemployed"), these validation processes did not entirely prevent discrepancies from occurring within the data.

**Recommendation:** HSAG recommends **Lakeshore Regional Entity** and the CMHSPs employ enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in non-competitive workforce and minimum wage status values. HSAG also recommends that **Lakeshore Regional Entity** and the CMHSPs continue to perform enhanced data quality and completeness checks before the data are submitted to the State.

**Weakness:** Through the review of the PIHP's oversight of affiliated CMHSPs, HSAG identified that CMHSP staff members' EHR data entry processes were not always consistent amongst each other.

**Why the weakness exists:** As related to reporting of the new performance indicators, although **Lakeshore Regional Entity** provided additional information to describe the procedures for coordinating the activities of its CMHSPs to ensure accuracy of the data for the new indicators, the procedures were not yet fully implemented as of the readiness review.

**Recommendation:** Due to the varied level of CMHSP readiness to leverage EHR documentation in reporting the new indicators, HSAG recommends **Lakeshore Regional Entity** conduct additional intensive monitoring efforts to oversee the first year of reporting for all three new indicators.

**Weakness:** A non-Medicaid member was erroneously included in the PIHP's member-level detail data provided for the PMV.

**Why the weakness exists:** Although the reason is not clear, an inaccurate enrollment date for the member was stored within the CMHSP's system used for the purpose of measure reporting.

**Recommendation:** HSAG recommends that **Lakeshore Regional Entity** enhance its oversight processes to ensure that accurate enrollment dates are stored within the CMHSPs' systems for the purposes of measure reporting. Additionally, HSAG recommends **Lakeshore Regional Entity** retain the exact member-level detail data that was used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Lakeshore Regional Entity**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.

## Compliance Review

### *Performance Results*

Table 3-15 presents an overview of the combined results of the three-year cycle of compliance reviews for **Lakeshore Regional Entity**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-15 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-15—Summary of Results for the Three-Year Cycle of Compliance Reviews for Lakeshore Regional Entity**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 5 | 3 | 2 | 1 | **88%** |
| **II** | Quality Measurement and Improvement | 8 | 5 | 3 | 3 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 3 | 1 | 1 | 0 | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 9 | 7 | 4 | 3 | **81%** |
| **VI** | Customer Service | 39 | 33 | 6 | 6 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 26 | 0 | NA | NA | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 10 | 3 | 3 | 0 | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 9 | 2 | 1 | 1 | **91%** |
| **X** | Provider Network | 12 | 11 | 1 | 1 | 0 | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 3 | 1 | **89%** |
| **XII** | Access and Availability | 19 | 12 | 7 | 7 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 33 | 21 | 20 | 1 | **98%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 13 | 1 | 1 | 0 | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 2 | 8 | 8 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 10 | 2 | 2 | 0 | **100%** |
| | **Total** | **269** | **200** | **69** | **62** | **7** | **97%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Lakeshore Regional Entity**'s plans of action remediated 62 of 69 identified deficiencies. Overall, 262 of 269 elements received a *Met* score, indicating that **Lakeshore Regional Entity** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Lakeshore Regional Entity** initially struggled with operationalizing all appeal functions, through the CAP process, **Lakeshore Regional Entity** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **Lakeshore Regional Entity** also successfully addressed several requirements related to QAPIP activities, member materials (member handbook and provider directory) and member rights, provider credentialing, performance indicators, and the use and disclosure of PHI procedures.

**Weaknesses**

**Weakness: Lakeshore Regional Entity** struggled to implement several UM requirements; specifically, service authorization requirements and notices of ABD. Insufficient information via an ABD notice may be a barrier for members in making an informed choice on whether or not to file an appeal.

**Why the weakness exists: Lakeshore Regional Entity**'s notice of ABD did not include the required citation, 42 CFR §440.230(d), providing the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures. **Lakeshore Regional Entity** also did not establish a process for providing members with an ABD notice when it denies a payment of a claim. Further, there appeared to be a lack of understanding of when an ABD notice must be sent to a member for untimely service authorization decisions.

**Recommendation:** HSAG recommends that **Lakeshore Regional Entity** revisit its procedures for generating ABD notices and reeducate staff on the appropriate citation(s) required to be included in a notice, and when a notice must be generated and sent to a member when **Lakeshore Regional Entity** fails to make a decision timely. HSAG also recommends that **Lakeshore Regional Entity**'s UM and claims departments collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.

## Region 4—Southwest Michigan Behavioral Health

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-16 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-16—Overall Validation Rating for Southwest Michigan Behavioral Health**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication* | *Not Met* | The percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period. | 76.9% | 76.4% ⇔ | | 80.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Southwest Michigan Behavioral Health** revised the baseline data results. The PIHP described that the baseline data submitted in the prior year improperly calculated gaps in Medicaid coverage, which is used to determine eligibility for inclusion into the study indicators.

Table 3-17 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-17—Remeasurement 1 Interventions for Southwest Michigan Behavioral Health**

| Intervention Descriptions | |
|---|---|
| In the absence of integration, the PIHP sent monthly member lists of individuals without a diabetes screening to the CMHSP physical health providers. | CMHSPs implemented protocols for diabetes screenings. |
| The PIHP lobbied at the state level to make the study indicator a joint metric with the physical health plans. | Implemented a regional policy. |
| The PIHP provided educational materials to the CMHSPs' clinicians on how to bill for diabetes and how to provide information to members on the importance of treatment for diabetes. | |

### *Strengths, Weaknesses, and Recommendations*

| | |
|---|---|
| **Strengths** | **Strength: Southwest Michigan Behavioral Health** designed a methodologically sound PIP. |
| | **Strength: Southwest Michigan Behavioral Health** utilized appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers. |
| **Weaknesses** | **Weakness: Southwest Michigan Behavioral Health**'s eligible population demonstrated a decrease in the percentage of members with schizophrenia or bipolar disorder taking an antipsychotic medication who were screened for diabetes. |
| | **Why the weakness exists: Southwest Michigan Behavioral Health** developed interventions targeting its CMHSPs and the individuals they serve, describing significant improvement among this population. However, no statewide policy was in place for the MHPs to coordinate with the PIHPs for this PIP, even though members who were not receiving services through the PIHP/CMHSP were included in the PIP study population. The PIHP identified that individuals receiving behavioral health services through the MHPs did not demonstrate improved performance, indicating that interventions targeting members receiving behavioral health services outside of the PIHP/CMHSP (i.e., MHP) must also be developed to achieve the desired outcomes. |
| | **Recommendation:** HSAG recommends **Southwest Michigan Behavioral Health** reassess barriers for individuals served both by, and outside of, the CMHSPs (i.e., MHPs) and develop appropriate and active interventions to address those barriers. |

## Performance Measure Validation

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

**Southwest Michigan Behavioral Health** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Southwest Michigan Behavioral Health** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

### *Performance Results*

Table 3-18 presents **Southwest Michigan Behavioral Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-18—Performance Measure Results for Southwest Michigan Behavioral Health**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 100.00% | 95.00% |
| *Adults* | 99.39% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 100.00% | 95.00% |
| *Adults* | 97.66% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 95.47% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 7.24% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.63% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 17.54% | — |
| *IDD Adults* | 10.95% | — |
| *MI/IDD Adults* | 6.90% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 98.40% | — |
| *IDD Adults* | 82.17% | — |
| *MI/IDD Adults* | 74.39% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 4.35% | 15.00% |
| *MI Adults and IDD Adults* | 10.65% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 21.85% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 53.13% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Southwest Michigan Behavioral Health**'s performance exceeded the corresponding MPS for seven of seven measure indicators, suggesting child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Final BH-TEDS data submitted by MDHHS included two individual records that contained data discrepancies related to member non-competitive workforce and minimum wage status.

**Why the weakness exists: Southwest Michigan Behavioral Health**'s validation processes did not entirely prevent discrepancies from occurring within the data.

**Recommendation:** HSAG recommends **Southwest Michigan Behavioral Health** and its CMHSPs employ enhancements to the recently implemented validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered. This validation process should account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system, data entry errors, and discrepancies in non-competitive workforce and minimum wage status values. HSAG also recommends that **Southwest Michigan Behavioral Health** and its CMHSPs clearly define the processes for entering the data into the PIHP's electronic medical record (EMR) and perform additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State. HSAG further recommends that **Southwest Michigan Behavioral Health** implement additional validation processes and procedures to ensure the accuracy of reported data for all performance indicators and ensure there is sufficient oversight of its CMHSPs and continuous monitoring of CAPs.

**Weakness:** Related to Indicator #1, one CMHSP acknowledged errors by the employee conducting the pre-admission screening as it relates to accurately recording a disposition date within the EMR system. After reviewing the member-level detail file provided by **Southwest Michigan Behavioral Health**, HSAG found four out of 338 cases that would be affected by this oversight, which accounted for a little over 1 percent of the CMHSP's Q1 SFY 2020 records reported for this indicator.

**Why the weakness exists:** There were no system edits or validations in place to prevent unpopulated data in the pre-admission screening field.

**Recommendation:** Upon identification of this data integrity risk in the existing process, **Southwest Michigan Behavioral Health** immediately requested a CAP of the CMHSP to remedy the deficiency related to not recording a disposition date in the pre-admission screening field. The CMHSP indicated that it will be adding signature validations to disallow unpopulated data in the pre-admission screening field. HSAG recommends that **Southwest Michigan Behavioral Health** monitor and verify the CMHSP CAP to ensure completeness of the information being captured for future reporting.

**Weakness:** HSAG identified that the member-level detail data counts did not always align with the final performance indicator calculated rates.

**Why the weakness exists:** **Southwest Michigan Behavioral Health** generated new data files instead of sending HSAG the member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS.

**Recommendation:** HSAG recommends **Southwest Michigan Behavioral Health** retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Southwest Michigan Behavioral Health**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.

## Compliance Review

### *Performance Results*

Table 3-19 presents an overview of the combined results of the three-year cycle of compliance reviews for **Southwest Michigan Behavioral Health**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-19 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-19—Summary of Results for the Three-Year Cycle of Compliance Reviews for Southwest Michigan Behavioral Health**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 8 | 0 | NA | NA | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 7 | 1 | 1 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 4 | 0 | NA | NA | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 13 | 3 | 2 | 1 | **94%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **VII** | Grievance Process | 26 | 21 | 5 | 5 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 13 | 0 | NA | NA | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 10 | 1 | 1 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 3 | 1 | **89%** |
| **XII** | Access and Availability | 19 | 17 | 2 | 2 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 47 | 7 | 7 | 0 | **100%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 10 | 0 | NA | NA | **100%** |
| **XVII** | Management Information Systems | 12 | 12 | 0 | NA | NA | **100%** |
| | **Total** | **269** | **241** | **28** | **26** | **2** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Southwest Michigan Behavioral Health**'s plans of action remediated 26 of 28 identified deficiencies. Overall, 267 of 269 elements received a *Met* score, indicating that **Southwest Michigan Behavioral Health** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Southwest Michigan Behavioral Health** initially struggled with operationalizing all appeal functions, through the CAP process, **Southwest Michigan Behavioral Health** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **Southwest Michigan Behavioral Health** also successfully addressed several requirements related to member materials (member handbook and provider directory) and the grievance process.

**Weaknesses**

**Weakness:** While **Southwest Michigan Behavioral Health** had two continued deficiencies after the CAP review, no trends of weakness were identified in any program areas.

**Recommendation:** While no trends of weakness in program areas were identified, HSAG recommends that the PIHP prioritize the remediation of the remaining two deficiencies identified from the CAP review; specifically, provide members with an ABD notice at the time of any action (i.e., a denial of payment) affecting a claim, and review PIHP quality issues at the time of a provider's recredentialing.

## Region 5—Mid-State Health Network

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-20 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-20—Overall Validation Rating for Mid-State Health Network**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test* | *Not Met* | The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period. | 33.6% | 36.1% ⇔ | | 36.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Mid-State Health Network** revised the baseline data results. The PIHP described that the baseline results submitted in the prior year reported data for the fiscal year rather than the calendar year. With the resubmission, the PIHP revised the plan-selected goal from 56.3 percent to 36 percent; however, the new plan-selected goal does not represent statistically significant improvement over the baseline rate.

Table 3-21 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-21—Remeasurement 1 Interventions for Mid-State Health Network**

| Intervention Descriptions | |
|---|---|
| Developed and implemented a process for quarterly data validation to ensure data received from the CareConnect 360 (CC360) extract in the ICDP is consistent with the HEDIS specifications and is completed within the expected time frames. | The CMHSP used care alerts to determine who does not have a claim for a completed lab. A record review is then completed to identify if a lab was ordered. If the results are in the record and a claim was submitted to Medicare, the CMHSP entered "addressed" into the ICDP. |
| Implemented a process for lab services to be obtained on-site at each CMHSP location, including mobile lab, trained medical staff members, and an on-site lab draw station. | Developed an information sheet to provide to members at the time of their appointment with instructions for accessing the transportation available in each CMHSP's geographical location. |

### *Strengths, Weaknesses, and Recommendations*

| | |
|---|---|
| **Strengths** | **Strength: Mid-State Health Network** designed a methodologically sound PIP. |
| | **Strength: Mid-State Health Network** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers. |
| **Weaknesses** | **Weakness:** Although **Mid-State Health Network** demonstrated some improvement in the study indicator outcomes for the first remeasurement, the goal of significant improvement was not achieved. |
| | **Why the weakness exists: Mid-State Health Network** implemented interventions that may not have a direct impact on the study indicator. |
| | **Recommendation:** As **Mid-State Health Network** progresses to the second remeasurement, HSAG recommends revisiting the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of active interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps. |

## Performance Measure Validation

HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no major concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, and oversight of the 12 affiliated CMHSPs.

**Mid-State Health Network** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Mid-State Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

### *Performance Results*

Table 3-22 presents **Mid-State Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-22—Performance Measure Results for Mid-State Health Network**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 98.60% | 95.00% |
| *Adults* | 99.17% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 98.28% | 95.00% |
| *Adults* | 95.14% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 98.39% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 8.58% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.19% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 19.31% | — |
| *IDD Adults* | 9.89% | — |
| *MI/IDD Adults* | 9.52% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 98.41% | — |
| *IDD Adults* | 56.07% | — |
| *MI/IDD Adults* | 55.06% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 4.35% | 15.00% |
| *MI Adults and IDD Adults* | 11.59% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 19.16% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 49.93% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength:** **Mid-State Health Network**'s performance exceeded the corresponding MPS for seven of seven measure indicators, suggesting child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Discrepancies were identified during PSV related to differences between the CMHSPs' EMR system and the data output file submitted to HSAG.

**Why the weakness exists:** **Mid-State Health Network** and its CMHSPs' validation processes did not entirely prevent errors from occurring within the data.

**Recommendation:** As a result of these errors, **Mid-State Health Network** modified the performance indicator submission layout to include additional data elements to support future validation and reporting. However, HSAG recommends that **Mid-State Health Network** continue to work with the CMHSP to evaluate whether front-end data entry edits or data elements should be implemented to support indicator reporting to ensure accurate data are collected up front. Further, HSAG recommends that **Mid-State Health Network** implement additional validation processes and procedures to ensure the accuracy of reported data for all performance indicators and continue to have sufficient oversight of CMHSPs.

**Weakness:** Final BH-TEDS data submitted by MDHHS included six member records with discrepant non-competitive workforce and minimum wage status data from one CMHSP.

**Why the weakness exists:** **Mid-State Health Network** and its CMHSPs' validation processes did not entirely prevent discrepancies from occurring within the data.

**Recommendation:** HSAG recommends that **Mid-State Health Network** and its CMHSPs employ enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in non-competitive workforce and minimum wage status values. HSAG also recommends that **Mid-State Health Network** and its CMHSPs continue to perform enhanced data quality and completeness checks before the data are submitted to the State.

**Weakness:** HSAG identified that the member-level detail data counts did not always align with the final performance indicator calculated rates.

**Why the weakness exists:** **Mid-State Health Network** generated new data files instead of sending HSAG the member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS.

**Recommendation:** HSAG recommends **Mid-State Health Network** retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Mid-State Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.

## Compliance Review

### *Performance Results*

Table 3-23 presents an overview of the combined results of the three-year cycle of compliance reviews for **Mid-State Health Network**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-23 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-23—Summary of Results for the Three-Year Cycle of Compliance Reviews for Mid-State Health Network**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 7 | 1 | 1 | 0 | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 6 | 2 | 2 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 4 | 0 | NA | NA | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 12 | 4 | 2 | 2 | **88%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 24 | 2 | 2 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 13 | 0 | NA | NA | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 10 | 1 | 1 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 4 | 0 | **100%** |
| **XII** | Access and Availability | 19 | 18 | 1 | 1 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 50 | 4 | 3 | 1 | **98%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **XVI** | Confidentiality of Health Information | 10 | 10 | 0 | NA | NA | **100%** |
| **XVII** | Management Information Systems | 14 | 14 | 0 | NA | NA | **100%** |
| | **Total** | **271** | **247** | **24** | **21** | **3** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Mid-State Health Network**'s plans of action remediated 21 of 24 identified deficiencies. Overall, 268 of 271 elements received a *Met* score, indicating that **Mid-State Health Network** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength: Mid-State Health Network** successfully addressed several requirements related to member materials (member handbook and provider directory), provider credentialing, and the appeal process.

**Weaknesses**

**Weakness: Mid-State Health Network**'s processes had the potential for members to not receive ABD notices timely or in accordance with federal managed care requirements.

**Why the weakness exists: Mid-State Health Network** monitored expedited service authorization compliance against a three-day time frame standard as opposed to the required 72 hour time frame. Additionally, **Mid-State Health Network** did not demonstrate an established process to ensure ABDs are developed and notices are sent to members when authorization decisions are untimely.

**Recommendation:** HSAG recommends that **Mid-State Health Network** update its chart review tools to reflect a 72-hour time frame standard for expedited authorizations. **Mid-State Health Network** should also implement procedures to ensure it and its delegates are rendering an ABD and sending notice for the failure to make an authorization decision timely (i.e., within 72 hours for expedited requests or 14 calendar days for standard requests). HSAG also recommends that **Mid-State Health Network** reeducate UM staff of these requirements.

## Region 6—Community Mental Health Partnership of Southeast Michigan

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-24 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-24—Overall Validation Rating for Community Mental Health Partnership of Southeast Michigan**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test* | *Not Met* | The percentage of members ages 18–64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year. | 65.6% | 65.8% ⇔ | | 72.2% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-25 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-25—Remeasurement 1 Interventions for Community Mental Health Partnership of Southeast Michigan**

| Intervention Descriptions | |
|---|---|
| Enhanced an existing data report to connect when a member has an upcoming appointment, does not have a lab completed, or the prescription for the lab has expired. Nurses and prescribers review pending labs and request the clinical teams follow up to assist members with completing their labs. | Developed a new data report that includes all potential lab information: labs from all known sources, which factors for the data discrepancies between CC360 and Virtual Integrated Patient Record, as well as labs associated with discrete values in the regional EHR. |
| Transitioned Great Lakes Michigan Connect to a new system that includes data from all hospitals, which includes the lab feeds for all CMHSPs in the region. | |

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Community Mental Health Partnership of Southeast Michigan** designed a methodologically sound PIP.

**Strength: Community Mental Health Partnership of Southeast Michigan** used appropriate quality improvement tools to conduct a causal/barrier analysis and developed a collaborative team to identify and prioritize barriers.

**Weaknesses**

**Weakness: Community Mental Health Partnership of Southeast Michigan** did not achieve the goal of significant improvement over the baseline rate for the first remeasurement period.

**Why the weakness exists:** Although **Community Mental Health Partnership of Southeast Michigan** implemented systematic interventions to capture completed labs, some of which are projected to have a long-term impact on the study indicators, the interventions did not result in significant improvement.

**Recommendation:** As **Community Mental Health Partnership of Southeast Michigan** progresses to the second remeasurement period, HSAG recommends revisiting the causal/barrier analysis process to ensure that the barriers identified continue to be barriers. The PIHP should develop active interventions to address the barriers to achieve the desired outcomes.

## Performance Measure Validation

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

**Community Mental Health Partnership of Southeast Michigan** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), 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.

### *Performance Results*

Table 3-26 presents **Community Mental Health Partnership of Southeast Michigan**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-26—Performance Measure Results for Community Mental Health Partnership of Southeast Michigan**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 99.43% | 95.00% |
| *Adults* | 99.38% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 100.00% | 95.00% |
| *Adults* | 91.33% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 99.12% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 7.31% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.98% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 17.62% | — |
| *IDD Adults* | 9.60% | — |
| *MI/IDD Adults* | 10.17% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 98.53% | — |
| *IDD Adults* | 56.08% | — |
| *MI/IDD Adults* | 66.95% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 9.80% | 15.00% |
| *MI Adults and IDD Adults* | 9.62% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 25.23% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 37.92% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Community Mental Health Partnership of Southeast Michigan**'s performance exceeded the corresponding MPS for six of seven measure indicators, suggesting most child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Although the rate for Indicator #4a fell below the MPS, the methodology within the MDHHS Codebook for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Community Mental Health Partnership of Southeast Michigan** consult with MDHHS to clarify the methodology specifically regarding the exceptions for this indicator.

**Weakness:** HSAG identified that the member-level detail data counts did not always align with the final performance indicator calculated rates.

