QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2021

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QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2020-2021

I. OVERVIEW

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid- State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The FY2015 contract expanded to include administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention. For FY2020, MSHN continues to sub-contract with CMHSPs within the region to provide Medicaid funded behavioral health services as well as directly contracting with Substance Use Disorder Providers within the region for the provision of all public funded SUD services.

The mission of MSHN is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational

functions and aspects of care and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented retained, contracted and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

a) Philosophical Framework

The program design is based on the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C. Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes.
- Quality problems can be seen as the result of defects in processes.
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams.
- Quality improvement work is grounded in measurement, statistical analysis and scientific method.
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, "the continuous study and adaptation of health care organization's functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services" (The Joint Commission, 2004-2005). MSHN employs the Plan-Do- Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R., 1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance.
- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established.
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and
- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its behavioral health contract providers through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and maximizing productivity and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated.
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success.
- An organizational culture that supports reporting errors and system failures, as the means to improvement, and is important and encouraged.
- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

II. ORGANIZATIONAL STRUCTURE AND LEADERSHIP [1]

a) Structure

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup or task specific Process Improvement Team.

b) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self-determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of

[1] Medicaid Managed Specialty Supports and Services Program Contract-Quality Assessment and Performance Improvement Program Technical Requirements

recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; Consumer Advisory activities at the local, regional and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements, and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, and committees/councils. MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures.

<u>Communication of Process and Outcomes:</u>

The MSHN Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements in collaborations with other committees and councils, and the CMHSP Participants and SUD Providers. A quality structure should identify clear linkages and reporting structures. Quarterly, members of the committees, councils, and other relevant MSHN staff review the status of the organizational performance measures to identify trends, correlations, and causal factors, establishing a quality improvement plan to address organizational deficiencies.

For any performance measure that falls below regulatory standards and/or established targets, quality improvement plans are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, the Board of Directors, and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

MSHN is responsible for reporting the status of regional PI projects and verification of Medicaid services to MDHHS. These reports summarize regional activities and achievements, and include interventions resulting from data analysis.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

c) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including quality management priorities as identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives an Annual Quality Assessment and Performance Improvement Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review of the Annual Quality Assessment and Performance Improvement Report through the Board of Directors, the QAPIP Report will include a list of the Board of Directors' and will be submitted to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Director of Compliance, Customer Service and

Quality, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan and Program in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of performance improvement plans as required.

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP.

The MSHN Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services is represented on the Council by MSHN SUD Staff. CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Having representation on organization-wide standing councils, committees and work groups, and
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the PIHP QIC and their local organization.

Councils and Committees

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends.

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and

prevention of substance use disorders; and serves to advise the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

SUD-Provider Advisory Council (PAC)

The PAC is charged with serving in an advisory capacity to MSHN to represent SUD providers offering input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, to support MSHN's focus on evidence-based, best practice service and delivery to persons served. The PAC will assist MSHN in establishing and pursuing state and federal legislative, policy and regulatory goals.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

III. PERFORMANCE MEASUREMENT

a) Establishing Performance Measures

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement.

The measures established reflect the organizational priorities, have clear expectations, promote transparency, and are accountable through ongoing monitoring. Each measure should have a baseline measurement when possible, have an established re-measurement frequency (at least annually) and should be actionable and likely to yield credible and reliable data over time.

Measures can be clinical and non-clinical. Desired performance ranges and/or external benchmarks are included when known.

MSHN is responsible for the oversight and monitoring of the performance of the CMHSP participants and the SUD Providers including, performance/process development, performance/process monitoring, performance/process improvement, and reporting to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement. Information is a critical product of performance measurement that facilitates performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information. Data is used for clinical decision-making, and organizational decision-making (e.g., strategic planning and day-to-day operations).

The PIHP quality management program uses but is not limited to the following means for identification of system issues and opportunities for improvement:

- growth areas identified from performance summaries and reports.
- stakeholder feedback from provider and member experiences.
- oversight and monitoring reviews from external and internal processes.
- appeals/grievance, customer service complaints.

Once an opportunity is identified a quality improvement process may be initiated.

Prioritizing Measures

Measures are chosen by MSHN leadership in collaboration with MSHN committees, councils, and work groups based upon the following three factors:

> Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high-risk services; continuity and coordination of care), or Non- Clinical (availability, accessibility, cultural competency; interpersonal aspects of care; appeals, grievance, relevancy to stakeholders due to the prevalence of a condition, the need for a service, access to services, complaints, satisfaction, demographics, health risks or the interests of stakeholders as determined through qualitative and quantitative assessment.)
> Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.
> Compliance: Adherence to law, regulatory, accreditation requirement and/or clinical standards of cares.

Performance Indicators [2]

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it's CMHSP Participants and Substance Use Disorder Providers are measuring performance through the use of standardized performance indicators.