**Why the weakness exists: Community Mental Health Partnership of Southeast Michigan** generated new data files instead of sending HSAG the member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS.

**Recommendation:** HSAG recommends **Community Mental Health Partnership of Southeast Michigan** retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Community Mental Health Partnership of Southeast Michigan**'s PIHP Medicaid members. These retained data should be used for future PMV submissions instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.

## Compliance Review

### *Performance Results*

Table 3-27 presents an overview of the combined results of the three-year cycle of compliance reviews for **Community Mental Health Partnership of Southeast Michigan**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-27 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-27—Summary of Results for the Three-Year Cycle of Compliance Reviews for Community Mental Health Partnership of Southeast Michigan**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 5 | 3 | 3 | 0 | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 4 | 4 | 4 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 3 | 1 | 1 | 0 | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 2 | 1 | 1 | 0 | **100%** |
| **V** | Utilization Management | 16 | 14 | 2 | 2 | 0 | **100%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 26 | 0 | NA | NA | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 10 | 3 | 3 | 0 | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 10 | 1 | 1 | 0 | **100%** |
| **X** | Provider Network | 12 | 10 | 2 | 2 | 0 | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 2 | 2 | **78%** |
| **XII** | Access and Availability | 19 | 17 | 2 | 2 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 47 | 7 | 7 | 0 | **100%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **XVI** | Confidentiality of Health Information | 10 | 9 | 1 | 1 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 12 | 0 | NA | NA | **100%** |
| | **Total** | **269** | **233** | **36** | **34** | **2** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength:** **Community Mental Health Partnership of Southeast Michigan**'s plans of action remediated 34 of 36 identified deficiencies. Overall, 267 of 269 elements received a *Met* score, indicating that **Community Mental Health Partnership of Southeast Michigan** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Community Mental Health Partnership of Southeast Michigan** initially struggled with operationalizing all appeal functions, through the CAP process, **Community Mental Health Partnership of Southeast Michigan** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **Community Mental Health Partnership of Southeast Michigan** also successfully addressed several requirements related to QAPIP activities, and member materials (member handbook and provider directory) and member rights.

**Weaknesses**

**Weakness:** Gaps in **Community Mental Health Partnership of Southeast Michigan**'s credentialing procedures have the potential to allow providers with quality or adverse concerns into its network.

**Why the weakness exists:** **Community Mental Health Partnership of Southeast Michigan**'s provider credentialing review tools did not include a review of all credentialing components required by contract. The credentialing checklist also did not consider appeal information or provider quality issues.

**Recommendation:** HSAG recommends that **Community Mental Health Partnership of Southeast Michigan** reconcile its provider credentialing review tools against initial and

recredentialing requirements in contract and update accordingly. HSAG also recommends that **Community Mental Health Partnership of Southeast Michigan** clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and provider quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Community Mental Health Partnership of Southeast Michigan**'s recredentialing review.

## Region 7—Detroit Wayne Integrated Health Network

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-28 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-28—Overall Validation Rating for Detroit Wayne Integrated Health Network**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* | *Not Met* | The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication. | 81.4% | 76.9% ↓ | | 80.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Detroit Wayne Integrated Health Network** revised the baseline data results. The PIHP described that the baseline results submitted in the prior year contained a programming logic flaw that did not specify the measurement year, capturing codes from any year, and impacted inclusion and exclusions for both the denominator and numerator resulting in the capture of too many records. The revised plan-selected goal of 80 percent is below the revised baseline rate of 81.4 percent. The goal should represent a statistically significant increase over the baseline performance.

Table 3-29 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-29—Remeasurement 1 Interventions for Detroit Wayne Integrated Health Network**

| Intervention Descriptions | |
|---|---|
| Monitored compliance with diabetes screening through clinical treatment chart audits. Findings from the chart audits provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee. | Measured and monitored compliance with labs ordered and drawn no less than quarterly through review of the HEDIS-like data in the healthcare analytics tool. Findings provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee. |

| Intervention Descriptions | |
|---|---|
| Members educated on the importance of having labs completed through community outreach initiatives and training and reinforced in a pilot program through face-to-face medication delivery and monitoring with members transitioning from an Aggressive Community Treatment program. | Provided education on Clinical Guidelines Procedures to service providers, practitioners, and PIHP staff though the Quality Operations Workgroup, Quality Improvement Steering Committee, and Improvement Practices Leadership meetings. |
| Educated provider network through community outreach initiatives and training on the importance of diabetes screening. | |

***Strengths, Weaknesses, and Recommendations***

**Strengths**

**Strength: Detroit Wayne Integrated Health Network** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

**Weaknesses**

**Weakness: Detroit Wayne Integrated Health Network** demonstrated a decrease in the percentage of diabetes screenings completed for the eligible population.

**Why the weakness exists: Detroit Wayne Integrated Health Network** implemented interventions that may not have a direct impact on the study indicator.

**Recommendation:** HSAG recommends **Detroit Wayne Integrated Health Network** revisit its causal/barrier analysis to ensure the appropriate barriers were identified and develop active, innovative interventions to address each barrier.

## Performance Measure Validation

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

**Detroit Wayne Integrated Health Network** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Detroit Wayne Integrated Health Network** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported.

### *Performance Results*

Table 3-30 presents **Detroit Wayne Integrated Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-30—Performance Measure Results for Detroit Wayne Integrated Health Network**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 98.47% | 95.00% |
| *Adults* | 96.48% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *Children* | 93.06% | 95.00% |
| *Adults* | 95.99% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 94.00% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 6.60% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 96.75% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 11.90% | — |
| *IDD Adults* | 9.20% | — |
| *MI/IDD Adults* | 6.50% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 98.90% | — |
| *IDD Adults* | 51.80% | — |
| *MI/IDD Adults* | 47.10% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 10.91% | 15.00% |
| *MI Adults and IDD Adults* | 20.41% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 21.70% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 38.21% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Detroit Wayne Integrated Health Network**'s performance exceeded the corresponding MPS for four of seven measure indicators, suggesting most child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Although indicators #4a and #4b fell below the MPS, the methodology within the MDHHS Codebook for these indicators allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Detroit Wayne Integrated Health Network** consult with MDHHS to clarify the methodology specifically regarding the exceptions for these indicators.

**Weakness:** Indicator #10 ranked above the MPS, indicating adults had a high percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge, which may result in higher costs associated with readmissions and a decrease in health status overall.

**Why the weakness exists:** The rate for Indicator #10 for the adult Medicaid members was below the MPS, suggesting there are opportunities to improve transition of care services and supports for adult Medicaid members to reduce their likeliness of readmissions.

**Recommendation:** HSAG recommends **Detroit Wayne Integrated Health Network** determine if it can leverage any of the successes it has had with lower pediatric Medicaid member readmissions and apply those interventions to its adult Medicaid members. Additionally, **Detroit Wayne Integrated Health Network** should conduct a full root cause analysis or focused study to identify any barriers specific to the adult Medicaid members that could be factors in increased readmission. Upon identification of a root cause and potential programs to leverage that have achieved success for pediatric Medicaid members, **Detroit Wayne Integrated Health Network** should implement appropriate interventions to improve the performance related to Indicator #10.

**Weakness:** HSAG reviewed the final BH-TEDS data submitted by MDHHS and identified one member record with discrepant non-competitive workforce and minimum wage status BH-TEDS data.

**Why the weakness exists: Detroit Wayne Integrated Health Network**'s validation processes did not entirely prevent discrepancies from occurring within the data.

**Recommendation:** HSAG recommends that **Detroit Wayne Integrated Health Network** continue to monitor the accuracy of its BH-TEDS data and review BH-TEDS validation processes to ensure they are sufficient to address all logical errors. This review should target the data entry protocols and validation edits in place to account for discrepancies in non-competitive workforce and minimum wage status values.

**Weakness:** HSAG identified that the member-level detail data counts did not always align with the final performance indicator calculated rates.

**Why the weakness exists:** **Detroit Wayne Integrated Health Network** generated new data files instead of sending HSAG the member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS.

**Recommendation:** HSAG recommends **Detroit Wayne Integrated Health Network** retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Detroit Wayne Integrated Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members exactly as reported to MDHHS in support of the performance indicators.

**Weakness:** **Detroit Wayne Integrated Health Network** had three performance indicators that did not meet the MPS.

**Why the weakness exists:** Although not entirely clear, **Detroit Wayne Integrated Health Network** may have interventions in place that are not leading to improved performance rates. Additionally, data collection processes may attribute to incomplete or inaccurate data.

**Recommendation:** HSAG recommends that **Detroit Wayne Integrated Health Network** continue existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes. **Detroit Wayne Integrated Health Network** should continue monitoring performance trends and targeting low performing areas, including an assessment of performance at the PIHP and individual provider level, as well as within core member demographics, to identify systemic patterns of performance. Further, **Detroit Wayne Integrated Health Network** should continue to use existing workgroups to identify root causes for low performance and disseminate best practices.

## Compliance Review

### *Performance Results*

Table 3-31 presents an overview of the combined results of the three-year cycle of compliance reviews for **Detroit Wayne Integrated Health Network**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-31 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-31—Summary of Results for the Three-Year Cycle of Compliance Reviews for Detroit Wayne Integrated Health Network**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 8 | 0 | NA | NA | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 6 | 2 | 2 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 3 | 1 | 1 | 0 | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 2 | 1 | 1 | 0 | **100%** |
| **V** | Utilization Management | 16 | 13 | 3 | 1 | 2 | **88%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 26 | 0 | NA | NA | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 12 | 1 | 0 | 1 | **92%** |
| **IX** | Subcontracts and Delegation | 11 | 9 | 2 | 2 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 2 | 2 | **78%** |
| **XII** | Access and Availability | 19 | 17 | 2 | 2 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 45 | 9 | 8 | 1 | **98%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **XVI** | Confidentiality of Health Information | 10 | 5 | 5 | 5 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 9 | 3 | 2 | 1 | **92%** |
| | **Total** | **269** | **231** | **38** | **31** | **7** | **97%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Detroit Wayne Integrated Health Network**'s plans of action remediated 31 of 38 identified deficiencies. Overall, 262 of 269 elements received a *Met* score, indicating that **Detroit Wayne Integrated Health Network** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Detroit Wayne Integrated Health Network** initially struggled with operationalizing all appeal functions, through the CAP process, with the exception of one element, **Detroit Wayne Integrated Health Network** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. **Detroit Wayne Integrated Health Network** also successfully addressed several requirements related to member materials (member handbook and provider directory) and the use and disclosure of PHI procedures.

**Weaknesses**

**Weakness:** While **Detroit Wayne Integrated Health Network** demonstrated a fair appeal process once an appeal was received, it did not consistently provide members with adequate or timely information on ABDs. Insufficient information via an ABD notice may be a barrier for members in making an informed decision on whether or not to file an appeal.

**Why the weakness exists: Detroit Wayne Integrated Health Network** was not providing members with an ABD notice at the time a denial of payment was made on a claim. Additionally, **Detroit Wayne Integrated Health Network**'s service authorization extension procedures exceeded the time frame allowable under federal managed care regulations.

**Recommendation:** HSAG recommends that **Detroit Wayne Integrated Health Network** revisit its procedures for extending authorization decisions. Once updated, education with UM staff members on appropriate extension time frame should be completed. HSAG also recommends that **Detroit Wayne Integrated Health Network**'s UM and claims departments collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.

**Weakness:** Gaps in **Detroit Wayne Integrated Health Network**'s credentialing procedures have the potential to allow providers into its network without meeting all credentialing requirements required by **Detroit Wayne Integrated Health Network**'s contract with MDHHS.

**Why the weakness exists:** **Detroit Wayne Integrated Health Network**'s credentialing checklist did not consider appeal information or provider quality issues. Additionally, how the consideration of grievances, appeal information, and provider quality issues at the time of a provider's recredentialing was unclear.

**Recommendation:** HSAG recommends that **Detroit Wayne Integrated Health Network** reconcile its credentialing checklist to ensure the consideration of grievances, appeal information, and quality issues are considered and documented for each provider. HSAG also recommends that **Detroit Wayne Integrated Health Network** clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Detroit Wayne Integrated Health Network**'s recredentialing review.

# Region 8—Oakland Community Health Network

## Validation of Performance Improvement Projects

### *Performance Results*

Table 3-32 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-32—Overall Validation Rating for Oakland Community Health Network**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* | *Not Met* | The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication. | 73.8% | 72.0% ↓ | | 83.8% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-33 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-33—Remeasurement 1 Interventions for Oakland Community Health Network**

| Intervention Descriptions | |
|---|---|
| Trained provider staff members on manual data entry into the healthcare analytics tool when diabetes screening is complete in order to refine data and improve accuracy. | Worked with healthcare analytics tool vendor to ensure system integration and reception of Healthy Michigan claims and members into the dataset. |
| Sent members served (who meet the criteria), as well as members who do not have a PCP, quarterly reminder letters to complete identified and specific annual screenings/vaccinations. | |

***Strengths, Weaknesses, and Recommendations***

| | |
|---|---|
| **Strengths** | **Strength: Oakland Community Health Network** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers. |
| **Weaknesses** | **Weakness: Oakland Community Health Network** did not use the same methodology across measurements for the project, documenting the inclusion of Healthy Michigan claims and members for part of the first remeasurement and none of the baseline measurement period.<br>**Why the weakness exists:** While it is unclear why the methodology was not consistently used, the inclusion of Healthy Michigan members during the first remeasurement does not allow for appropriate comparability between measurement periods.<br>**Recommendation:** HSAG recommends **Oakland Community Health Network** use the approved PIP methodology to calculate and report data accurately and consistently for each measurement period. |
| | **Weakness: Oakland Community Health Network** demonstrated a decrease in the percentage of diabetes screenings for the eligible population during the first remeasurement period.<br>**Why the weakness exists:** The study indicator rates should be interpreted with caution as the same methodology was not used across measurement periods.<br>**Recommendation:** HSAG recommends **Oakland Community Health Network** use the same methodology for each measurement period. The PIHP should revisit its causal/barrier analysis and develop active interventions to address the barriers identified. |

## Performance Measure Validation

HSAG evaluated **Oakland Community Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), and BH-TEDS data production. **Oakland Community Health Network** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

**Oakland Community Health Network** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Oakland Community Health Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported.

### *Performance Results*

Table 3-34 presents **Oakland Community Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-34—Performance Measure Results for Oakland Community Health Network**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 95.56% | 95.00% |
| *Adults* | 91.51% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *Children* | 97.37% | 95.00% |
| *Adults* | 94.64% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 99.00% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 8.03% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 98.60% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 19.87% | — |
| *IDD Adults* | 14.31% | — |
| *MI/IDD Adults* | 8.71% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 99.09% | — |
| *IDD Adults* | 57.22% | — |
| *MI/IDD Adults* | 60.53% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 11.54% | 15.00% |
| *MI Adults and IDD Adults* | 10.53% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 19.06% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 35.25% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Oakland Community Health Network**'s performance exceeded the corresponding MPS for five of seven measure indicators, suggesting most child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Although Indicator #4a fell below the MPS, the methodology within the MDHHS Codebook for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Oakland Community Health Network** consult with MDHHS to clarify the methodology specifically regarding the exceptions for this indicator.

**Weakness:** Indicator #1 fell below the MPS, indicating adults are not always getting a psychiatric inpatient care pre-admission screening disposition completed within three hours, which may result in less effective coordination of services and treatment for the members based on their needs.

**Why the weakness exists:** The rate for Indicator #1 for the adult Medicaid members was below the MPS, suggesting barriers exist to timely completion of a psychiatric inpatient care pre-admission screening disposition for these members.

**Recommendation:** HSAG recommends **Oakland Community Health Network** conduct a root cause analysis or focused study to determine why some adult Medicaid members are not always getting a psychiatric inpatient care pre-admission screening disposition completed within three hours. Upon identification of a root cause, **Oakland Community Health Network** should implement appropriate interventions to improve the performance related to Indicator #1.

**Weakness:** Upon HSAG's review of the member-level detail data provided by **Oakland Community Health Network**, HSAG noted that **Oakland Community Health Network** categorized members under multiple exception categories (e.g., refused and consumer chose not to use PIHP services), creating ambiguity in the actual reason for the exception.

**Why the weakness exists:** Providers are not consistently selecting the actual exception reason supported by claims and event notes, but instead are selecting multiple reasons allowed under the MDHHS Codebook.

**Recommendation:** HSAG recommends **Oakland Community Health Network** continue to work with related provider networks on providing clear documentation of exceptions. Additionally, HSAG recommends **Oakland Community Health Network** develop a consistent process for assigning exceptions as it relates to Indicator #4b.

**Weakness:** HSAG identified that the member-level detail data counts did not always align with the final performance indicator calculated rates.

**Why the weakness exists:** **Oakland Community Health Network** generated new data files instead of sending HSAG the member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS.

**Recommendation:** HSAG recommends **Oakland Community Health Network** retain the exact member-level detail data that were used for the final performance indicator rate calculation and reporting to MDHHS. These data should be stored in a readily retrievable viewable file and only include **Oakland Community Health Network**'s PIHP Medicaid members. These retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid members, exactly as reported to MDHHS in support of the performance indicators.

## Compliance Review

### *Performance Results*

Table 3-35 presents an overview of the combined results of the three-year cycle of compliance reviews for **Oakland Community Health Network**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-35 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-35—Summary of Results for the Three-Year Cycle of Compliance Reviews for Oakland Community Health Network**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 8 | 0 | NA | NA | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 5 | 3 | 3 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 4 | 0 | NA | NA | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 11 | 5 | 2 | 3 | **81%** |
| **VI** | Customer Service | 39 | 32 | 7 | 6 | 1 | **97%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **VII** | Grievance Process | 26 | 23 | 3 | 3 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 11 | 2 | 2 | 0 | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 9 | 2 | 2 | 0 | **100%** |
| **X** | Provider Network | 12 | 10 | 2 | 2 | 0 | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 4 | 0 | **100%** |
| **XII** | Access and Availability | 19 | 17 | 2 | 2 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 46 | 8 | 5 | 3 | **94%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 9 | 1 | 1 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 10 | 2 | 2 | 0 | **100%** |
| | **Total** | **269** | **228** | **41** | **34** | **7** | **97%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Oakland Community Health Network**'s plans of action remediated 34 of 41 identified deficiencies. Overall, 262 of 269 elements received a *Met* score, indicating **Oakland Community Health Network** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength: Oakland Community Health Network** successfully addressed several requirements related to member materials (member handbook and provider directory), CIs, the grievance process, and provider credentialing.

**Weaknesses**

**Weakness: Oakland Community Health Network**'s process for service authorizations provided confusing and inaccurate information to members. Insufficient information via notices may be a barrier for members in making an informed decision on whether or not to file an appeal or a grievance.

**Why the weakness exists: Oakland Community Health Network**'s member notices for untimely service authorization decisions and service authorization decisions contained confusing and inaccurate language. It was unclear if **Oakland Community Health Network** was also providing members with an ABD notice to members when a payment on a claim was denied. Additionally, there appeared to be confusion on when and how to appropriately operationalize these UM requirements.

**Recommendation:** HSAG recommends **Oakland Community Health Network** review its service authorization member notices against federal managed care requirements and update accordingly. Staff education should be complete to ensure staff understanding of what type of notice should be sent and when and what content must be included in each type of notice. Additionally, HSAG recommends that **Oakland Community Health Network**'s UM and claims departments collaborate in developing a process to generate an ABD notice when a payment on a claim is denied.

**Weakness: Oakland Community Health Network**'s appeal process had the potential to unnecessarily delay access to care and services due to inadequate information being provided to members or by inappropriately delaying the appeal resolution time frame.

**Why the weakness exists: Oakland Community Health Network**'s written notice of a denial of an expedited appeal request did not include the reason why a member did not meet expedited criteria and instead informed the member that **Oakland Community Health Network** could not meet the requirements to support the request. Additionally, **Oakland Community Health Network** inappropriately extended an appeal time frame in the benefit of the PIHP and not in the best interest of the member.

**Recommendation:** HSAG recommends that **Oakland Community Health Network** revise its denied expedited appeal request template letter and educate staff members on the appropriate content that must be included in this notice. Additionally, HSAG recommends that **Oakland Community Health Network** complete staff education on the appropriate reason for when an appeal resolution time frame may be extended. This education should ensure that extensions are not applied until near the expiration of the appeal time frame.

## Region 9—Macomb County Community Mental Health

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-36 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-36—Overall Validation Rating for Macomb County Community Mental Health**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness (SMI)* | *Not Met* | 30-day Hospital Readmission | 14.2% | 15.3% ⇔ | | 13.0% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Table 3-37 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-37—Remeasurement 1 Interventions for Macomb County Community Mental Health**

| Intervention Descriptions | |
|---|---|
| Initiated team meetings with the Access (intake unit) psychiatrist, Access leadership, and Access managers to identify the appropriate level of care needed following hospitalization. Members at high risk for recidivism were identified for case reviews. | Increased trainings on Assisted Outpatient Treatment (Kevin's Law) for hospitals, law enforcement, and court staff members. |
| Access Specialty teams worked with hospital discharge planners to plan for post-hospital services. | Purchased assistance from an outside vendor to create hospital utilization dashboards. |

### *Strengths, Weaknesses, and Recommendations*

| | |
|---|---|
| **Strengths** | **Strength: Macomb County Community Mental Health** designed a methodologically sound PIP. |
| **Weaknesses** | **Weakness: Macomb County Community Mental Health** demonstrated an increase in the percentage of adults with SMI readmitted to a hospital within 30 days post discharge.<br>**Why the weakness exists:** While it is unclear what led to the increase in hospital readmissions, the performance suggests that there were barriers to timely follow-up care and treatment after an inpatient stay.<br>**Recommendation:** As **Macomb County Community Mental Health** progresses to the second remeasurement, HSAG recommends revisiting the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Macomb County Community Mental Health** should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps. |

## Performance Measure Validation

HSAG evaluated **Macomb County Community Mental Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), and BH-TEDS data production. **Macomb County Community Mental Health** is a stand-alone PIHP; therefore, the PMV did not include a review of CMHSP oversight.

**Macomb County Community Mental Health** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Macomb County Community Mental Health** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported.

### *Performance Results*

Table 3-38 presents **Macomb County CMH Services**' performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-38—Performance Measure Results for Macomb County Community Mental Health**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 99.07% | 95.00% |
| *Adults* | 99.37% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 78.43% | 95.00% |
| *Adults* | 76.95% | 95.00% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 98.32% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 5.29% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 98.53% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 17.97% | — |
| *IDD Adults* | 5.75% | — |
| *MI/IDD Adults* | 6.52% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 99.41% | — |
| *IDD Adults* | 25.88% | — |
| *MI/IDD Adults* | 35.94% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 10.13% | 15.00% |
| *MI Adults and IDD Adults* | 14.93% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 15.50% | — |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 44.96% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Macomb County Community Mental Health**'s performance exceeded the corresponding MPS for five of seven measure indicators, suggesting most child and adult members were able to access behavioral health and SUD services timely.

**Weaknesses**

**Weakness:** Although the children and adult rates for Indicator #4a fell below the MPS, the methodology within the MDHHS Codebook for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Macomb County Community Mental Health** consult with MDHHS to clarify the methodology specifically regarding exceptions for this indicator.

## Compliance Review

### *Performance Results*

Table 3-39 presents an overview of the combined results of the three-year cycle of compliance reviews for **Macomb County Community Mental Health**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-39 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-39—Summary of Results for the Three-Year Cycle of Compliance Reviews for Macomb County Community Mental Health**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 6 | 2 | 1 | 1 | **88%** |
| **II** | Quality Measurement and Improvement | 8 | 4 | 4 | 3 | 1 | **88%** |
| **III** | Practice Guidelines | 4 | 2 | 2 | 2 | 0 | **100%** |

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 10 | 6 | 5 | 1 | **94%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 26 | 0 | NA | NA | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 13 | 0 | NA | NA | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 6 | 5 | 5 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 8 | 4 | 4 | 3 | 1 | **88%** |
| **XII** | Access and Availability | 19 | 16 | 3 | 3 | 0 | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 53 | 1 | 1 | 0 | **100%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 10 | 0 | NA | NA | **100%** |
| **XVII** | Management Information Systems | 12 | 12 | 0 | NA | NA | **100%** |
| | **Total** | **268** | **236** | **32** | **28** | **4** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Macomb County Community Mental Health**'s plans of action remediated 28 of 32 identified deficiencies. Overall, 264 of 268 elements received a *Met* score, indicating **Macomb County Community Mental Health** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Macomb County Community Mental Health** initially struggled with operationalizing all delegation oversight functions and ensuring all contract provisions were included in each subcontract, through the CAP process, **Macomb County Community Mental Health** demonstrated consistent monitoring of delegated functions and inclusion of required subcontract content. **Macomb County Community Mental Health** also successfully addressed several requirements related to member materials (member handbook and provider directory), CIs, provider credentialing, and performance indicators.

**Weaknesses**

**Weakness:** While **Macomb County Community Mental Health** had four continued deficiencies after the CAP review, no trends of weakness were identified in any one program area.

**Recommendation:** While no trends of weakness in any one program area were identified, HSAG recommends that **Macomb County Community Mental Health** prioritize the remediation of the remaining four deficiencies identified from the CAP review; specifically, the PIHP should ensure a comprehensive annual evaluation of its QAPIP, ensure results of assessment of member experience with services are acted upon and appropriately evaluated for effectiveness, include all required content in ABD notices, and recredential all providers timely.

## Region 10 PIHP

### Validation of Performance Improvement Projects

#### *Performance Results*

Table 3-40 displays the overall validation status, the baseline and Remeasurement 1 results, and the PIHP-designated goal for the PIP topic.

**Table 3-40—Overall Validation Rating for Region 10 PIHP**

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| *Medical Assistance for Tobacco Use Cessation* | *Met* | 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. | 6.9% | 9.9% ↑ | | 8.2% |

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

Within the most recent submission, **Region 10 PIHP** revised the baseline data results. The PIHP described that the baseline data submitted in the prior year contained an error in the programing logic used to determine diagnoses and months of service.

Table 3-41 displays the interventions implemented to address the barriers identified by the PIHP using quality improvement and causal/barrier analysis processes.

**Table 3-41—Remeasurement 1 Interventions for Region 10 PIHP**

| Intervention Descriptions | |
|---|---|
| Increased staff knowledge on tobacco effects on members' health, including higher death rate, and increased knowledge on tobacco cessation options and resources. | Developed and deployed resources to increase member knowledge and understanding of tobacco effects on health and medication assistance cessation options and resources. |
| Developed training for staff members. Trained staff members on assessment and interventions for medication-assisted treatment (MAT) for tobacco cessation. Developed a method for staff members to refer members served for MAT for smoking cessation. | Addressed tobacco cessation awareness/education opportunities at the weekly "Wellness Wednesday" by regularly communicating the importance of tobacco cessation, available nicotine replacement therapy (NRT) |

| Intervention Descriptions | |
|---|---|
| | options, and the fact that tobacco cessation services are safe and effective. |
| Completed a tobacco use assessment for all members served who have a serious and persistent mental illness diagnosis. | Created an agency environment that supports tobacco cessation. |
| Facilitated the availability of community resources regarding smoking/tobacco use cessation to members served at Sanilac CMHSP. | Offered focus groups to provide support, coping mechanisms, and information regarding the dangers of tobacco use and the benefits of tobacco cessation. |
| Provided educational materials for, and received feedback from, those staff members who have direct contact with the members served regarding tobacco cessation and services. | CMHSP medical director/designee communicated to all CMHSP SMI programs about the opportunity for members served at the CMHSP to receive NRT at the Peoples Clinic. |
| Expanded member awareness of the annual Great American Smoke-Out. | Increased member engagement with PCP. |
| Implemented staff orientation and annual refresher training in the "5 A's" approach (Ask, Advise, Assess, Assist, and Arrange) to tobacco cessation by the Michigan Department of Community Health. | |

***Strengths, Weaknesses, and Recommendations***

**Strengths**

**Strength: Region 10 PIHP** met 100 percent of the requirements for data analysis and implementation of improvement strategies.

**Strength: Region 10 PIHP** achieved the goal of statistically significant improvement over the baseline rate for the first remeasurement period.

**Weaknesses**

**Weakness:** There were no identified weaknesses.

**Recommendation:** Although there were no identified weaknesses, HSAG recommends as **Region 10 PIHP** progresses into the second remeasurement, the PIHP revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The PIHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

## Performance Measure Validation

HSAG evaluated **Region 10 PIHP**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators and identified no concerns with the PIHP's eligibility and enrollment data system, medical services data system (claims and encounters), BH-TEDS data production, and oversight of its four affiliated CMHSPs.

**Region 10 PIHP** received an indicator designation of *Reportable* for all indicators (other than the new indicators for SFY 2020 in which data were not available and received an indicator designation of *Not Applicable*), signifying that **Region 10 PIHP** had calculated these indicators in compliance with the MDHHS Codebook specifications and the rates could be reported.

### *Performance Results*

Table 3-42 presents **Region 10 PIHP**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

**Table 3-42—Performance Measure Results for Region 10 PIHP**

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 99.73% | 95.00% |
| *Adults* | 99.91% | 95.00% |
| ***#2a: The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#2b: The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD.*** | | |
| *Medicaid SUD* | NA | — |
| ***#3: The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment.*** | | |
| *SED Children* | NA | — |
| *MI Adults* | NA | — |
| *IDD Children* | NA | — |
| *IDD Adults* | NA | — |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***$^{+}$ | | |
| *Children* | 97.53% | 95.00% |
| *Adults* | 96.67% | 95.00% |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.+*** | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 93.68% | 95.00% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 7.38% | — |
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 98.76% | — |
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 12.30% | — |
| *IDD Adults* | 8.15% | — |
| *MI/IDD Adults* | 7.24% | — |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 97.95% | — |
| *IDD Adults* | 55.74% | — |
| *MI/IDD Adults* | 60.53% | — |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | 7.69% | 15.00% |
| *MI Adults and IDD Adults* | 14.15% | 15.00% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 16.54% | — |

| Performance Indicator | Rate | Minimum Performance Standard |
|---|---|---|
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 49.04% | — |

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.

+ While this PIHP achieved a *Reportable* designation for this indicator, due to variation in PIHP interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to the MPS.

NA indicates that data were not available for the indicator for SFY 2020.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Region 10 PIHP**'s performance exceeded the corresponding MPS for six of seven measure indicators, suggesting child and adult members were able to access behavioral health services timely.

**Weaknesses**

**Weakness:** Although the rate for Indicator #4b fell below MPS, the methodology within the MDHHS Codebook for Indicator #4b allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results.

**Recommendation:** HSAG recommends **Region 10 PIHP** consult with MDHHS to clarify the methodology specifically regarding the exceptions for this indicator.

## Compliance Review

### *Performance Results*

Table 3-43 presents an overview of the combined results of the three-year cycle of compliance reviews for **Region 10 PIHP**. The table shows the number of elements for each of the 17 standards that received a score of *Met* in the two prior years' (SFY 2018 and SFY 2019) compliance reviews. Table 3-43 also presents the number of elements that required a CAP during the two prior years' compliance reviews and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

**Table 3-43—Summary of Results for the Three-Year Cycle of Compliance Reviews for Region 10 PIHP**

| Prior Years (SFY 2018, SFY 2019) and Current Year (SFY 2020) Scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| Compliance Monitoring Standard | | Total # of Applicable Elements | Number of Elements | | | | Total Compliance Score |
| | | | Prior Years | | Current Year | | |
| | | | *M* | *# CAPs* | *M* | *NM* | |
| **I** | QAPIP Plan and Structure | 8 | 8 | 0 | NA | NA | **100%** |
| **II** | Quality Measurement and Improvement | 8 | 7 | 1 | 1 | 0 | **100%** |
| **III** | Practice Guidelines | 4 | 4 | 0 | NA | NA | **100%** |
| **IV** | Staff Qualifications and Training | 3 | 3 | 0 | NA | NA | **100%** |
| **V** | Utilization Management | 16 | 12 | 4 | 3 | 1 | **94%** |
| **VI** | Customer Service | 39 | 34 | 5 | 5 | 0 | **100%** |
| **VII** | Grievance Process | 26 | 20 | 6 | 6 | 0 | **100%** |
| **VIII** | Members' Rights and Protections | 13 | 13 | 0 | NA | NA | **100%** |
| **IX** | Subcontracts and Delegation | 11 | 9 | 2 | 2 | 0 | **100%** |
| **X** | Provider Network | 12 | 12 | 0 | NA | NA | **100%** |
| **XI** | Credentialing | 9 | 5 | 4 | 2 | 2 | **78%** |
| **XII** | Access and Availability | 19 | 19 | 0 | NA | NA | **100%** |
| **XIII** | Coordination of Care | 11 | 11 | 0 | NA | NA | **100%** |
| **XIV** | Appeals | 54 | 23 | 31 | 30 | 1 | **98%** |
| **XV** | Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | NA | NA | **100%** |
| **XVI** | Confidentiality of Health Information | 10 | 4 | 6 | 6 | 0 | **100%** |
| **XVII** | Management Information Systems | 12 | 10 | 2 | 2 | 0 | **100%** |
| | **Total** | **269** | **208** | **61** | **57** | **4** | **99%** |

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

**Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2018 or SFY 2019 reviews.

**Number of Elements:** The number of elements that required a CAP in either the SFY 2018 or SFY 2019 reviews that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

**Total Compliance Score:** Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in either the SFY 2018 or SFY 2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

### *Strengths, Weaknesses, and Recommendations*

**Strengths**

**Strength: Region 10 PIHP**'s plans of action remediated 57 of 61 identified deficiencies. Overall, 265 of 269 elements received a *Met* score, indicating **Region 10 PIHP** has a managed care regulatory structure with the ability to improve healthcare outcomes, strengthen quality of care, promote effective use of data, and manage costs.

**Strength:** While **Region 10 PIHP** initially struggled with operationalizing all appeal functions, through the CAP process, **Region 10 PIHP** demonstrated the ability to provide members with a fair process to challenge the denial of coverage of, or payment for, medical assistance. While one element remained deficient in this program area, significant improvement had been made. **Region 10 PIHP** also successfully addressed several requirements related to member materials (member handbook and provider directory), the grievance process, and the use and disclosure of PHI procedures.

**Weaknesses**

**Weakness:** Gaps in **Region 10 PIHP**'s credentialing procedures have the potential to allow providers into its network without meeting all credentialing requirements required by **Region 10 PIHP**'s contract with MDHHS.

**Why the weakness exists: Region 10 PIHP**'s credentialing worksheet did not include all requirements and did not consider appeal information or provider quality issues. Additionally, how grievances, appeal information, and provider quality issues are considered and documented for each provider at the time of the provider's recredentialing was unclear.

**Recommendation:** HSAG recommends that **Region 10 PIHP** reconcile its credentialing worksheet against credentialing requirements and update accordingly. HSAG also recommends that **Region 10 PIHP** clearly identify in policy what provider-specific performance monitoring must be considered at the time of recredentialing, including grievances, appeal information, and provider quality issues. Provider quality issues should also be defined to include the types of data and sources included as part of **Region 10 PIHP**'s recredentialing review.

# 4. Follow-Up on Prior EQR Recommendations for PIHPs

From the findings of each PIHP's performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Michigan Behavioral Health Managed Care program. The recommendations provided to each PIHP for the EQR activities in the *State Fiscal Year 2019–2020 External Quality Review Technical Report* are summarized in Table 4-1 through Table 4-10. The PIHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-10.

## Region 1—NorthCare Network

**Table 4-1—Prior Year Recommendations and Responses for NorthCare Network**

| 1. Recommendation—Performance Measures |
|---|
| 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:<br><br>**Ratings Below the MPS**<br>• *#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<br><br>**Increase in Readmissions >5 Percent From Previous Year**<br>• *#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 |
| ***MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• PI [performance indicator] #2 – NorthCare has had various conversations with our providers ensuring that they understand how this measure is calculated. NorthCare is one of a few, if not the only, PIHP that has changed the way this indicator had been calculated ensuring that individuals have a FTF [face to face] assessment within 14 calendar days versus counting individuals who were given a choice of receiving a list of providers to call or accepting an appointment outside the 14 calendar days with nothing "offered" within those 14 days being counted as individual choice and therefore excluded from the count. NorthCare changed this practice in FY18.<br>• An analysis of data from Qtrs [quarters] 1, 2, 3 of FY20 was conducted to identify licensed sites with the highest number of outliers. This will allow us to focus our improvement efforts specific to their respective challenges. NorthCare had a total of 22 unique licensed sites reporting during any one or |

| 1. Recommendation—Performance Measures |
|---|
| more of these three quarters. Out of these, four licensed sites had a total of 10 or more outliers over the three quarters. (NOTE: Quarter 3 numbers are preliminary as of this writing and are calculated based on the new methodology.) In reviewing outliers from the largest SUD provider, we have identified insufficient documentation as one cause of not meeting this measure. NorthCare has stressed the importance of documenting all offered appointments to ensure these are appropriately considered in calculating this measure. Improvement is noted from FY19 to the first two quarters in FY20. Starting with the 3rd quarter of FY20 this measure is changed in that there will be no exceptions considered and no state required benchmark. NorthCare will continue to work with the providers of these licensed sites to identify barriers and interventions to shorten the number of days between request for non-emergent services and FTF assessment. This will be an ongoing process. Going forward, we are working with our EHR [electronic health record] vendor to align reporting as best we can with the new Codebook (Effective 4/1/2020) and various guidance we have received from MDHHS. Beginning with Q3 [quarter 3] FY20 there will be no minimum threshold.<br>• NorthCare Network staff have brainstormed with [name of provider*] staff on ways to improve access to care. [name of provider*] is our largest SUD provider and the one that is a consistent outlier for PI #2. Overall issues are capacity and lack of proper documentation. These discussions have focused on the documentation which has improved. We have also learned that [name of provider*] is combining their two call centers and hiring one additional staff which will help connect the caller at time of their initial call and reduce the need for call backs, etc. NorthCare is also working on updating the rate structure at [name of provider*]. Wage adjustments are one factor in the rate structure. Wage adjustments tend to improve staff retention. Staff retention/training impact PI reporting. Maintaining staff trained in the scheduling process should improve the overall performance.<br>• In addition, a new outpatient provider was added to the SUD Provider panel during FY20. Multiple outpatient locations (up to 4) will be added in the Western Upper Peninsula (Gogebic, Houghton, Ontonagon) during FY21. Marquette county will have an additional outpatient provider during the first quarter of FY21. Outpatient programming is being planned in Menominee county. The location will be brought on once staff have been hired, potentially during the first quarter of FY21.<br>• #10 – FY19 data shows NorthCare well below the standard of 15% or below for both children at 8.06% and adults at 10.27%. FY20 data is also well below the 15% or below standard for Quarters 1 and 2; Children are at 7.14% and 0% respectively while adults are at 9.71% and 7.5% respectively. NorthCare continues to monitor. It is unclear why this measure is listed in this report. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• PI #2 - Quarter 1 FY20 data shows a compliance score of 89.89% and Quarter 2 is 89.20%, which is up from the 84.0% to 88.51% range achieved in FY19.<br>• #10 – Continues to be under the 15% threshold for both children and adults for quarters 1 and 2 of FY20. Children are at 7.14% for Q1 and 0% for Q2; Adults are at 9.71% for Q1 and 7.5% for Q2. |
| c. Identify any barriers to implementing initiatives:<br>• Progress in working with SUD providers on improving this measure has been delayed due to issues around COVID-19 needing to take priority as well as staff schedules while working remotely and conducting site reviews by desk audit. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations. HSAG recommends that the PIHP continue to monitor and implement improvement strategies with its providers to ensure performance metrics continue to improve and reach the MPS. |

| 2. Recommendation—Compliance Review |
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| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:<br>• NorthCare Network staff responsible for each of their areas are responsible to ensure completion of corrective action. Monitoring of each CMHSP is done via annual site reviews. NorthCare's QI [Quality Improvement] Coordinator has drafted a quarterly CAP monitoring form which will provide a centralized area for tracking progress. For this year, NorthCare has completed the June and July HSAG CAP monitoring form, which was also updated for the 8/28/2020 submission.<br>• 2018 Compliance Monitoring – 12 of 14 standards completed:<br>– St. VI 4.a Customer Handbook – Completed by 6/4/2020<br>– St. VI b. Provider Listing/Directory – on track for completion by 9/30/2020<br>– St. VIII 8 Enrollee Grievance – Completed by 6/4/2020<br>– St IX 5 Subcontracts/Delegation – Completed by 6/4/2020<br>– St X 5 Provider Network – Completed by 6/4/2020<br>– St XII 3 Access and Availability – Completed by 7/17/2020<br>– St XIV 3 Appeals Process – Completed by 6/4/2020<br>– St XIV 4 Appeals – Medicaid Srvs [services] Continuation or Reinstatement – Policies updated by 2/7/2019, eliminated use of ranges effective 8/26/2020; report for monitoring on track for completion by 9/30/2020.<br>– St XIV 4 Appeals – Right to Examine Records – Completed by 6/4/2020<br>– St XIV 9 Expedited Appeal Resolution – Completed by 6/4/2020<br>– St XIV 10 Appeals – Extension of Timeframes – Completed by 6/4/2020<br>– St XIV 11 Appeal Resolution Notice Format – Completed by 6/4/2020<br>– St XIV 12 Appeal Resolution Notice Content – Completed by 6/4/2020<br>– St XVII 2 Management Information Systems – Completed by 6/4/2020<br>• 2019 Compliance Monitoring – 10 of 14 standards completed:<br>– St I 5 QAPIP – BTC [behavior treatment committee] – Completed by 6/4/2020<br>– St I 7 Quality Measure & Improvement – Critical Incident Reporting – Completed by 6/4/2020<br>– St I 8 QAPIP – Assessment of Member Experiences w/Services – Completed 9/10/2020<br>– St III 3 Practice Guidelines – on track for completion by 10/15/2020 |

**2. Recommendation—Compliance Review**

- St V.8 UM [utilization management] – Notice of ABD Content – Completed by 6/4/2020
- St V.9 UM – Timing of Notice-Adequate ABD – completed 9/24/2020
- St V.11 UM – Srv [service] Auth [authorization] Decisions – on track for completion by 10/28/20 (October deploy of new fields to authorization); interim monitoring report implemented until then.
- St V.12 UM – Extend Srv Auth Time Frame – on track for completion by 10/28/20 (October deploy of new fields to authorization)
- St V.14 UM – Limited Exceptions – completed 9/24/2020
- St VIII.9 – Member Rights – Written Notification of Significant Change – Completed by 6/4/2020
- St VIII.11 – Member Rights – Advance Directives – Completed by 6/4/2020
- St XI.3 Credentialing – Retain Rights for Provider Selection – Completed for implementation 10/1/2020
- St XI.6 – Credentialing – Case File Review Initial Credentialing – Completed for implementation 10/1/2020
- St XI.7 – Credentialing – Case File Review Initial Credentialing – Completed for implementation 10/1/2020
- St XI.8 – Credentialing – Case File Review Organizational Credentialing – Completed for implementation 10/1/2020

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Improvement in compliance is noted and documented in our HSAG CAP progress reports.

c. Identify any barriers to implementing initiatives:
- Delays due to COVID-19.

**HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate two deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices.

**3. Recommendation—Performance Improvement Projects**

HSAG recommended that **NorthCare Network** take proactive steps to ensure a successful PIP. Specifically, **NorthCare Network** should address all *General Comments* in the *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.

| 3. Recommendation—Performance Improvement Projects |
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| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• NorthCare has developed a fish bone causal analysis and risk analysis matrix. Interventions implemented have both a direct and indirect impact on study indicator outcomes. Staff are working on various data points and reports to ensure monitoring and follow-up. We have also initiated a focused PIP workgroup as bringing project information to current committees with full agendas have not proved to be effective. This will better assist NorthCare in identifying barriers and interventions at the provider level with front line staff involvement. This workgroup, with representation from all CMHSPs, had their first meeting on September 23, 2020 and will meet monthly until determined to move to every other month or quarterly for the life of the project. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• NorthCare did see a small improvement in the follow-up within 7 days for adults which we really cannot relate to any specific intervention. A major issue was the data and the errors we found during the first remeasurement period which required us to re-run our baseline and 1st remeasurement period after the report used was corrected. |
| c. Identify any barriers to implementing initiatives:<br>• NorthCare contracted with [name of vendor*] to develop a report to pull our FUH PIP data in accordance with HEDIS 2018 standards. As noted, when we received the 1st remeasure report, we noted some errors and then analyzed baseline data closer and saw errors there as well. This took some time to correct. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue to evaluate its interventions to ensure they are having a direct impact on performance. |

*****Provider and/or vendor names were redacted for privacy purposes.

# Region 2—Northern Michigan Regional Entity

**Table 4-2—Prior Year Recommendations and Responses for Northern Michigan Regional Entity**

| 1. Recommendation—Performance Measures |
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| 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:<br><br>***Not Reported* Performance Measure Rates**<br>• *#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*<br>• *#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*<br><br>**Ratings Below the MPS**<br>• #3: The percent o*f new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—IDD Children and IDD Adults<br>• *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*<br><br>**Performance Declined >2 Percent From Previous Year**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—Medicaid SUD |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Indicators 1 and 2 were deemed Not Reported (NR) as a result of HSAG's performance measure validation. 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 the PIHP submits valid and accurate data to MDHHS. NMRE implemented the HSAG recommendations following the CY 2019 which included issues around correctly calculating member months and member years, following the time parameters for Indicators 1 and 2, and exception criteria applied to cases reported for Indicator 2. The initiatives involved NMRE staff providing education to CMH [community mental health] staff and reviewing the definitions and the methods of counting to determine accurate months and years, as well as criteria to be defined as an exclusion. |

| 1. Recommendation—Performance Measures |
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| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• NMRE received CY 2020 ISCAT [information systems capabilities assessment tool] results on September 25, 2020. The results identify full compliance with these previously noted areas of "Not Met." |
| c. Identify any barriers to implementing initiatives:<br>• No barriers were identified during the implementation process. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations and subsequently received an indicator designation of *Reportable* for all indicators in SFY 2020. |

| 2. Recommendation—Compliance Review |
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| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Standard I—QAPIP Plan and Structure<br>NMRE scored 5/8 elements on the Standard<br>– The QAPIP had not been approved annually due to a "pause and reset" mode by the CEO [Chief Executive Officer]. FY 19 QAPIP was approved by the governing board on June 26, 2019. FY 20 QAPIP was approved February 26, 2020.<br>– NMRE developed a standardized behavior treatment template for reporting behavior treatment quarterly to the NMRE from the CMHs. NMRE Quality Oversight Committee [QOC] reviewed the template and all definitions as it relates to behavior treatment. NMRE is trending behavior treatment quarterly. Comprehensive report was developed and posted to the NMRE website. The report was provided to CMHs through the QOC.<br>– The NMRE developed an annual QAPIP report in FY 20 to distribute to Network Providers and post on its website that illustrates the effectiveness and successes of its QAPIP. Although this report was available in the past, it was not as robust as HSAG would have liked; the NMRE drafted a more comprehensive plan. |

**2. Recommendation—Compliance Review**

- Standard II—Quality Measurement and Improvement

  NMRE scored 4/8 elements

  – The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence an RCA [root cause analysis] of the event. The NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting procedure section (H) states that "the NMRE and its Network Providers will, within three (3) business days after an incident occurs, classify it as a sentinel event, risk event, critical incident, or non-sentinel death." As stated in the "Definitions" section of the policy/procedure a "Network Provider" is "any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel." The NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting procedure section (K)(1) states that, "The NMRE will ensure that Network Providers initiate a Root Cause Analysis within five (5) days of any perceived sentinel event immediately once the incident was determined to be a sentinel event, utilizing an approved review process." The five days requirement reflects three (3) days to determine whether the event was a sentinel event and two (2) days to commence an RCA. This is compliant with the standard, however, the NMRE revised the procedure to clarify this section for HSAG reviewers and to eliminate any risk of misinterpretation.

  – The PIHP must analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.

  – The PIHP must ensure that persons involved in the review of sentinel events have the appropriate credentials to review the scope of care. NMRE has added the language to the SUD provider monitoring tool to assure that the RCA process is conducted within the appropriate time frames as well as the appropriate staff have been involved in the process. Review of critical incidents, sentinel events, and risk events is included in the NMRE's Quality Oversight Committee's work plan. The NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting procedure section (R) states that "The NMRE will require each Network Provider to analyze, at least quarterly, critical events, sentinel events, non-sentinel deaths, and risk events to determine what actions are needed to remediate problems or situations to prevent reoccurrence." The NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting procedure section (S) states that "Quarterly reviews of risk events will serve at the basis for a report that classifies the reason for the events." The NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting procedure section (T) states that "The NMRE will ensure that each Network Provider demonstrates appropriate remediation at the staff and system level, when applicable, and maintain adequate records to document evidence of remedial efforts." The NMRE Quality Oversight Committee will review aggregated data on critical incidents, sentinel events, and risk events as part of its work plan, no less frequently than quarterly. NMRE is trending the data quarterly.

  – The PIHP must conduct periodic quantitative and qualitative assessments of member experiences with services. The assessments must be representative of the persons served and the services and supports offered and meet all requirements of this element. The NMRE conducts region-wide surveys for recipients of mental health medical services, mental health case management (adult and child) services, mental health outpatient, mental health psychosocial rehabilitation, mental health

| 2. Recommendation—Compliance Review |
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assertive community treatment, mental health home-based services, substance use disorder outpatient, substance use disorder methadone, substance use disorder subacute detox, and substance use disorder residential services. Additionally, the NMRE conducts the Recovery Self-Assessment (RSA) annually. The NMRE has struggled to implement a satisfaction survey for recipients of intellectual/developmental disabilities (IDD) services. Quality measures widely used with other Medicaid populations do not easily translate and address the more complex health care and social needs of individuals with IDD. Quality of life and individual experience perspectives are difficult to quantify consistently given the need to gather data through interviews, surveys, etc. and the subjectivity involved with topics such as quality of life. Goals, outcomes of care, and supportive services are personalized and can mean different things to individuals with complex conditions, which makes the use of standardized metrics and tools difficult. The NMRE Quality Oversight Committee will develop a suitable survey tool for the IDD population, possibly using components from the HCBS Experience of Care Survey. Survey results will be aggregated into a report for review by the Quality Oversight Committee, the regional Consumer Council (Regional Entity Partners), and the NMRE Governing Board. Areas of dissatisfaction will be investigated with measures to remediate the dissatisfaction implemented as deemed necessary by the NMRE Quality Oversight Committee. The IDD survey will be developed and implemented by 7/1/2020. The Quality Improvement Structure for the NMRE is established through the Quality Oversight Committee. The membership of the Quality Oversight Committee has one member from each CMH representing it as well as the Managing Director of Substance Use Disorder Services. The purpose of this is for each representative to be the link between the PIHP and the provider QI programs. This allows information to flow out to the providers, quality improvement developed at the local level where the beneficiaries are served and the results to flow back to the PIHP through the representative of the provider at QOC. The PIHP receives all CMH QI meeting minutes and is able to see that the information is flowing out to the local quality improvement teams. The QOC disseminates all results to the committee who then disseminates it out to the local CMH staff and beneficiaries by putting reports in lobbies, having the link to the NMRE website where anyone can click on the website and find results of surveying, as well as other information. The PIHP has developed an IDD and Opioid Health Home satisfaction survey. This survey will be implemented as soon as the COVID-19 pandemic has subsided to an appropriate level to begin surveying again.

- Standard III—Practice Guidelines

  NMRE scored 3/4 on this standard.

  – The PIHP disseminates the guidelines to all affected providers and, upon request, to members and potential members. Practice Guidelines were updated in June 2020. Due to COVID, the majority of committees were not meeting due to addressing the crisis that was on hand. The goal of the region was to keep services going for clients and keeping everyone safe and assuring that there was enough PPE for providers in residential facilities. Therefore, some of the committees that had this on the agenda to address did not get it addressed when projected. The Regional Consumer Council (REP) did not meet in person between March and August. Customer Service Specialist will disseminate during the September REP meeting. Regional Provider Network Management group will be receiving the copies of practice guidelines in September 2020 for dissemination. The Regional Clinical Leadership reviewed the practice guidelines at the May 15th, 2020 meeting for any suggested changes. No changes were suggested. The practice guideline content remained the same however a new template was utilized and then they were shared with the clinical leadership group thru email. The SUD program directors and clinical leadership group received them however

**2. Recommendation—Compliance Review**

it was not captured in the meeting minutes, and therefore they were redistributed in September 2020 at these committees as well at the provider network meeting and the consumer REP group.

- Standard V—Utilization Management

  NMRE scored 9/16 in this area of review.

  – Procedures—Prospective (preauthorization), concurrent and retrospective procedures are established. The PIHP has revised new annual monitoring tools for the CMH providers and this area is addressed on the monitoring tool and policy/procedure will be addressed during the site reviews.

  – Notice of Adverse Benefit Determination: The NMRE and its Network Providers are utilizing the Notice of Adverse Benefit Determination template included in the current MDHHS-PIHP Contract Attachment P6.3.1 Exhibit A. This document was already in use on September 2019 when HSAG site review team was onsite, however records reviewed from previous time period did not reflect this.

  – The PIHP must have a mechanism in place to ensure that, for a denial of payment for services, an ABD notice is provided to the member at the time of the action affecting the claim. Trainings conducted by the Customer Service Department regarding Grievance and Appeals contains instructions regarding the necessity of adverse benefit determination notices and their proper implementation. Providers must show ABDs during the PIHP audit to demonstrate that they are being utilized appropriately.

  – The PIHP must have a process to ensure that, for service authorization decisions not reached within 14 days for standard request, or 72 hours for an expedited request, the authorization needs to be handled as a denial and the member must receive notice of ABD on the date that the time frame expires. EHR is able to identify and track when authorizations go beyond the allowed time frame. The access center pulls a report daily to review the auths [authorizations] to determine who is still not been authorized and approaching close to 14 days. The access center is waiting on further documentation from the provider to determine if the authorization meets medical necessity. If the authorization request reaches 14 days and the paperwork has not been submitted the access center staff send the denial.

  – The PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances. The PIHP did not have any examples to demonstrate compliance however they developed the template in case there is a situation when the timeframe needs to extended.

  – The PIHP must assure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. The NMRE added the following language under (C) Program Structure... “The NMRE will assure that compensation to individuals or entities that conduct utilization management activities is not structured wo as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.”

- Standard VIII—Members’ Rights and Protections

  NMRE scored 11/13 on this standard

  – The PIHP must ensure that members are provided written notice of any significant change in the information specified in 438.10(g) at least 30 days before the intended effective date of the change. The NMRE Member Information Policy has been updated to state that each member will receive:

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"written notice of any significant change in the information specified in 438.10(g) (member handbook) at least 30 days before the intended effective date of the change."

- The PIHP must ensure that annually (e.g., at the time of person-centered planning) the member is provided the estimated annual cost to the PIHP of each covered support and service he/she is receiving. Each CMH provided an example of the ECOS [estimated cost of services] to demonstrate compliance.

- Standard XI—Credentialing

  NMRE scored 5/9 on this standard

  - If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers, it must meet all requirements associated with the delegation of PIHP functions and be responsible for oversight regarding delegated credentialing or recredentialing decisions. The PIHP must comply with (and ensure delegates performing credentialing functions comply with) all initial credentialing requirements as outlined in its contract with MDHHS. The PIHP must comply with (and ensure delegates performing credentialing functions comply with) all recredentialing requirements as outlined in its contract with MDHHS. The PIHP must comply with (and ensure that delegates performing credentialing functions comply with) all organizational credentialing requirements as outlined in its contract with MDHHS. The NMRE evaluated its credentialing review tools to ensured they aligned with the requirements outlined in the MDHHS-PIHP contract. The NMRE is in the process of verifying that provider procedures have been implemented in accordance with the requirement through annual site reviews.

- Standard XVI—Confidentiality of Health Information

  NMRE scored 6/10 on this standard

  - The PIHP must have documented processes and procedures to support that it maintains the confidentiality, security, and integrity of member information that is used in connection with the performance of its contract with MDHHS to the extent and under the conditions specified in HIPAA [Health Insurance Portability and Accountability Act], the Michigan Mental Health Code (PA [Public Act] 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2. The PIHP must have documented processes and procedures to support it complies with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule, and Breach Notification Rule, and 42 CFR Part 2 with respect to all PHI [protected health information] and SUD treatment information that it generates, receives, maintains, uses, discloses, or transmits in the performance of its functions. The NMRE approved its Consent to Share Information policy and procedure, Social Security Number Privacy policy and procedure, Breach Notification policy and procedure by March 1, 2020.
  - The PIHP's breach notification letter must include a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; a description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved); any steps individuals should take to protect themselves from potential harm resulting from the breach; a brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address. The NMRE Breach procedure Section (D) states that "Notice to affected individuals is written in plain language

| 2. Recommendation—Compliance Review |
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| and contains the following information (included in the NMRE's Breach Notification Letter template): 1. A brief description of what happened, including the date of the breach and the date of the discovery of breach, if known; 2. A description of the type of unsecured PHI involved in the breach (social security numbers, dates of birth, addresses, bank account or credit card numbers, diagnoses, disability codes, etc.); 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach; 4. A brief description of what the NMRE and/or its Network Providers are doing to investigate the breach, mitigate harm to individuals, and protect against further breaches; 5. Contact information to enable affected individuals to contact the NMRE including a toll-free telephone number, email address, website, and mailing address."<br>– The PIHP's process must ensure that, in the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under paragraph (d)(1)(i) of this section, a substitute form of notice reasonably calculated to reach the individual will be provided. However, the process must also indicate that a substitute notice is not required in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under paragraph (d)(1)(ii). The NMRE Breach Notification procedure section (D) states that "Notifications may be provided in more than one mailing, as information is made available. If NMRE has determined that any affected individuals are deceased and has the addresses of their next of kin or personal representatives, notification will be sent to the next of kin or personal representative. If there is insufficient or outdated contact information that precludes direct written or electronic notification, a substitute form of notice reasonably believed to reach the individual will be sent. If there is insufficient or outdated contact information for fewer than 10 individuals, the substitute notice may be provided by an alternative form of written notice, by telephone, or by other means. IF there is insufficient or outdated contact information for more than 10 individuals, the substitute notice will be in the form of either a conspicuous posting for a period of 90 days on the homepage of the nmre.org website, or a conspicuous notice in major print or broadcast media in the NMRE geographic area where affected individuals are likely to reside. The notice will include a toll-free telephone number that individuals can access to learn whether their PHI was included in the breach that will remain active for at least 90 days." This is compliant with the standard. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• See above under each element |
| c. Identify any barriers to implementing initiatives:<br>• Standard I—QAPIP Plan and Structure<br>– NMRE continues to struggle with getting reliable data to be able to trend it in consistent categories. NMRE is looking at revising the template so the fields will only allow options from a drop-down menu to be selected.<br>• Standard V—Utilization Management<br>– The NMRE continues to have concerns with the template's adherence to 42 CFR §440.10, as this document is not at a 4th grade reading level. According to online readability checking software, the state required notice tests at an 11.3 on the Flesch-Kincaid Grade Level scale, a 56.6 at Reading Ease (10th-12th grade level and "Fairly Difficult"), and an 11 on the Coleman Liau Index. Please see the attached Readability Results document. The State Required Notice was also shown to the Regional Entity Partners consumer group, who expressed dissatisfaction with the templates citing |

| 2. Recommendation—Compliance Review |
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| issues with the length and difficulty of the language, as well as the 'dehumanizing' and impersonal format. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices and QAPIP requirements. |
| **3. Recommendation—Performance Improvement Projects** |
| HSAG recommended that **Northern Michigan Regional Entity** take proactive steps to ensure a successful PIP. Specifically, **Northern Michigan Regional Entity** should address all *General Comments* in the *2019 PIP Validation Report Follow-Up Care for Children Prescribed ADHD Medication for Region 2—Northern Michigan Regional Entity* and the following recommendations:<br>• 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.<br>• **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.<br>• **Northern Michigan Regional Entity** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***<br>• Percentage Score of Evaluation Elements Met* 100%<br>Percentage Score of Critical Elements Met** 100%<br>Validation Status*** *Met*<br>*Met:* High confidence/confidence in reported PIP results. All critical evaluation elements were Met, and 80 to 100 percent of all evaluation elements were Met across all activities.<br>No recommendations to address. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• N/A [not applicable] |
| c. Identify any barriers to implementing initiatives:<br>• N/A |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue to evaluate its interventions to ensure they are having a direct impact on performance and are demonstrating improved performance over a period of time. |

# Region 3—Lakeshore Regional Entity

**Table 4-3—Prior Year Recommendations and Responses for Lakeshore Regional Entity**

| 1. Recommendation—Performance Measures |
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| 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:<br><br>**Ratings Below the MPS**<br>• *#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<br>• *#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<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children<br>• *#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<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• When a CMHSP does not meet the 95% Standard, LRE requires the CMHSP to complete a MMBPIS Plan of Correction. If a CMHSP does not meet standards for five out of 9 quarters, they are required to report monthly until they meet MPS for two quarters in a row.<br>• LRE 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.<br>– CMHSPs provide quarterly data to the LRE by the 15th of the month in which it is due to MDHHS.<br>– QI Staff randomly selects a specific number of cases for each CMHSP for each indicator.<br>– CMHSP staff are required to upload proof documents within 5 workdays for review and validation by QI staff for the indicators chosen.<br>– Any issues are discussed with the CMHSPs and fixed prior to submission to MDHHS on the last day of the month.<br>– Data is reviewed and discussed at QI ROAT [Regional Operations Advisory Team] meeting prior to submission to MDHHS. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• The region has seen improvement for all indicators except #3 – MI Child. This indicator will no longer be tracked as it has been replaced effective 4/1/2020. |

| 1. Recommendation—Performance Measures |
|---|
| c. Identify any barriers to implementing initiatives:<br>• Changes to two CMHSP EMRs [electronic medical record] resulted in delays in data submission and/or completeness of data. These issues have been resolved as the CMHSP EMRs are fully functional. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue its efforts to review any noted exceptions to ensure documentation exists to support the exception. HSAG also recommends that the PIHP conduct regular audits of sample data to ensure correct entry of claims by the providers. |

| 2. Recommendation—Compliance Review |
|---|
| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• All policies, procedures, and documents have been updated, created, and/or implemented as stated.<br>• Committees and workgroups have been convened and are meeting regularly to address specified goals.<br>• CMHSP and Provider site review tools have been updated to include new standards and requirements as identified.<br>• Where appropriate, documentation has been presented to the LRE Board of Directors, stakeholders, consumers and the general public through either presentation, distribution, or posting on the organization's website.<br>• Training requirements have been met as identified. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Regional Clinical Practice Guidelines (CPGs) have been adopted and are now being used by all member CMHSPs.<br>• Appeal process is being completed by Beacon Health Options in a consistent regional manner used by all CMHSPs.<br>• Organizational Credentialing is consistent across the region.<br>• Improved site review process – included development of a virtual site review in response to the COVID-19 pandemic. |

| 2. Recommendation—Compliance Review |
|---|
| c. Identify any barriers to implementing initiatives:<br>• COVID-19 pandemic negatively impacted the organization's ability to complete functions in a timely manner (e.g., provider site reviews were not complete within the required time frame due to the inability to visit sites in person). |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to service authorization requirements and ABD notices. |
| **3. Recommendation—Performance Improvement Projects** |
| HSAG recommended that **Lakeshore Regional Entity** take proactive steps to ensure a successful PIP. Specifically, **Lakeshore Regional Entity** should address all *General Comments* in the *2019 PIP Validation Report Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) for Region 3—Lakeshore Regional Entity* and the following recommendations:<br>• 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.<br>• **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.<br>• **Lakeshore Regional Entity** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• The LRE scored 100 percent in 2019 and is currently at 90 percent this year on the draft report (prior to submitting updated data). Both years' standards were met and it is anticipated that the 2020 score will improve to at or close to 100 percent. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• N/A |
| c. Identify any barriers to implementing initiatives:<br>• Several interventions that were developed required more face-to-face contact and have been put on hold due to the COVID-19 pandemic restrictions |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations and subsequently achieved the goal of statistically significant improvement over the baseline rate for the first remeasurement period. |

# Region 4—Southwest Michigan Behavioral Health

**Table 4-4—Prior Year Recommendations and Responses for Southwest Michigan Behavioral Health**

| 1. Recommendation—Performance Measures |
|---|
| 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** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:<br><br>**Ratings Below the MPS**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—SED Children and IDD Children<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*<br><br>**Performance Declined >2 Percent From Previous Year**<br>• *#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 |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• SWMBH has implemented a new data collection template and strategy for submission of all MMBPIS indicators, including the timeliness standard for mentally ill adult and children. After this review, SWMBH proceeded to meet this indicator at the States indicated benchmark of 95% for (7) consecutive quarters. With this being said, the new MDHHS sponsored performance indicators will not have a benchmark for this indicator for FY2020. SWMBH will still hold our Region to high standard and enforce Corrective Action Plans when necessary.<br>• When a CMHSP's data is received, SWMBH reviews 5-7% of all indicators or 2 entries to ensure accuracy. During the Delegated Function Site Review, SWMBH reviews at least 5% from each indicator and requires the CMHSP to show where documentation is held in their own EMR system to review for accuracy. Internal Primary Source Verification review is completed, and results are noted in the CMHSP annual site review template for follow-up as necessary. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Please view the following snapshot from our "Quarterly MMBPIS Summary Dashboard – FY2020" Excel spreadsheet below for FY2019 (Note: screenshot begins at the quarter indicated in letter (a) and ends at FY20Q1 due to the State removing the standards for the majority of indicators cited for FY20Q2 and beyond): |

## 1. Recommendation—Performance Measures

| MMBPIS Indicator # | MMBPIS Performance Indicator | State Standard | Q3 2018 | Q4 2018 | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 | Q1 2020 |
|---|---|---|---|---|---|---|---|---|---|
| 2c | Request to Intake DD Children | 95.00% | 100.00% | 100.00% | 96.77% | 100.00% | 100.00% | 100.00% | 100.00% |
| 3a | First Service MI Children | 95.00% | 96.82% | 97.18% | 94.61% | 95.26% | 97.72% | 93.60% | 96.31% |
| 3c | First Service DD Children | 95.00% | 100.00% | 100.00% | 91.23% | 100.00% | 96.83% | 100.00% | 96.77% |
| 4b | Detox Follow Up | 95.00% | 95.97% | 95.08% | 93.98% | 94.64% | 97.04% | 95.05% | 95.47% |

c. Identify any barriers to implementing initiatives:
There were no identified barriers to implementing these initiatives.

**HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by the PIHP meeting the MPS in seven of seven measures. HSAG recommends that the PIHP continue to monitor and implement improvement strategies with its CMHSPs to ensure data are being entered into the system appropriately, and discrepancies in data are prevented.

## 2. Recommendation—Compliance Review

**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 recommended that **Southwest Michigan Behavioral Health** h 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 recommended 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.

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

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

**SWMBH had (3) Standards with identified Corrective Action Plan Follow-up items. The below descriptions represent the primary efforts/activities that were completed for each recommendation:**

- **Standard II – Quality Measurement**: SWMBH has submitted evidence, showing the results of our Consumer Satisfaction Surveys were not only discussed with our Regional Quality, Consumer and Provider Committees, but also distributed widely through our Quarterly Provider and Member Newsletters. Additionally, the results are available to all Members and Providers on the SWMBH website Newsletter section and in the Annual Quality Program Evaluation Report. SWMBH has also

| 2. Recommendation—Compliance Review |
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| asked it's CMHSP partners to discuss their opportunities for internal performance improvement, based on their individual CMHSP survey scores. This has been reflected in the Regional Quality Committee meeting minutes.<br>SWMBH has the unique ability to separate consumer service types from our survey results, as each participant is assigned a unique identification code.<br>For this reason, SWMBH is able to include members receiving LTSS into our survey methodology. We perform analysis on consumers receiving LTSS services, as we do for the rest of our service population.<br>• **Standard V – Utilization Management:** SWMBH has implemented all state mandated templates including the Adverse Benefit Determination on 7.1.19. Training on the use and completion of the templates with the regional representatives was completed on August 23, 2019. The training included examples and samples of plain language and content to be included.<br>• **Standard XI – Credentialing:** SWMBH modified the Credentialing Applications (both Individual Practitioner and Organizational) to include fields to track timeliness of Credentialing. The fields added are: Initial/Recredentialing start date; Credentialing Completion date; Credentialing Decision date". Participant CMHSPs are required to use SWMBH's Credentialing Applications. These updated Applications, as well as the SWMBH Credentialing Checklists, are on the Regional Provider Network Management Committee Meeting Agenda for its regularly scheduled meeting on March 20, 2020. This Committee is made up of representatives from each of SWMBH's participant CMHSPs, who are responsible for credentialing at their agencies. SWMBH amended its FY20 CMHSP Site Review Tool – Credentialing File Worksheets to add elements to foster more intense oversight of delegated credentialing activities during the file review. Lastly, SWMBH has begun to use the Care Management Credentialing module within its Smartcare Managed Care Information System to track credentialing performed by SWMBH. This module allows for input of the relevant credentialing dates and allows for reports to be run automatically. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• SWMBH showed a marked improvement with recent consumer satisfaction survey results: +2.76% net improvement across all categories for the adult and child surveys. The improvements are largely attributed to the efforts, education and analysis completed by the SWMBH Quality Department and relevant Regional workgroups.<br>• Improvements with our Credentialing Policies and Processes were helpful in preparations for NCQA – MBHO [National Committee for Quality Assurance – Managed Behavioral Healthcare Organizations] Accreditation and various Integrated Care Partner audits. |
| c. Identify any barriers to implementing initiatives:<br>• There were no identified barriers to implementing these initiatives. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate two deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices and provider credentialing. |

| 3. Recommendation—Performance Improvement Projects |
|---|
| HSAG recommended that **Southwest Michigan Behavioral Health** take proactive steps to ensure a successful PIP. Specifically, **Southwest Michigan Behavioral Health** should address all *General Comments* in the *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:<br>• 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.<br>• **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.<br>• **Southwest Michigan Behavioral Health** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• SWMBH now sends regular enrollee lists of individuals qualifying for SSD [Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications] in MY [measurement year] with and without screenings. Additionally, CMHSP's have now put protocols into place to ensure that necessary glucose/HbA1c [hemoglobin A1c] screenings are administered, educational one-pagers explaining the importance of such screenings have been sent out, and a regional policy concerning the SSD metric has been implemented. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• N/A – The PIP is still in the process of being reviewed and validated by HSAG and MDHHS. |
| c. Identify any barriers to implementing initiatives:<br>• For CY 2019, one important item of CMH feedback was a perceived reluctance on psychiatrists' part to prescribe glucose or hbA1c labs, believing them instead to be the responsibility of their patients' primary care providers. While not barriers to implementing the above initiatives *per se*, this decidedly mitigates their efficacy post-implementation. No amount of education or information can move the needle where a provider is unwilling to act on either. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue to evaluate its interventions to ensure they are having a direct impact on performance. Since the PIHP recognized provider reluctance to prescribe certain labs as a possible barrier to improving performance, HSAG recommends the PIHP also consider how coordination of care efforts can be initiated or increased between its contracted behavioral health providers and physical health providers. The PIHP could consider a joint effort with the physical health plans in Michigan. |

# Region 5—Mid-State Health Network

**Table 4-5—Prior Year Recommendations and Responses for Mid-State Health Network**

| 1. Recommendation—Performance Measures |
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| 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:<br><br>**Ratings Below the MPS**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—IDD Children<br>• *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults<br><br>**Performance Declined >2 Percent From Previous Year**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—IDD Adults<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days* |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Mid-State Health Network completed additional analysis of the affected indicators to determine the causal factors related to the decrease in performance. The analysis was reviewed with the Quality Improvement Council (QIC). An improvement plan identifying targeted interventions and time frames for completion was completed to address the causal factors. The interventions and performance are monitored quarterly by the QIC. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Interventions developed to address the deficiency have been implemented according to the work plan of the organizations.<br>– Indicator 3: The full impact of the interventions was to occur by July of 2020. The Michigan Department of Health and Human Services discontinued specifications of Indicator 3 in this report. MSHN will be unable to determine achievement of full impact of Indicator 3 for this report.<br>– Indicator 4a: FY19Q1-95.59%, FY20Q1-95.14%, FY20Q2-95.92, FY20Q3-currently aggregating<br>– Indicator 4b: FY19Q1-95.59%, FY20Q1-98.39%, FY20Q2-97.83, FY20Q3-currently aggregating |
| c. Identify any barriers to implementing initiatives:<br>• The Michigan Department of Health and Human Services discontinued the Indicator 3 as previously written. The interventions will continue, however the specifications for the measure has changed. The data for Indicator 3 as written above will not be received by the PIHP for FY20Q3. |

| 1. Recommendation—Performance Measures |
|---|
| • The national pandemic has resulted in modifications to services provided. It is unknown at this time how the interventions to address the causal factors have affected the outcome, or to what degree the changes because of the pandemic have affected the outcome. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by seven out of seven measures exceeding the MPS. Due to some noted documentation errors within the most recent PMV, HSAG recommends that the PIHP continue to monitor and validate claims data and implement improvement strategies with its providers to ensure data are accurate and performance metrics continue to improve and exceed the MPS. |

| 2. Recommendation—Compliance Review |
|---|
| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• MSHN reviewed the areas below based on the recommendations in the 2018–2019 Compliance Review. The relevant MSHN Committee/Council determined action steps and monitoring of effectiveness. QAPIP work plan was revised to address the completion of action steps, and the effectiveness of the interventions based on quarterly and annual monitoring reports. The implementation of all action steps has been completed. Policies/Procedures and templates have been approved or are in process for final approval.<br>I. <u>The Quality Assessment and Performance Improvement Program (QAPIP) and Structure</u>: The QAPIP Plan and Review was completed and communicated to the provider network through email and posting to the MSHN website. Policies and procedures were updated to address how the QAPIP is communicated to the network providers.<br>II. <u>QAPIP and Measurement/Improvement Activities</u>: The policies and procedures were updated to improve how the data (assessment of member experiences for all service groups and sentinel events/critical incidents) is reported, analyzed, and communicated on a quarterly basis. Interventions, causal factors, barriers, and measures of effectiveness have been and/or will be identified based on the results of the analysis. Training was provided to the provider network on changes to the process. The compliance with the policies/procedures, including data reporting and implementation of required actions steps is measured through scheduled audits. |

| 2. Recommendation—Compliance Review |
|---|
| V. Utilization Management: Policies, procedures, and templates were updated to standardize the method for tracking and reporting the ABDs. The standardized method includes the tracking of timeframes for service authorization decisions and issuing notification letters to ensure the required timelines for standard or expedited authorizations are adhered to. The reports that monitor the timeframes will be analyzed for causal factors, barriers, and trends/patterns that are outside the standards. Interventions and measures of effectiveness will be identified based on the results of the analysis to improve performance. The compliance with the policy/procedures and data reporting will be measured through scheduled audits and monitoring reports.<br>XI. Credentialing: Policies, procedures, and templates were updated to include and clarify the required elements and expectations for credentialing and re-credentialing, inclusive of the appeal process for adverse credentialing decisions. Modifications were made to provider contracts and delegation requirements consistent with requirements and standards. Updates were made to the monitoring protocol to include the specific requirements and expectations. The compliance with the policy/procedures and data reporting will be measured through scheduled audits and monitoring reports. The results of the scheduled audits will be summarized, interventions and measures of effectiveness will be identified based on the results of the analysis to improve performance. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• The impact of the completion of the action steps have not be fully realized at this point in the process. Performance data is currently being reported and analyzed for growth areas, causal factors, barriers, and identification of interventions to improve performance. The performance and effectiveness of the interventions will be monitored through audit reports and performance summaries on a quarterly basis through the Quality Improvement Council, Customer Services Committee, Utilization Committee, and the Provider Advisory Council relative to the measure. |
| c. Identify any barriers to implementing initiatives:<br>• Barriers include actions/inactions as a result of the pandemic. The oversight committees (policy committee etc.) were canceled or postponed as a result of the pandemic. Therefore, approval of policies/procedures were postponed resulting in delayed implementation. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate two deficiencies identified during the current three-year cycle of compliance reviews related to service authorization requirements. |
| **3. Recommendation—Performance Improvement Projects** |
| HSAG recommended that **Mid-State Health Network** take proactive steps to ensure a successful PIP. Specifically, **Mid-State Health Network** should address all *General Comments* in the *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:<br>• 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.<br>• **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. |

| 3. Recommendation—Performance Improvement Projects |
|---|
| • **Mid-State Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• The general comments were addressed to ensure the impact of any modifications to the specifications of the HEDIS measure was identified. Evaluation outcomes were identified to clearly identify the impact of the intervention on the indicator.<br>• The PIHP utilized and continues to utilize the regional Quality Improvement Council and the regional Medical Directors group to identify region wide barriers to receiving a LDL-C and an HbA1c test as well as causal factors and interventions to overcome the barriers. Each CMHSP reviewed and continues to review their local data quarterly using their local quality improvement process. Feedback is provided regarding barriers to the PIHP.<br>• The process used for the causal/barrier analysis was and is brainstorming and the completion of a Fishbone Diagram.<br>• The evaluation of the effectiveness of the interventions to address the barriers was completed quarterly. The interventions were modified to exclude completed action steps and implement additional interventions to remove the barriers identified, thus improving performance. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Increased coordination/communication with primary care.<br>• Increased number of individuals being monitored for diabetes resulting in improved health.<br>– The rate of monitoring in the PIHP has demonstrated an increase since 2018 baseline data (33.6%) to 2019 data (36.1%).<br>– The status report for the first 5 months of 2020 (39.6%) indicates continued improvement. |
| c. Identify any barriers to implementing initiatives:<br>• MSHN is dependent on the data provided by MDHHS through Care Connect 360 and processed by ICDP. The following factors have an impact on the project:<br>– System errors or issues related to the attribution of a record to a designated CMHSP at the State level may impact the results.<br>– Claims submitted by the physicians' offices do not include claims submitted to Medicare for the required lab work, or lab work billed under a code not included within the value set of the HEDIS specifications.<br>• A factor having an impact on the ability to implement interventions includes the effects of COVID 19 and Executive Orders issued by the Governor. March 2020 through June 2020 (at the time of this reporting) was under various levels of stay at home orders interfering with the ability for individuals to receive non-essential life sustaining services. Contributing factors include limited transportation issues, limited access to laboratories, and physician offices. This has affected all individuals in which we serve, with a significant effect on those that are elderly and/or have compromised immune systems. It |

| 3. Recommendation—Performance Improvement Projects |
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| is unknown at this time the impact this has had and will have going forward on the ability to obtain the required lab work for this measure. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by performance improvement. Based on the PIHP's identification of barriers, HSAG recommends that the PIHP evaluate its ability to obtain claim records sent to Medicare payors and provide education to providers on appropriate coding of lab work. |

## Region 6—Community Mental Health Partnership of Southeast Michigan

**Table 4-6—Prior Year Recommendations and Responses for Community Mental Health Partnership of Southeast Michigan**

**1. Recommendation—Performance Measures**

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:

***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**

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

**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 ongoing 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

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

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

**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

| 1. Recommendation—Performance Measures |
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| SUD providers were given training/guidance on documenting the data in the electronic health record (EHR) and system changes were made to improve performance in this indicator. The data is cleaned by PIHP and CMH Core Provider staff quarterly where ongoing education occurs with SUD providers if data entry errors occur. Changes were made in the CMHPSM EHR that SUD access, in the form of a system titled "SUD Wrapper" which tracks transitions in care including follow up from a detoxification unit discharge. The system requires SUD providers to identify when they have discharged a person from detox and the next follow up appt in order to complete claims. The PI indicators related to SUD continue to be reviewed quarterly by the CMHPSM CPT Committee as the PIHP monitoring and are incorporated in the PIHP Monitoring of SUD providers for FY 20.<br><br>**Ratings Below the MPS**<br>• #3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional—MI Adults, IDD Children, IDD Adults, and Total<br>The PIHP has been monitoring this area of performance and corrective action plans submitted by CMHSPs on a quarterly basis and found an improvement in this indicator consistently beginning at Q3 of FY 18/19. The majority of performance issues were related to low denominator numbers, consumer engagement, or staff error with data or comprehension. Interventions included staff training and implementing engagement initiatives.<br><br>**Performance Declined >2 Percent From Previous Year**<br>• #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<br>The PIHP has been monitoring this area of performance and corrective action plans submitted by CMHSPs on a quarterly basis and found an improvement in this indicator consistently beginning<br>The majority of performance issues were related to consumer engagement or staff error with data or comprehension. Interventions included staff training and implementing engagement initiatives. System changes were made with the EHR and a regional training for all Access staff was provided in February and March of 2020.<br>• #3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional—SED Children<br>The PIHP has been monitoring this area of performance and corrective action plans submitted by CMHSPs on a quarterly basis and found an improvement in this indicator consistently beginning at QII of FY 18/19. Areas of intervention included improving communication from hospitals on discharges, engagement with consumers/families, and training staff to reduce data entry errors.<br>• #4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days—SED and IDD Children<br>The PIHP has been monitoring this area of performance and corrective action plans submitted by CMHSPs on a quarterly basis and found an improvement in this indicator consistently beginning at Q3 of FY 18/19. Areas of intervention included improving communication from hospitals on discharges, engagement with consumers/families, and training staff to reduce data entry errors. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• #4b: Data results in this indicator consistently improved beginning at QIII of FY 19: 91%; QIV FY19: 95%; QI FY20: 99%; QII FY20: 96%; QIII FY20: 98% |

| 1. Recommendation—Performance Measures |
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| • #3 MI Adults, IDD Children, IDD Adults, and Total: The following performance in most recent five quarters are as follows: QII of FY 18/19 95.56%; QIII of FY 18/19: 92.31% QIV of FY 18/19: 96.15%; QI of FY 19/20: 99.12%; QII of FY 19/20: 96.12%<br>• #2 IDD Adults: Data results in this indicator consistently improved beginning at QIII of FY19, with 100% compliance from FY19 QIII to FY20 QII (QIII data is in the process of submission)<br>• #3 SED Children: Data results in this indicator consistently improved beginning at QII of FY19: QII FY 19: 97.10% QIII FY 19: 98.91% QIV FY19: 97.98% QIFY 20: 97.99% QII FY 20: 97.32%<br>• #4a SED and IDD Children: The following performance in most recent three quarters are as follows: QIII of FY 18/19: 96.43%; QIV of FY 18/19: 93.33%; QI of FY 19/20: 92.86%. FY20 data: QI 100%, QII, 100% |
| c. Identify any barriers to implementing initiatives:<br>• Communications from hospitals, COVID-19 challenges for consumers/families (managing school changes, reluctance to have contacts/engage in services) |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by six of seven indicators with an MPS exceeding the MPS. HSAG recommends that the PIHP continue to monitor and implement improvement strategies with its CMHSPs to ensure performance metrics continue to improve and either reach or exceed the MPS. |

| 2. Recommendation—Compliance Review |
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| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Corrective action plans and progress reports were submitted in a timely manner.<br>• At the onset of the 2020, internal progress reviews are monitored and completed with each regional committee in their relevant standards on a monthly basis that include progress on implementation of each plan of action, successes or barriers in remediating each deficiency, and revised actions steps, if necessary. EQR related standards and CAPs have been imbedded in the agenda items of each relevant committee/department meeting to ensure periodic reviews are documented. |

| 2. Recommendation—Compliance Review |
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| • An internal audit of all CAP areas began February 2020 and will continue as a standard procedure for the roles of Chief Operating Officer and Compliance Manager on a monthly basis. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• All CAP areas have been reassessed to ensure they incorporate all the aspects of the standard requirements. The majority of CAP areas that were pending or did not have all elements addressed have been re-assessed, implemented, and completed or close to completion. Four elements are pending due to needing to extend due dated based on barriers described below. As a result of this review some improvements were made to the credentialing and re-credentialing process, two aspects of which are in revision (checklists in ensuring required information is in files and checklists for monitoring of credentialing and re-credentialing files).<br>• Each committee/department relevant to EQR standards has a documented process in reviewing their applicable standards and CAPs monthly with oversight by the PIHP COO and Compliance Manager. |
| c. Identify any barriers to implementing initiatives:<br>• COVD-19 has affected the ability to implement initiatives as system changes and resources have needed to quickly and continually shift to address consumer service needs and provider network capacity.<br>• Staff turnover was a barrier in that the previous Compliance Director left the agency and there was a gap in filling the position. The CMHPSM Chief Operating Officer has acted as the Compliance Officer for the PIHP in the interim since beginning the position February 2020. A Compliance Manager was hired August 2020 and is in the process of training that includes implementing the system changes made above to ensure successful completeness and documentation. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate two deficiencies identified during the current three-year cycle of compliance reviews related to provider credentialing. |

| 3. Recommendation—Performance Improvement Projects |
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| HSAG recommended that **Community Mental Health Partnership of Southeast Michigan** take proactive steps to ensure a successful PIP. Specifically, **Community Mental Health Partnership of Southeast Michigan** should address all *General Comments* in the *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:<br>• 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.<br>• **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.<br>• **Community Mental Health Partnership of Southeast Michigan** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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 |

| 3. Recommendation—Performance Improvement Projects |
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| process should be ongoing and cyclical and decisions to revise, continue, or discontinue an intervention should be data-driven. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• CMHPSM has made revisions to its June 2020 PIP submission and internal PI processes that includes a manual of PI/quality tools to use in completing causal/barrier analysis, implementing interventions to address those barriers, documentation of the process and steps used to determine barriers to improvement. The tools include documentation of a and reporting to the Regional CPT Committee on the outcome of these activities. The regional workgroup assigned to this project has been trained on the use of these tools and documentation will be maintained by the PIHP.<br>• This process and implementation of PI tolls is underway in identifying and implementing active, innovative interventions that have the potential to directly impact study indicator outcomes, and includes a process for evaluating the performance of each intervention and the impact on the study indicators that allows for continual refinement of the intervention/improvement strategy as an ongoing and cyclical and decision process to revise, continue, or discontinue an intervention, and ensuring measures are data based and decisions are data-driven. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• There have been no noted performance improvements to date. |
| c. Identify any barriers to implementing initiatives:<br>• COVID-19 related challenges on both provider and consumer/family level have been significant barriers to improvements and these factors re included in the above described PI processes. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue to evaluate its interventions to ensure they are having a direct and positive impact on performance. |

# Region 7—Detroit Wayne Integrated Health Network

**Table 4-7—Prior Year Recommendations and Responses for Detroit Wayne Integrated Health Network**

| 1. Recommendation—Performance Measures |
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| 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:<br><br>***Not Reported* Performance Measure Rates**<br>• *#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*<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*<br>• *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*<br>• *#10: The percent of SED and IDD children and MI and IDD adults readmitted to an inpatient psychiatric unit within 30 days of discharge*<br><br>**Ratings Below the MPS**<br>• *#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 |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br><br>Detroit Wayne Integrated Health Network (DWIHN) reviewed the performance activities for the indicators that were Not Reportable (NR). Initiatives include the following.<br>• Indicator # 2. Data was pulled utilizing the Date of Request to Reschedule. Indicator logic should be calculated from the original Request Date on the Non-Emergent Intake Form, not the Date of Request to Reschedule. Providers must document the date of the rescheduled offer date and the date of the original offer date.<br>– PCE has reprogrammed the logic for Indicator # 2 to pull the start date from the Request Date only. Providers were re-educated through the Provider Performance Indicator Workgroup and the Quality Operations Technical Assistance Workgroup meetings for documenting exceptions and providing clear notation of the rescheduled date and the original date offered.<br>• Indicator # 3. HSAG noted during the review, that there were 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. |

| 1. Recommendation—Performance Measures |
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| – After consultation with MDHHS, it was confirmed that services on the same claim as the assessment are allowable. MDHHS also stated that if a service qualifies as a first follow-up service, it should be used to calculate the indicator whether that service is on the same claim as the assessment or on a different claim.<br>• Indicator # 4a. The data had cases in which the exceptions were not being recorded through the non-emergent intake.<br>– PCE revised the logic from for appropriate reporting.<br>• Indicator # 4b. The data had cases in which the exceptions were not being recorded through the non-emergent intake. Follow up services in SUD was readmitting the client after detox discharge.<br>– PCE revised the logic from for appropriate reporting.<br>• Indicator # 10. The data had cases that were noted as readmissions, due to the closing of the Fiscal Year. Cases were reassigned as "new" admissions when they should have been concurrent reviews, inflating the number of readmissions for the reporting period.<br>– PCE revised the logic from for appropriate reporting.<br><br>**Ratings Below the MPS**<br>• Indicator # 1. Data for FY 2019–2020 Q1, Q2 and Q3 have met the required standard of 95% or better. Initiatives have included meeting and working with our crisis center to train and re-educate the team on proper documentation for noting medical clearance as well as contacting the Clinically Responsible Providers (CRSP) for review of members presenting to the emergency department (ED). |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• DWIHN implemented required plans of actions for each Non-Reportable (NR) deficiency identified in FY 2018–2019. During the FY 2019–2020 review, DWIHN demonstrated improvement in the reporting of the performance indicator data, noting significant improvements in those areas of deficiency from the 2018–2019 review. |
| c. Identify any barriers to implementing initiatives:<br>• None Identified. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by a *Reportable* designation for all applicable indicators in the most current PMV. However, HSAG recommends that the PIHP continue to monitor and implement improvement strategies with its providers to ensure all performance metrics continue to show improvement and reach or exceed the MPS. |

| 2. Recommendation—Compliance Review |
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| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary. |

| 2. Recommendation—Compliance Review |
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| Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• DWIHN has completed the CAP and submitted to HSAG implementation and supporting documentation for FY 2017–2018 and FY 2018–2019. On September 25, 2020, DWIHN submitted additional information as requested by HSAG. DWIHN is the process of implementing the interventions identified in the CAP to successfully resolve each deficiency noted.<br>• Periodic reviews are conducted to ensure that all areas identified as action steps are implemented as outlined in the submitted CAP. Reviews will include updating HIPAA, Clinical Practice Guidelines, Enrollee/Member Appeals and Member Handbooks ensuring that information is available and current for our members rights as it relates to continuation of services, appeals process and clinical guidelines. DWIHN has also updated and addressed the extension of service authorizations timeframe as noted in the revised UM Provider Procedures for Prior Authorized Behavioral Health Services policy. Medversant Technologies, LLC, software will be fully implemented by December 2020. Medversant will allow for identification of group affiliation, verification of DWIHN's and provider network staff, also providing automatic updates to our provider directory in real time. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• DWIHN has developed a HCBS Residential and Non-Residential Survey/Checklist allowing for new providers or an existing provider with a new setting or service to provide services to HCBS participant for 90 days until a full review can be completed by DWIHN's Quality Improvement unit. The full review is conducted utilizing DWIHN's Monitoring Audit Tool this has allowed DWIHN to create a HCBS compliance list which is available on DWIHN's website. |
| c. Identify any barriers to implementing initiatives:<br>• Due to the COVID-19 Pandemic Outpatient Provider Meetings were not conducted for 4 months. Ongoing meetings have begun to occur via the Blue Jean platform. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices, service authorization requirements, terminated provider notices, provider credentialing, and appeal resolution notices. |
| **3. Recommendation—Performance Improvement Projects** |
| HSAG recommended that **Detroit Wayne Integrated Health Network** take proactive steps to ensure a successful PIP. Specifically, **Detroit Wayne Integrated Health Network** should address all *General Comments* in the *2019 PIP Validation Report Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications for Region 7—Detroit Wayne Mental Health Authority* and the following recommendations:<br>• 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 |

| 2. Recommendation—Compliance Review |
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| 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.<br>• **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.<br>• **Detroit Wayne Integrated Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• DWIHN continues to provide information to providers regarding performance for *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Who Are Using Antipsychotic Medication.* Information is provided through the Quality Operations Technical Advisory Workgroup (QOTAW) and the Quality Improvement Steering Committee (QISC). Education will continue at the QOTAW meeting regarding the importance of having metabolic lab draws for diabetic screening. This information is also available on DWIHN's website under "***For Providers/Provider Resources/Forms, Guidelines and Tools"***.<br>• Each intervention is reviewed and evaluated for recommendations through the QISC and the Improving Practice Leadership Team (IPLT) monthly meetings. DWIHN has implemented the intervention of the Access Center (Wellplace) submitting text messages reminding members of required labs. Going forward, this intervention is a service that will be provided by DWIHN's network providers. DWIHN will determine the effectiveness of the intervention by reviewing the number of clients that have labs related to this measure in Care Management Technology (CMT). |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• DWIHN continues to offer community outreach through MyStrength which is portal on DWIHN's website that allows members to manage their behavioral health and physical goals providing them the resources to help them achieve their goals. In 2018 Member enrollment in MyStrength increased from 2,274 to 2,724 in 2019 and over 4,500 in 2020. This increase is due to major interventions presented to DWIHN's network practitioners during community outreach initiatives. |
| c. Identify any barriers to implementing initiatives:<br>• Due to the COVID-19 pandemic face to face meetings have been temporally discontinued in accordance with Michigan COVID-19 guidelines. DWIHN's provider network is currently using telehealth to provide behavioral health services for members through online platforms that allows members to connect with their providers/practitioners. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, HSAG recommends that the PIHP continue to evaluate its interventions to ensure they are having a direct impact on performance and result in an increase in the percentage of diabetes screenings completed for the eligible population. |

# Region 8—Oakland Community Health Network

**Table 4-8—Prior Year Recommendations and Responses for Oakland Community Health Network**

| 1. Recommendation—Performance Measures |
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| 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:<br><br>**Ratings Below the MPS**<br>• *#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<br>• *#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<br>• *#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<br><br>**Performance Declined >2 Percent from Previous Year**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—Medicaid SUD |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• **Indicator #1:** An EHR logic change was implemented in FY19, more accurately capturing the served population. Staffing changes were analyzed and moved to more appropriate peak times. Triage dispositions were more accurately calculated by the EHR to more accurately represent the 180 measure. Going forward in 2020, staff are currently discussing shortening the emergency assessment to help shorten the amount of time to hospitalization decision.<br>• **Indicator #2:** Children population initiatives that were implemented in FY19 by core providers included staff training, hiring additional intake staff, supervisors monitoring intake calendars, adjusting walk-in policies, and core providers and the OCHN access department communicating about common methodology in the scheduling process. CCBHC [Certified Community Behavioral Health Clinic] calendar issues have also been addressed and resolved.<br>• **Indicator #3:** No PIPs have been issued to providers for indicator #3a, as this indicator has been in-compliance every quarter for the last 2 fiscal years.<br>• **Indicator #10:** Actions taken to reduce hospital recidivism include reviewing outliers to increase levels of care, increasing contracts, assessing suicide risk during inpatient stays, schedulers providing monthly reports of all discharges for quality monitoring, and program managers meeting biweekly for clinical reviews.<br>• OCHN targets all measures for focus in the QAPIP. For each measure, Performance Improvements Plans were developed and implemented by providers who fell below the standard. These measures are monitored quarterly by the Quality Improvement Committee. |

| 1. Recommendation—Performance Measures |
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| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• **Indicator #2**: In the first three months of the 2020 calendar year, the **Indicator 2** rates improved to 98.53%, which is approximately a 1% increase over the previous two quarters, and on average a 2-3% increase between 2019 and 2020. Scheduling and communication related interventions to SED scheduling concerns were successful and have been incorporated into normal practice.<br>• **Indicator #3:** This measure has been in compliance (between 98% – 100%) for CY19 and CY20. No performance improvement was implemented |
| c. Identify any barriers to implementing initiatives:<br>• COVID-19 has presented numerous challenges to efficiency and timeliness, especially regarding the #1 Indicator. Core providers and the crisis unit are short-staffed and cannot always handle the shifting priorities and health concerns COVID brings.<br>• Another barrier relates to follow-up after discharge (**#4a indicator**). Contacting people for follow-up appointments via telehealth poses a new myriad of issues when reaching out to individuals served as opposed to in-person appointments.<br>• With the MDHHS update to performance indicators #2a and #3a, we foresee a drastic change in the calculation of said indicators. With no exclusions to #2a or #3a beginning in Q3 FY20, we will likely see a large drop in the compliance rates for all populations at all providers. Performing root causes analysis to identify initiatives to improve those rates will be vital. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations. HSAG recommends that the PIHP continue to monitor and implement improvement strategies internally and with providers to ensure performance metrics demonstrate improvement and reach the MPS. HSAG further recommends the PIHP evaluate its noted barriers, implement interventions to mitigate these barriers, and continue to conduct root cause analyses to identify priority focus areas (e.g., access to follow-up services, use of telehealth services). |

| 2. Recommendation—Compliance Review |
|---|
| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |

| 2. Recommendation—Compliance Review |
|---|
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• In response to HSAG findings, OCHN made several revisions to Policies and Procedures to address deficiencies, including the Sentinel and Other Reportable Events Policy, Due Process Policy, Orientation Policy, Provider Application Procedure, Onboarding Procedure, and Provider Monitoring Procedure.<br>• In addition to revisions to Policies and Procedures, some written forms and materials were also revised. Such materials include the Customer Services Handbook, Grievance and Appeal Rights Brochure, and Due Process-ABD Notice.<br>• A quarterly analysis report was developed for Risk Events, Critical Incidents and Sentinel Events. This was done previously but had not been done in the FY prior to the review. There was also a change in the review process for Critical Incidents, to ensure Sentinel Events were identified timely. OCHN changed the process so that individual Clinical Analysts conduct the review, rather than the SERC [Sentinel Event Review Committee] to allow for a more expedient review. All events are reviewed each week at the SERC meeting for review and discussion by that team. Each completed RCA [root cause analysis] is reviewed at the SERC meeting within the required timeframe and either approved or sent back to the agency for further action.<br>• The Member Experience Report was shared more widely in FY20, with presentations at two committees comprised of people we serve, leadership teams, Rights Committee, Quality committee, and the Board, as well as being posted on the OCHN website.<br>• Credentialing Audits were conducted in February and March of 2020. Reports were distributed to the providers and Performance Improvement Plans were issued to those providers who had deficiencies on areas that needed improvement (even if their score was 95% when PIPs are traditionally not issued). These audits included the review of mechanisms to review member grievances and complaints, appeals and quality issues during the credentialing process. OCHN also reviewed each organization's credentialing policies to ensure the inclusion of this requirement.<br>• There was a large amount of work done to assist in meeting the Organizational Credentialing standards. This includes the development of a committee, procedures, and tracking mechanisms. Currently, OCHN is reaching out to other CMHs [CMHSPs]/PIHPs to discuss their existing provider credentialing system. For the current time, OCHN is utilizing Smartsheets and Excel to capture all necessary data.<br>• The OCHN Breach Notification template has been updated to include steps individuals should take to protect themselves from potential harm resulting from the breach. The OCHN Breach Notification Policy also addresses this requirement. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• There was significant improvement noted in the area of Credentialing as we prepared for our NCQA survey. The audits that were conducted, and trainings that were provided, led to a great improvement in credentialing processes, and audit results.<br>• Most of the findings related to changes to administrative forms, policies and materials, which would not yield a performance rating. |

| 2. Recommendation—Compliance Review |
|---|
| c. Identify any barriers to implementing initiatives:<br>• The changes to the Due Process-ABD forms were delayed by the EHR vendor. The project was finally complete in July of 2020.<br>• OCHN has encountered several barriers in implementing HSAG CAP items related to organizational credentialing. Due to disruptions of the COVID-19 emergency service provision, administrative tasks have been impacted. The PCE Credentialing Module, which OCHN hoped would be in place prior to FY21, will not be added to OCHN's EMR until at least October 2020, if not later. When completed, this EMR module will streamline provider documentation, contract management, and reports. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices, service authorization requirements, the member handbook, and member appeals. |

| 3. Recommendation—Performance Improvement Projects |
|---|
| HSAG recommended that **Oakland Community Health Network** take proactive steps to ensure a successful PIP. Specifically, **Oakland Community Health Network** should address all *General Comments* in the *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:<br>• 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.<br>• **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.<br>• **Oakland Community Health Network** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• In 2019, Oakland Community Health Network (OCHN) sent individuals-served (who met flagged metric criteria) reminder letters on a quarterly basis to complete their annual diabetes screening. In the fall of 2019, OCHN elected to send duplicate reminder letters to individuals who continued to be flagged in subsequent quarters, when comparing quarterly data. When data is compiled and analyzed for the subsequent quarter, it is reviewed against the previous quarter to identify duplicates (flagged individuals). Individuals who still require their diabetes screening are sent another reminder letter, in the following quarter. This intervention occurred in 2019, however, is planned to continue in 2020. To |

| 3. Recommendation—Performance Improvement Projects |
|---|
| evaluate this intervention, OCHN staff will also conduct and track quarterly outreach calls to all flagged individuals who receive a reminder letter in 2020. This intervention will measure the effectiveness of the reminder letter leading to the individual completing their annual diabetes screening in 2020. The later intervention is scheduled to occur in 2020. Similarly, in 2020, the Integrated Health Committee will continue to discuss barriers and solutions of improving metric performance at their quarterly meetings, to support causal and barrier analysis with the provider network.<br>• During 2019, 707 reminder letters were sent to individuals-served during the 2019 calendar year. In tracking recipients and completed screenings; 44% of individuals who received an initial reminder letter during 2019 completed their diabetes screening during the calendar year. 166 duplicate letters were also sent in the fall of 2019 for individuals who were flagged for a subsequent quarter for not receiving their screening, in the previous quarter. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• In comparison to the 2018 baseline year, performance in 2019 fell by 1.8% and measured 11.8% below the performance standard goal. It is important to highlight that during 2019, the population dataset was enhanced by ProAct CMT [Care Management Technologies] to include beneficiaries and claims with Healthy Michigan (a Medicaid expansion) insurance. OCHN verified with the Michigan Department of Health and Human Services that individuals with Healthy Michigan (Medicaid expansion based upon income) could be included within the metric's population. Previously, Healthy Michigan individuals and claims were excluded from the population dataset, as OCHN was not aware they could be included within the metric population.<br>• After the inclusion of Healthy Michigan claims and beneficiaries, the numerator and denominator increased more than 10% overall from baseline. This is important for consideration, as the initial baseline measurement did not include Healthy Michigan claims and beneficiaries during the 2018 calendar year, as well as a majority of the 2019 calendar year. This is a factor that impacts the comparability of the measurement periods, as the 2019 data includes a larger population and the change became integrated in November 2019. This enhancement, however, supports increased accuracy and comparability for the 2020 calendar year. While performance improvement was not achieved in 2019, increased validity will support performance improvement is 2020. |
| c. Identify any barriers to implementing initiatives:<br>• Oakland Community Health Network and Network providers identified a barrier of unknown testing through discussion at the Integrated Health Committee quarterly meeting. For example, individuals-served who receive their testing through grant-funded services or through a primary care physician, do not submit testing claims through the Core Provider Agencies. Therefore, these claims are not captured in CC360 and will not be included within the performance metric. While it is difficult to address unknown data, case managers are encouraged to identify individuals that receive screenings through other methods, and if the screenings were completed but not captured, provider staff are instructed to manually enter the data into ProAct CMT. As this is a challenging barrier to address with the Provider Network and with case managers, manual data entry training is scheduled in 2020 as a provider intervention to be implemented to support improved data documentation and performance. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, a change in methodology was noted, which did not allow for comparison of results over time. HSAG recommends that the PIHP continue to monitor and implement improvement strategies to ensure performance metrics demonstrate improvement and reach the MPS. HSAG further recommends the PIHP continue to implement interventions to ensure test claims from all payment streams and sources are included in the results data. |

# Region 9—Macomb County Community Mental Health

**Table 4-9—Prior Year Recommendations and Responses for Macomb County Community Mental Health**

| 1. Recommendation—Performance Measures |
|---|
| 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:<br><br>***Not Reported* Performance Measure Rates**<br>• *#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*<br>• *#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*<br><br>**Ratings Below the MPS**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—SED Children, MI Adults, IDD Children, and IDD Adults<br>• *#4a: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days*—MI and IDD Adults<br><br>**Performance Declined >2 Percent From Previous Year**<br>• *#3: The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional*—Total |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• KPI [key performance indicator] 1 is consistently met in Macomb County. A real time monitoring tool was developed for KPI 2 and 4, to assist Access to meet the benchmarks. Full KPI analysis occurs at the PIHP Quality Council and are also reported quarterly at the Quality Provider meeting. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Continuous improvement practices continue. |
| c. Identify any barriers to implementing initiatives:<br>• Staff turnover is a barrier. Macomb County continues to mandate training of the new access managers on the necessity to achieve the benchmarks. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by a designation of *Reportable* for all performance indicators in the most current PMV. However, HSAG recommends that the PIHP continue to monitor performance data, evaluate for barriers, and implement improvement strategies with its providers. |

| 2. Recommendation—Compliance Review |
|---|
| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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 |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Effective June 2020, Macomb County Community Mental Health (MCCMH) has been meeting monthly via zoom to discuss progress made. In the meetings MCCMH also discussed barriers that would impact the CAP to be successful. When barriers have been identified, we have problem solved to find a solution to make sure the CAP continues to be effective. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• MCCMH is in the process of collecting evidence to ensure effectiveness of the CAP. |
| c. Identify any barriers to implementing initiatives:<br>• None identified at this time. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to QAPIP requirements, ABD notices, and provider credentialing. |

| 3. Recommendation—Performance Improvement Projects |
|---|
| HSAG recommended that **Macomb County Community Mental Health** take proactive steps to ensure a successful PIP. Specifically, **Macomb County Community Mental Health** should address all *General Comments* in the *2019 PIP Validation Report Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness (SMI) for Region 9—Macomb County Community Mental Health* and the following recommendations:<br>• 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.<br>• **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.<br>• **Macomb County Community Mental Health** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Monthly meeting's occurring to discuss barriers and interventions. Consultation with HSAG occurred July 2020. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• None at this time. |
| c. Identify any barriers to implementing initiatives:<br>• Staff turnover is a barrier. The access consulting psychiatrist became the PIHP Medical Director. The Access Center is currently recruiting a new psychiatrist. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP demonstrated an increase in the percentage of adults with SMI readmitted to a hospital within 30 days post discharge. Due to this increase, HSAG recommends the PIHP evaluate whether there is a correlation between members not following up with a provider within seven days of discharge and being readmitted to the hospital within 30 days of the initial discharge. HSAG further recommends the PIHP prioritize its focus on ensuring members are able to see a provider within seven days of inpatient discharge to help mitigate inpatient recidivism. |

# Region 10 PIHP

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

| 1. Recommendation—Performance Measures |
|---|
| 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:<br><br>***Not Reported* Performance Measure Rates**<br>• *#4b: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days*<br><br>**Ratings Below the MPS**<br>• *#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 |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• Following an email from HSAG dated August 11, 2020, Region 10 PIHP staff located the SFY 2018–2019 External Quality Review Technical Report on the MDHHS website. Region 10 PIHP was not previously advised this report was published, nor was Region 10 PIHP provided with information on how to access the report or when the report became available. Following the review of the SFY 2019 External Quality Review Technical Report, it was found that the report contained additional comments and recommendations that were not previously identified to Region 10 PIHP.<br>• Region 10 PIHP received the Final SFY 2019 Validation of Performance Measures Report on October 3, 2019. The recommendation in this report specifically addressed Performance Indicator 4b. Region 10 PIHP implemented a more robust process to review for the review of Substance Use Disorder (SUD) Performance Indicators.<br>• Region 10 PIHP discusses any questions or issues during monthly Quality Management Committee meetings.<br>• Region 10 PIHP monitors Performance Indicator root cause analyses and corrective action plans of providers through the contract monitoring process.<br>• Region 10 PIHP reviews and presents Performance Indicator reports at Quality Assessment and Performance Improvement Program Committee meetings, the Quality Improvement Committee meetings, and PIHP Board meetings. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Region 10 PIHP's performance with Performance Indicator #10 has improved since the first quarter of fiscal year 2019.<br>• Region 10 PIHP has enhanced the review, analysis, and follow-up processes for SUD Performance Indicators. |

| 1. Recommendation—Performance Measures |
|---|
| c. Identify any barriers to implementing initiatives:<br>• None |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by an indicator designation of *Reportable* for all performance indicators. However, Indicator #4b performed below the MPS, indicating the PIHP should continue to monitor and implement improvement strategies with its providers to ensure all performance metrics improve and reach or exceed the MPS. The PIHP should also consult with MDHHS on the exception methodology within the MDHHS Codebook. Additionally, the PIHP's response suggests that it is not aware of the federal managed care rule that requires the annual EQR technical report to be published to MDHHS' website by April 30 of each year, and MDHHS has published the annual EQR technical reports to its website since SFY 2005–2006. HSAG strongly recommends that the PIHP familiarize itself with the applicable federal managed care requirement located in 42 CFR §438.364. The PIHP should also implement a process to ensure that PIHP staff members obtain the annual EQR technical report on April 30 of each year. |
| **2. Recommendation—Compliance Review** |
| **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 recommended 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:<br>• Progress on implementation of each plan of action.<br>• Successes or barriers in remediating each deficiency.<br>• Revised actions steps, if necessary.<br><br>Once all plans of action are fully implemented, HSAG recommended 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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• On December 18, 2018, Region 10 PIHP received the Final Report and Corrective Action Plan (CAP) template following the 2017–2018 Compliance Monitoring Review. After receiving confirmation from HSAG that MDHHS extended the CAP submission deadline, Region 10 PIHP submitted the final CAP on February 6, 2019.<br>• While HSAG Reviewers were on-site during the 2018–2019 Compliance Monitoring Review (September 13, 2019), Region 10 PIHP staff asked about the status of the 2017–2018 Compliance Monitoring Review CAP. The HSAG Reviewers stated that HSAG and MDHHS representatives had not determined the approval process for CAPs.<br>• On December 20, 2019, Region 10 PIHP received the Final Report and CAP template following the 2018–2019 Compliance Monitoring Review. After confirmation from HSAG that MDHHS extended the CAP submission deadline, Region 10 PIHP submitted the final CAP on March 6, 2020. |

| 2. Recommendation—Compliance Review |
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| • As of September 1, 2020, Region 10 PIHP has not received confirmation from HSAG, nor MDHHS, that the 2017–2018 or 2018–2019 Compliance Monitoring Review CAPs have been approved.<br>• As written on the 2017–2018 and 2018–2019 Compliance Monitoring Review Final Reports and CAP templates, 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 templates to provide CAPs in response to the elements and required actions included. The additional CAP requirements listed on page 5-152 of the SFY 2019 External Quality Review Technical Report were not included on the 2017–2018 or 2018–2019 Compliance Monitoring Review Final Reports or CAP templates.<br>• Region 10 PIHP completed all tasks as requested during the 2019–2020 PIHP Compliance Review – CAP Review Process which addressed CAPs from both the 2017–2018 and 2018–2019 Compliance Monitoring Reviews. Region 10 PIHP submitted progress reports on May 29, 2020 and July 13, 2020 which summarized the steps that have been completed on each action plan to date, and any identified barriers to completion by the date specified in the CAP. A final response with supporting documentation was also submitted by Region 10 PIHP on August 26, 2020. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Region 10 PIHP has updated documents and improved processes to align and comply with state and federal requirements.<br>• Region 10 PIHP has strengthened staff support in multiple areas.<br>• Region 10 PIHP has enhanced monitoring of its provider network. |
| c. Identify any barriers to implementing initiatives:<br>• PIHP and CMH staffing capacity impacted the completion of PIHP Affiliate (CMH) provider directories.<br>• The feasibility of group services due to the COVID-19 safety guidelines impacted the completion of qualitative assessments of members experiences with services. |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations; however, the PIHP continues to remediate seven deficiencies identified during the current three-year cycle of compliance reviews related to ABD notices, provider credentialing, and appeal resolution notices. Additionally, while the PIHP indicated that it had not received approval of its CAPs as of September 2020, this should not delay implementation. Further, the PIHP indicated that the recommendations included in the SFY 2019 EQR technical report were not included in the SFY 2018 or SFY 2019 compliance review reports or CAP templates. However, while some recommendations included in the annual EQR technical reports may align with recommendations in EQR activity-specific reports, the intent of the annual EQR technical report is to not only include previously identified recommendations but additional recommendations program wide. HSAG strongly recommends the PIHP familiarize itself with the federal managed care requirements located in 42 CFR §438.364. The PIHP should also implement a process to ensure that staff members obtain the annual EQR technical report on April 30 of each year and subsequently review and address the recommendations made by the EQRO. |

| 3. Recommendation—Performance Improvement Projects |
|---|
| HSAG recommended that **Region 10 PIHP** take proactive steps to ensure a successful PIP. Specifically, **Region 10 PIHP** should address all *General Comments* in the *2019 PIP Validation Report Medical Assistance for Tobacco Use Cessation for Region 10—PIHP* and the following recommendations:<br>• 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.<br>• **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.<br>• **Region 10 PIHP** should implement active, innovative interventions that have the potential to directly impact study indicator outcomes.<br>• **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. |
| ***MCE's Response (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*** |
| a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:<br>• On October 21, 2019, Region 10 PIHP received the Revised 2019 PIP Validation Report. The recommendations included in this report align with the recommendations listed above.<br>• On June 30, 2020 and August 14, 2020, Region 10 PIHP submitted revised PIP Validation Tools for review by HSAG.<br>• Causal/barrier analyses were completed by each CMH affiliate, as determined by the Region 10 PIHP Quality Management Committee.<br>• Region 10 PIHP documented the process and steps for causal/barrier analyses in revised PIP Validation Tools and within an attachment to the revised PIP Validation Tools.<br>• Region 10 PIHP implemented active, innovative interventions with the potential to directly impact study indicator outcomes.<br>• Region 10 PIHP implemented a process to evaluate the performance of each intervention and the impact on study indicators. |
| b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>• Region 10 PIHP's preliminary findings from the comparison of baseline data to calendar year 2019 data show an increase in the percentage of persons with Serious Mental Illness who have received Medical Assisted Treatment for Tobacco Use Cessation. |
| c. Identify any barriers to implementing initiatives:<br>• Barriers to implementing initiatives include provider staff knowledge of tobacco cessation, individuals' awareness of and education on tobacco cessation, some providers encourage/enable tobacco use, individuals' connections with primary care physicians, psychiatry staff not ordering medication assisted treatment, lack of assessments for tobacco use, and lack of a program in support of tobacco cessation. |

| 3. Recommendation—Performance Improvement Projects |
| --- |
| **HSAG Assessment:** HSAG has determined that the PIHP addressed the prior recommendations as demonstrated by attaining statistically significant improvement. However, HSAG recommends that the PIHP continue to evaluate its noted barriers and implement interventions that will mitigate these barriers and have a direct and positive impact on performance. |

# 5. PIHP Comparative Information

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 Behavioral Health 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 Behavioral Health Managed Care program and to identify areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

## PIHP EQR Activity Results

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

### *Validation of Performance Improvement Projects*

For the SFY 2020 validation, the PIHPs submitted Remeasurement 1 data for their ongoing PIHP-specific PIP topic. Table 5-1 provides a comparison of the validation scores, by PIHP.

**Table 5-1—Comparison of Validation by PIHP**

| Overall PIP Validation Status, by PIHP | | Design, Implementation, and Outcomes Scores | | |
|---|---|---|---|---|
| | | Met | Partially Met | Not Met |
| NorthCare | *Not Met* | *85%* | *5%* | *10%* |
| NMRE | *Not Met* | *80%* | *10%* | *10%* |
| LRE | *Met* | *95%* | *0%* | *5%* |
| SWMBH | *Not Met* | *90%* | *0%* | *10%* |
| MSHN | *Not Met* | *90%* | *5%* | *5%* |
| CMHPSM* | *Not Met* | *86%* | *5%* | *10%* |
| DWIHN | *Not Met* | *85%* | *5%* | *10%* |
| OCHN | *Not Met* | *80%* | *10%* | *10%* |
| MCCMH | *Not Met* | *75%* | *15%* | *10%* |
| Region 10 | *Met* | *100%* | *0%* | *0%* |

* Percentage totals may not equal 100 due to rounding.

The validation statuses for the PIHPs that received an overall *Not Met* validation score are related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. For the SFY 2020 PIP, achieving statistically significant improvement was an MDHHS-approved critical element, and only two of the 10 PIHPs achieved this high level of performance improvement. Although

three of the eight remaining plans achieved some improvement, overall, they received a *Not Met* validation status.

## Performance Measure Validation

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 *Do Not Report (DNR)* audit designations.

Table 5-2 presents the SFY 2019 and SFY 2020 statewide results for the validated performance indicators with year-over-year comparative rates. MDHHS defined an MPS for seven performance indicators. For these performance indicators, the statewide rates that met or exceeded the MPS are denoted by green font, while those that did not meet the MPS are denoted by red font. Performance indicators in black font do not have an established MPS.

**Table 5-2—SFY 2019 and SFY 2020 Statewide Performance Measure Rates**

| Performance Indicator | 2019 Rate | 2020 Rate |
|---|---|---|
| ***#1: The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.*** | | |
| *Children* | 96.53% | 98.63% |
| *Adults* | 97.28% | 97.64% |
| ***#4a: The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *Children* | 97.66% | 95.17% |
| *Adults* | 94.49% | 93.41% |
| ***#4b: The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.***[+] | | |
| *The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days.* | 96.13% | 96.39% |
| ***#5: The percentage of Medicaid recipients having received PIHP managed services.*** | | |
| *The percentage of Medicaid recipients having received PIHP managed services.* | 6.96% | 7.11% |
| ***#6: The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.*** | | |
| *The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.* | 97.48% | 97.79% |

| Performance Indicator | 2019 Rate | 2020 Rate |
|---|---|---|
| ***#8: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.*** | | |
| *MI Adults* | 14.96% | 16.31% |
| *IDD Adults* | 9.51% | 10.01% |
| *MI/IDD Adults* | 8.20% | 8.73% |
| ***#9: The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*** | | |
| *MI Adults* | 91.24% | 98.54% |
| *IDD Adults* | 45.82% | 53.64% |
| *MI/IDD Adults* | 43.53% | 56.95% |
| ***#10: The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge.**** | | |
| *SED Children and IDD Children* | NA | 7.98% |
| *MI Adults and IDD Adults* | 11.23% | 14.70% |
| ***#13: The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).* | 19.56% | 19.37% |
| ***#14: The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*** | | |
| *The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).* | 44.82% | 45.04% |

* A lower rate indicates better performance.

+ Due to variation in PIHPs' interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates in comparison to MPS.

NA indicates that data were not available for the indicator for SFY 2019 and/or 2020.

Compared to performance in the prior year, the statewide rates experienced a variety of changes. Indicator #9 changed by the most percentage points as it increased by more than 7 percentage points for MI Adults, by just under 8 percentage points for IDD Adults, and by more than 13 percentage points for MI/IDD Adults. Indicators #1, 4b, 5, 6, 8, and 14 demonstrated smaller increases with Indicator #1 improving by 2.1 percentage points for the adult population while the other performance indicators improved, but by fewer percentage points. Indicators #4a and #10 demonstrated worsening performance with Indicator #4a declining by 2.49 percentage points for children and 1.08 percentage points for adults. Due to the current MDHHS Codebook methodology for Indicator #4a, it is unclear if the worsening performance signifies that a lower percentage of children and adults were seen for follow-up care within seven days of discharge from a psychiatric inpatient unit in SFY 2020 than in SFY 2019, or

if the rates were impacted by the methodology allowance of exceptions and PIHP interpretation of the definition of exceptions. Indicator #10 showed a higher than 3 percentage point increase for MI Adults and IDD Adults from SFY 2019 to SFY 2020, demonstrating worse performance as a higher percentage of these adults were readmitted to an inpatient psychiatric unit within 30 days of discharge in 2020.

Table 5-3 presents a two-year comparison of the PIHP-specific results for the SFY 2020 validated performance indicators.

**Table 5-3—Current Year (CY) and Prior Year (PY) PIHP-Specific Performance Measure Rate Percentages**

| Performance Indicator | | Region 1 NorthCare | Region 2 NMRE | Region 3 LRE | Region 4 SWMBH | Region 5 MSHN | Region 6 CMHPSM | Region 7 DWIHN | Region 8 OCHN | Region 9 MCCMH | Region 10 PIHP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **#1** | Children | 100.00% | 96.30% | 98.85% | 100.00% | 98.60% | 99.43% | 98.47% | 95.56% | 99.07% | 99.73% |
| | Adults | 100.00% | 96.99% | 95.71% | 99.39% | 99.17% | 99.38% | 96.48% | 91.51% | 99.37% | 99.73% |
| **#4a+** | Children | 100.00% | 95.83% | 93.02% | 100.00% | 98.28% | 100.00% | 93.06% | 97.37% | 78.43% | 97.53% |
| | Adults | 100.00% | 93.80% | 95.58% | 97.66% | 95.14% | 91.33% | 95.99% | 94.64% | 76.95% | 96.67% |
| **#4b+** | Consumers | 100.00% | 98.61% | **DNR** | 95.47% | 98.39% | 99.12% | 94.00% | 99.00% | 98.32% | 93.68% |
| **#5** | Medicaid Recipients | 7.47% | 7.92% | 6.13% | 7.24% | 8.58% | 7.31% | 6.60% | 8.03% | 5.29% | 7.38% |
| **#6** | HSW Recipients | 99.47% | 97.95% | 97.17% | 97.63% | 97.19% | 97.98% | 96.75% | 98.60% | 98.53% | 98.76% |
| **#8** | MI Adults | 18.76% | 20.47% | 16.20% | 17.54% | 19.31% | 17.62% | 11.90% | 19.87% | 17.97% | 12.30% |
| | IDD Adults | 9.40% | 12.13% | 9.80% | 10.95% | 9.89% | 9.60% | 9.20% | 14.31% | 5.75% | 8.15% |
| | MI/IDD Adults | 9.98% | 18.81% | 10.02% | 6.90% | 9.52% | 10.17% | 6.50% | 8.71% | 6.52% | 7.24% |
| **#9** | MI Adults | 97.00% | 99.16% | 98.46% | 98.40% | 98.41% | 98.53% | 98.90% | 99.09% | 99.41% | 97.95% |
| | IDD Adults | 43.86% | 48.03% | 64.87% | 82.17% | 56.07% | 56.08% | 51.80% | 57.22% | 25.88% | 55.74% |
| | MI/IDD Adults | 53.13% | 75.16% | 71.19% | 74.39% | 55.06% | 66.95% | 47.10% | 60.53% | 35.94% | 60.53% |
| **#10** | SED Children and IDD Children* | 7.14% | 4.62% | 8.16% | 4.35% | 4.35% | 9.80% | 10.91% | 11.54% | 10.13% | 7.69% |

| Performance Indicator | | Region 1 NorthCare | Region 2 NMRE | Region 3 LRE | Region 4 SWMBH | Region 5 MSHN | Region 6 CMHPSM | Region 7 DWIHN | Region 8 OCHN | Region 9 MCCMH | Region 10 PIHP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | MI Adults and IDD Adults* | 9.71% | 9.77% | 9.36% | 10.65% | 11.59% | 9.62% | 20.41% | 10.53% | 14.93% | 14.15% |
| **#13** | IDD Adults | 16.49% | 22.02% | 14.44% | 21.85% | 19.16% | 25.23% | 21.70% | 19.06% | 15.50% | 16.54% |
| **#14** | MI Adults | 55.41% | 51.24% | 48.12% | 53.13% | 49.93% | 37.92% | 38.21% | 35.25% | 44.96% | 49.04% |

*DNR (Do Not Report)* indicates that the rate was determined "materially biased."

* A lower rate indicates better performance.

+ Due to variation in PIHPs' interpretation of the methodology and allowable exceptions, caution is advised for interpreting this indicator's rates and PIHP to PIHP comparison.

Best performing PIHPs' rates are denoted in green font for performance indicators that have an MPS.

Worst performing PIHPs' rates are denoted in red font for performance indicators that have an MPS.

In comparison of the PIHP-specific results for the SFY 2020 validated performance indicators, **NorthCare Network** demonstrated the best PIHP performance overall, achieving the best rate on three performance indicators with 100 percent for both child and adult populations reported for Indicator #1 and Indicator #2, as well as 100 percent for Indicator #4b. **Southwest Michigan Behavioral Health** also demonstrated strong performance with the best rate for one population within three of the performance indicators. **Oakland Community Health Network** demonstrated the worst PIHP performance overall, with the worst rate for both child and adult populations reported for Indicator #1 as well as the worst rate for the SED Children and IDD Children populations for Indicator #10.

## Compliance Review

HSAG calculated the overall performance in each of the 17 performance areas. Table 5-4 compares the Medicaid managed care program's average compliance score in each of the 17 performance areas with the compliance score achieved by each PIHP. The percentages of requirements met for each of the 17 standards reviewed during the SFY 2020 compliance review are provided.

**Table 5-4—Summary of SFY 2020 Compliance Review Results**

| Standard | R1 | R2 | R3 | R4 | R5 | R6 | R7 | R8 | R9 | R10 | Medicaid Program |
|---|---|---|---|---|---|---|---|---|---|---|---|
| I | 100% | 75% | 88% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | **95%** |
| II | 100% | 88% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | **98%** |
| III | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **98%** |
| IV | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| V | 88% | 81% | 81% | 94% | 88% | 100% | 88% | 81% | 94% | 94% | **89%** |
| VI | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% | 100% | 100% | **100%** |
| VII | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| VIII | 100% | 100% | 100% | 100% | 100% | 100% | 92% | 100% | 100% | 100% | **99%** |
| IX | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **99%** |
| X | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| XI | 100% | 100% | 89% | 89% | 100% | 78% | 78% | 100% | 88% | 78% | **90%** |
| XII | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| XIII | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| XIV | 100% | 100% | 98% | 100% | 98% | 100% | 98% | 94% | 100% | 98% | **99%** |
| XV | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| XVI | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| XVII | 100% | 100% | 100% | 100% | 100% | 100% | 92% | 100% | 100% | 100% | **99%** |
| **Total Score** | **99%** | **97%** | **97%** | **99%** | **99%** | **99%** | **97%** | **97%** | **99%** | **99%** | **98%** |

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

Indicates standards in which PIHPs did not achieve full compliance.

## Statewide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each PIHP and of the overall strengths and weaknesses of the Michigan Behavioral Health Managed Care program related to the provision of healthcare 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 the Behavioral Health Managed Care program.

### *Strengths*

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

- Through their participation in the state-mandated PIP, the PIHPs focused their efforts on specific quality outcomes—particularly quality and access to care and services—which should ultimately result in better health outcomes for Michigan Behavioral Health Managed Care program members. Overall, the PIHPs designed methodologically sound PIPs supported by the use of key research principals. The PIHPs also reported appropriate data collection methods, data analysis results, and implemented timely improvement strategies. Although the PIHPs have not demonstrated significant improvement to date, regular evaluation and subsequent implementation of effective improvement strategies implemented over time should improve the mental health and wellness of the PIHPs' 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 mental health diagnoses. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive appropriate care and services to manage their illness. Members receiving appropriate and timely follow-up care with a mental health practitioner after discharge promotes recovery, while reducing the risk of suicide, repeat hospitalization, and the overall cost of healthcare.
  - 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, and that behavior modification strategies are evaluated for effectiveness. Appropriate and effective treatment of ADHD leads to better control of ADHD symptoms, and improvements in children's interactions and relationships with others and their ability to focus in school.
  - Increasing HbA1c and LDL-C testing among Medicaid members with diabetes and schizophrenia. Adults with SMI are more likely to suffer from chronic physical health conditions, such as diabetes, hypertension, and cardiovascular disease than the general

population.[6-1] Monitoring HbA1c and LDL-C test results can assist in controlling diabetes; prevent serious health complications such as kidney damage, eye damage, skin conditions, and amputations; and lead to improvement in the 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 and other metabolic diseases. Uncontrolled diabetes can lead to adverse health problems and even death.
  - 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 improve treatment adherence, reduce risk of poorer mental health, and ultimately reduce 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. As stated by the Centers for Disease Control and Prevention, smoking leads to disease and disability and harms nearly every organ system of the body. Smoking is also the leading cause of preventable death.[6-2] Promoting tobacco cessation is expected to reduce smoking-related health risks in members and prevent chronic diseases, while improving their overall well-being.

- The assessment of the PIHPs' eligibility and enrollment data system; medical services data system, including claims and encounters; BH-TEDS data production; and oversight of affiliated CMHSPs, as applicable, confirmed in general that the PIHPs are collecting data and calculating MDHHS-developed performance indicators in accordance with the MDHHS Codebook specifications. Additionally, nine out of the 10 PIHPs were able to successfully report data for all indicators, suggesting BHDDA and its PIHPs are able to accurately report on members' ability to access behavioral health and SUD services timely. Further, performance measure rates demonstrated statewide strengths in quality, timeliness, and access to care to many behavioral health and SUD services.
  - Three PIHPs, **NorthCare Network**, **Southwest Michigan Behavioral Health**, and **Mid-State Health Network**, exceeded the established MPS for all indicators, indicating most members in regions 1, 4, and 5 had timely access to behavioral health and SUD treatment providers.
  - The statewide aggregated score for Indicator #1: *The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours* exceeded the MPS, indicating most members in the State are evaluated for psychiatric inpatient services within three hours of request. Only one PIHP, **Oakland Community Health Network**, did not meet the MPS of 95 percent for the adult population.

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[6-1] Janssen EM, McGinty EE, Azrin ST, Juliano-Bult D, Daumit GL. Review of the evidence: prevalence of medical conditions in the United States population with serious mental illness. Gen Hosp Psychiatry. 2015 May-Jun;37(3):199-222. doi: 10.1016/j.genhosppsych.2015.03.004. Epub 2015 Mar 14. PMID: 25881768; PMCID: PMC4663043. Available at: https://pubmed.ncbi.nlm.nih.gov/25881768/. Accessed on: Nov 1, 2020.

[6-2] Centers for Disease Control and Prevention. *Tips From Former Smokers*®: Overviews of Diseases/Conditions, reviewed March 16, 2020. Available at: https://www.cdc.gov/tobacco/campaign/tips/diseases/index.html. Accessed on: Nov 1, 2020.

- Results from the three-year compliance review cycle indicated all 10 PIHPs have the ability to appropriately manage and adhere to the expectations established for the Michigan Behavioral Health Managed Care program through State and federal requirements, as demonstrated by SFY 2020 aggregated compliance review results scoring between 97 percent and 99 percent and the majority of previously identified deficiencies from the first two years in the review cycle being remediated. These high-performance scores indicate the PIHPs have strong foundations in place to provide medically necessary quality and accessible behavioral healthcare services to their members.
  - The program-wide overall PIHP compliance score was 98 percent, indicating the PIHPs have the processes, procedures, and systems in place to effectively implement the managed care functions required by 42 CFR §438, meet the requirements in their contracts with MDHHS, and provide services in support of the Behavioral Health Managed Care program.
  - All PIHPs scored 100 percent in the Staff Qualifications and Training; Customer Service; Grievance Process; Provider Network; Access and Availability; Coordination of Care; Disclosure of Ownership, Control, and Criminal Convictions; and Confidentiality of Health Information standards, suggesting the PIHPs employ qualified staff members to carry out the requirements of the contract with MDHHS, the provider network is sufficient to deliver behavioral health and SUD services to members, and have certain program integrity and privacy practices in place to support compliance with federal regulations related to the use and disclosure of PHI and ensure network providers are permitted to provide services and be reimbursed by Medicaid dollars.

## *Weaknesses*

HSAG's comprehensive assessment of the PIHPs and the Behavioral Health Managed Care program also identified areas of focus that represent significant opportunities for improvement within the program.

### Access to Services and Barriers to Care

- Based on HSAG's assessment of the PIP, PMV, and compliance review results, evidence supports Behavioral Health Managed Care program members may be experiencing barriers to care that prevent them from accessing certain behavioral health services.
  - Although the PIHPs developed methodologically sound PIPs, the goal of demonstrating significant improvement was not achieved for eight of the 10 PIHPs during the first remeasurement, with a decrease in performance for seven of the PIP topics. The statewide performance across the PIPs indicate the quality improvement strategies do not appear to be targeting the appropriate barriers, or areas in need of improvement, to achieve the desired outcomes, and/or there may be barriers across the Medicaid program that are inhibiting the PIHPs from seeing real improvement in the identified focus areas.
  - Most statewide average performance measure scores exceeded their MDHHS-established MPS; however, Indicator #4a for the adult population fell below the MPS. While Indicator #4a for the adult population fell below the MPS, the MDHHS Codebook methodology for Indicator #4a allowed for a relatively large volume of exceptions based on the members who refused and

missed appointments, which led to unclear interpretation of PIHP performance and results. Further, although Indicator #10 met MPS statewide, the percentage of readmissions for adults to an inpatient psychiatric unit have increased by more than 3 percentage points over the past year, indicating it may be more difficult for the PIHP, inpatient hospital, or members to schedule follow-up care, or members are not attending scheduled appointments as expected.

– Although the PIHPs demonstrated high performance across most compliance standards over the three-year compliance cycle, challenges remain in areas of the program related to UM functions, member appeals, and provider credentialing, potentially contributing to members unawareness of certain member rights related to accessing services or accessing providers that have not been properly credentialed in accordance with program requirements, which could negatively impact the delivery of quality services.

## *Quality Strategy Recommendations for the Behavioral Health Managed Care Program*

The MDHHS CQS was designed to improve the health and welfare of the people of the State of Michigan and address the challenges facing the State. Through its CQS, MDHHS is focusing on population health improvement on behalf of all of the Medicaid members they serve, while accomplishing its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs. MDHHS uses three foundational principles to guide implementation of the CQS to improve the quality of care and services. The principles include:

- A focus on health equity and decreasing racial and ethnic disparities.
- Addressing social determinants of health.
- Using an integrated data-driven approach to identify opportunities and improve outcomes.

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following quality improvement initiatives, which focus on barriers members may face when accessing services, and target goals #1, 3, and 4 within the MDHHS CQS.

**Goal #1:** Ensure high quality and high levels of access to care.

**Goal #3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders.

**Goal #4:** Reduce racial and ethnic disparities in healthcare and health outcomes.

- MDHHS BHDDA could consider conducting a program-wide survey/interview of members receiving PIHP services who have recently accessed psychiatric inpatient services to determine potential barriers members have to accessing timely care, both prior to being seen inpatient, while accessing inpatient services, and after being discharged from the hospital.
  – Each PIHP could identify and outreach to members who have received a specific set of psychiatric services within a designated time period (e.g., within three months).

  - MDHHS and/or the PIHPs could offer an incentive for the members to complete the telephonic or in-person survey.
  - MDHHS and/or MDHHS and the PIHPs could develop and ask a predefined set of questions that focus on member experience while obtaining a specific set of behavioral health services, including experiences with obtaining timely services, barriers to receiving care, perception of member/provider relationship, perception of member/PIHP relationship, and perception of collaboration efforts prior to/after discharge.
  - The PIHPs could consider working with the CMHSPs to administer the survey during a follow-up visit.
  - MDHHS and/or the PIHPs could stratify survey respondents' demographics to identify any health disparities (e.g., race, ethnicity, ZIP Code)
  - MDHHS and/or the PIHPs could leverage the information gained from the surveys to identify potential barriers members are experiencing when seeking specific behavioral health services and develop interventions to eliminate those barriers and support program improvement.
- MDHHS BHDDA could consider collaborating with the PIHPs to identify common barriers that exist amongst the PIHPs in ensuring adult Medicaid members have timely access to follow-up care within seven days of discharge from a psychiatric inpatient unit. Upon identification of common barriers and the root cause of the common barriers, MDHHS should further consider developing a general intervention to test within all PIHPs in order to improve adult Medicaid members' timely access to this follow-up care.
- MDHHS BHDDA indicated that the methodology within the MDHHS Codebook for indicators #4a and #4b allowed for a relatively large volume of exceptions based on the members who refused and missed appointments, which led to unclear interpretation of the PIHP performance and results. Based on this, HSAG recommends MDHHS BHDDA continue its efforts to restructure the methodology to disallow exceptions, which will allow for all members to be included in the indicators and provide a clear understanding of PIHP performance, ensuring consistency in PIHP reporting.
- HSAG further recommends the following quality improvement initiatives, which specifically addresses CQS Goal #1 and Objective 1.3 to implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.

  **Goal #1—**Ensure high quality and high levels of access to care.

  **Objective 1.3—**Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
- While MDHHS calculated the applicable performance indicators in compliance with MDHHS Codebook specifications, the raw data from some PIHPs did not directly match the final performance indicator data that the PIHPs submitted to MDHHS. This appeared to be due to PIHPs submitting CMHSP-specific data to HSAG during its PMV, whereas the performance indicator data the PIHPs submitted to MDHHS were consolidated by the PIHPs into a single submission, inclusive of its CMHSPs' data. Additionally, some of the PIHPs indicated a lack of clarity related to the naming conventions and time-to-treatment measurements specific to the new indicators. To address these concerns, MDHHS could consider reviewing the MDHHS Codebook for opportunities to clarify performance indicator specifications to ensure the PIHPs and MDHHS are able to align

primary data sources' documentation directly to the final performance indicator rates as reported to MDHHS and calculated by the PIHPs, CMHSPs, and MDHHS.
  - MDHHS could focus on adding additional details to define denominators, numerators, exclusions, and omissions for each performance indicator.
  - MDHHS could further consider deploying additional validation steps in reviewing the raw data prior to finalizing the performance indicator rates.
- MDHHS could continue to enhance its statewide monitoring efforts in the areas of UM, appeals, and provider credentialing to support program improvement in these areas.
  - MDHHS could provide program-wide feedback through the MDHHS quality forum as a standing agenda item.
  - MDHHS could develop initiatives with the PIHPs to address any common deficiencies.

# Appendix A. External Quality Review Activity Methodologies

## Activity Methodologies

### *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 SFY 2020, the PIHPs submitted Remeasurement 1 data on one of the 10 state-recommended PIP topics. HSAG conducted the validation on the PIP study Design (Steps I through VI), Implementation (Step VII through VIII), and Outcomes (Steps IX and X) 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

Since these PIPs were initiated in SFY 2018, 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.[1-1] Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each PIHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP 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 SFY 2020 submissions, the PIHPs reported Remeasurement 1 data and were validated for Steps I through IX in the PIP Validation Tool.

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

[1-1] 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/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 10, 2020.

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

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The PIHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* 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, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to MDHHS and the PIHPs.

### Description of Data Obtained and Related Time Period

For SFY 2020, the PIHPs submitted Remeasurement 1 data. The study indicator measurement period dates for the PIP are listed below.

**Table A-1—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) |

## *Performance Measure Validation*

### Activity Objectives

As set forth in 42 CFR §438.350(a), 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 reported by the PIHP.
- Determine the extent to which the specific performance measures reported by the PIHP (or on behalf of the PIHP) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table A-3 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of SFY 2020, which began October 1, 2019, and ended December 31, 2019. Table A-4 lists the performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook. Since data were not available for three performance indicators (i.e., #2a, #2b, and #3) for SFY 2020, HSAG conducted a readiness review of information systems and processes used for data collection and reporting that will be used to calculate future performance indicator rates.

### Technical Methods of Data Collection and Analysis

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **Information Systems Capabilities Assessment Tool (ISCAT) and Mini-ISCAT**—The PIHPs and CMHSPs (as applicable) 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 2020. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

## PMV Activities

HSAG conducted PMV via Webex with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The Webex activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the PMV 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) and Mini-ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.

- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files, which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and Webex review, these data were also reviewed for verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the Webex and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify the PIHPs have system documentation that supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the Webex meeting and reviewed the documentation requirements for any post-Webex activities.

### 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 A-2 shows the data sources used in the validation of performance measures and the periods to which the data applied.

**Table A-2—Data Sources and Timeframe**

| Data Sources | Period to Which Data Applied |
|---|---|
| ISCAT and Mini-ISCAT(s), if applicable (from PIHPs) | SFY 2019 |
| Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs) | SFY 2019 |
| Previous performance measure results reports (from MDHHS) | SFY 2019 |
| Performance measure results (from PIHPs and MDHHS) | 1st Quarter SFY 2020 |
| Supporting documentation (from PIHPs and MDHHS) | SFY 2019 |
| Webex interviews and systems demonstrations (from PIHPs and MDHHS) | During Webex Review |

Table A-3 displays the performance indicators calculated by the PIHPs and Table A-4 displays the performance indicators calculated by MDHHS that were included in the validation of performance measures, the subpopulations, the validation review period to which the data applied, and the agency responsible for calculating the indicator.

**Table A-3—Performance Indicators Calculated by PIHPs**

| Indicator | | Sub-Populations | Review Period | Calculated By |
|---|---|---|---|---|
| **#1** | The percentage of persons during the reporting period receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. | • Children<br>• Adults | 1st Quarter SFY 2020 | PIHP |
| **New** **#2a** | The percentage of new persons during the reporting period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. | • MI Adults<br>• SED Children<br>• IDD Adults<br>• IDD Children | Not Applicable | PIHP |
| **New** **#3** | The percentage of new persons during the reporting period starting any medically necessary ongoing covered service within 14 days of completing the non-emergent biopsychosocial assessment. | • MI Adults<br>• SED Children<br>• IDD Adults<br>• IDD Children | Not Applicable | PIHP |
| **#4a** | The percentage of discharges from a psychiatric inpatient unit during the reporting period who were seen for follow-up care within 7 days. | • Children<br>• Adults | 1st Quarter SFY 2020 | PIHP |
| **#4b** | The percentage of discharges from a substance abuse detox unit during the reporting period who were seen for follow-up care within 7 days. | • Consumers | 1st Quarter SFY 2020 | PIHP |
| **#10** | The percentage of readmissions of SED children and IDD children and MI adults and IDD adults during the reporting period to an inpatient psychiatric unit within 30 days of discharge. | • MI Adults and IDD Adults<br>• SED Children and IDD Children | 1st Quarter SFY 2020 | PIHP |

*New indicator for SFY 2020.

**Table A-4—Performance Indicators Calculated by MDHHS**

| Indicator | | Sub-Populations | Review Period | Calculated By |
|---|---|---|---|---|
| **New** **#2b** | The percentage of new persons during the reporting period receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUD. | • Medicaid SUD | Not Applicable | MDHHS |
| **#5** | The percentage of Medicaid recipients having received PIHP managed services. | • Medicaid Recipients | 1st Quarter SFY 2020 | MDHHS |
| **#6** | The percentage of Habilitation Supports Waiver (HSW) enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. | • HSW Recipients | 1st Quarter SFY 2020 | MDHHS |
| **#8** | The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively. | • MI Adults<br>• IDD Adults<br>• MI/IDD Adults | SFY 2019 | MDHHS |
| **#9** | The percentage of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. | • MI Adults<br>• IDD Adults<br>• MI/IDD Adults | SFY 2019 | MDHHS |
| **#13** | The percentage of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). | • IDD Adults | SFY 2019 | MDHHS |
| **#14** | The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). | • MI Adults | SFY 2019 | MDHHS |

*New indicator for SFY 2020.

## Compliance Review

### Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS elected to review the full set of standards over the previous two review periods, as displayed in Table A-5.

**Table A-5—Division of Standards Over Review Periods**

| SFY 2018 | SFY 2019 |
|---|---|
| Standard VI—Customer Service | Standard I—QAPIP Plan and Structure |
| Standard VII—Grievance Process | Standard II—Quality 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 |

After the SFY 2018 and SFY 2019 compliance reviews, PIHPs were required to develop CAPs for each element that did not achieve full compliance. For the SFY 2020 review period, MDHHS requested that HSAG conduct a comprehensive desk review of the SFY 2018 and SFY 2019 CAPs. The goal of this CAP activity was to ensure that each PIHP achieved full compliance, to the extent possible, with all federal and State requirements reviewed as part of the previous two years' compliance review activities.

This report presents the combined results of the SFY 2018 and SFY 2019 compliance reviews, and the SFY 2020 CAP review. MDHHS and the individual PIHPs use the information and findings from the compliance reviews to:

- Evaluate the quality and timeliness of and access to healthcare services furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

## Technical Methods of Data Collection and Analysis

Prior to beginning 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. For SFY 2020, HSAG used the completed SFY 2018 and SFY 2019 CAP templates that were customized based on each PIHP's performance in those reviews. This customized tool included only those standards for which the PIHP had scored less than 100 percent and only those elements for which the PIHP had scored *Not Met*. The CAP review templates were enhanced to document the PIHPs' progress on implementing, and HSAG's evaluation of, each plan of action. The review processes and scoring methodology used by HSAG in evaluating the PIHPs' compliance were consistent with the CMS publication, *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations*: *A Mandatory EQR-Related Activity*, October 2019.[A-2]

For each of the PIHPs, HSAG's desk review consisted of the following activities:

- Preparing and forwarding to each PIHP a detailed timeline and description of the CAP review process.
- Reviewing each plan of action.
- Preparing and forwarding to each PIHP the CAP review templates and preliminary feedback to each plan of action, as applicable.
- Monitoring the progress of each plan of action through two progress reports submitted by the PIHPs.
- Providing technical assistance to the PIHPs, as requested.
- Reviewing supporting documentation submitted by the PIHPs for each plan of action.
- Outreaching to PIHPs on elements that do not appear to meet requirements and/or require additional clarification from the PIHPs after HSAG's desk review of supporting documentation.
- Reviewing additional documentation and/or PIHP responses to HSAG's requests for clarification.
- Evaluating the degree to which each plan of action resulted in compliance with federal Medicaid managed care regulations and the associated MDHHS contract requirements.

Reviewers used the CAP review templates to document findings regarding PIHP compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The CAP review templates listed the score for each element evaluated.

HSAG evaluated and scored each element addressed in the CAP review as *Met* or *Not Met*. The overall score for each of the 17 standards was determined by totaling the number of *Met* (1 point) and *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 22, 2020.

standard. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2018 and SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards. The scoring methodology used for the three-year cycle is displayed in Table A-6.[A-3]

**Table A-6—Scoring Methodology[A-4]**

| Compliance Score | Point Value | Definition |
|---|---|---|
| *Met* | Value = 1 point | *Met* indicates "full compliance" defined as all of the following:<br>• All documentation and data sources reviewed, including PIHP data and documentation, are present and provide supportive evidence of congruence.<br>• 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:<br>• Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.<br>• Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions, and determined through follow-up discussions.<br>• 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. |

[A-3] Since this year's compliance review activity included a review of elements that received a score of *Not Met* during the previous two years' compliance review activities, all scoring definitions may not apply to the CAP review (for example, case file reviews and systems demonstrations were included in the SFY 2017–2018 and SFY 2018–2019 reviews, but were not included in the SFY 2019–2020 CAP review).

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 22, 2020.

## 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
- Letter templates and redacted notices
- Narrative and/or data reports across a broad range of performance and content areas

Table A-7 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 A-7—Description of Data Sources**

| Data Obtained | Time Period to Which the Data Applied |
|---|---|
| SFY 2018 CAPs | CAP submissions as of January 31, 2019 |
| SFY 2019 CAPs | CAP submissions as of March 11, 2020 |
| Progress Report #1 | Status of each plan of action as of June 4, 2020 |
| Progress Report #2 | Status of each plan of action as of July 17, 2020 |
| Desk review documentation | Documentation in effect as of August 28, 2020 |