When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. The form will be reviewed by the MSHN CO and the MSHN contractor to ensure sufficient corrective action planning. Regional trends will be identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

[2] Quality -Michigan Mission Based Performance Indicator System Policy

Performance Improvement Projects [3]

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per year. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is subject to validation by the external quality review (EQR) organization and requires the use of the EQR's form. The second or additional PI project(s) is chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. The QIC approves the performance improvement projects and presents to relevant committees and councils for collaboration.

Data collected through the performance improvement projects are aggregated, analyzed and reported at the QIC meeting. A project/study description is written and identifies the data collection timeframe, the data collection tool, data source, and whether measure if local or regional. The project/study description incorporates the use of standardized data collection tools and consistent data collection techniques. Each data collection delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Additionally, if sampling is used, sampling method used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

b) Data Collection and Setting Performance Targets:

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

Established performance targets set through contract requirements will be utilized to measure performance. If there is no set performance target, baseline data should be considered prior to setting a target. Baseline data is a snapshot of the performance of a process or outcome that is considered normal, average, or typical over a period. The baseline may already be established through historical data or may still need to be collected. Baseline data should be collected for a period of time, typically up to one year, prior to establishing performance targets. When collecting baseline data, it is important to establish a well- documented, standardized and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.).

[3] MSHN Quality Performance Improvement Policy

Once the baseline has been collected for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks, when available and deemed to be within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks, when available, then a performance target should be established that is at, or greater than, the state and national average.

When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

a) *Minimum or Acceptable Level.* Performance standards can be considered "minimum" or "acceptable" levels of success.
b) *Challenge Level*. This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
c) *Better Than Before.* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

Targets may be defined in several ways including the following:

a) Defining a set target percentage for achievement - to meet the outcome being measured.
b) Defining a percentage increase/decrease change to be achieved.

c) Data Analysis and Reporting

The data should be reviewed at the established intervals and analyzed for undesirable patterns, trends, or variations in performance. In some instances, further data collection and analysis may be necessary to isolate the causes of poor performance or excessive variability.

The appropriate council, committee, or workgroup, in collaboration with the QIC, will prepare a written analysis of the data, citing trends and patterns, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Region wide quality improvement efforts will be developed based on the patterns and trends identified through data analysis and will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups, etc. In some instances, provider level corrective action may be necessary in addition to, or in lieu of, region wide improvement efforts.

d) Performance Improvement Action Steps

Process improvements are achieved by taking action based upon data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to ensure any improvements achieved are truly associated with the action. Adhering to the following steps promotes process integrity:

- Develop a step by step action plan, limiting the number of variables impacted.
- Implement the action plan, preferably on a small or pilot scale initially, and
- Study the data to check for expected results;
- Modify or develop interventions to obtain expected result.

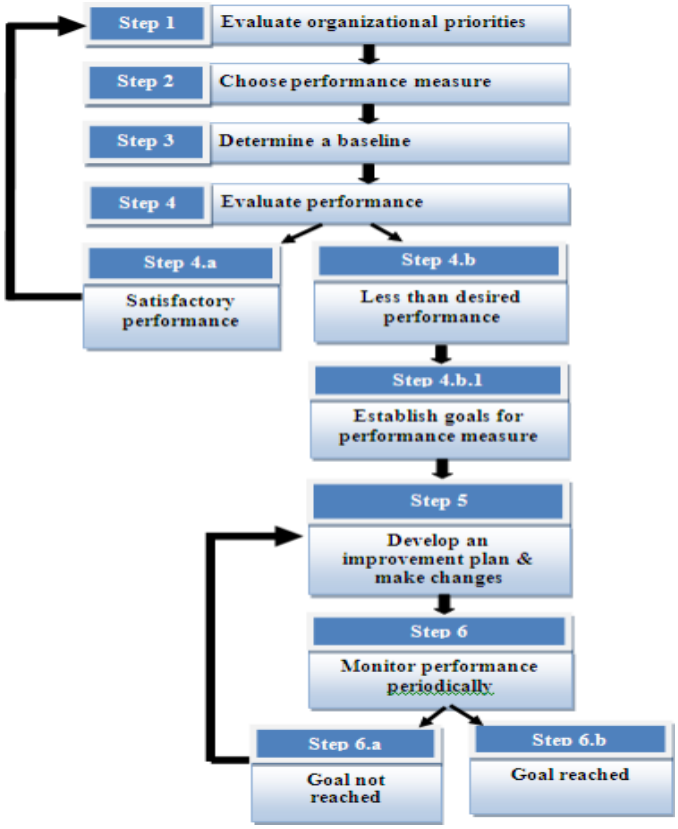
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to insure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

When the established minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a quality improvement plan that includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the plans of correction. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Process Map of Performance Management Pathway (defined by HRSA)



IV. STAKEHOLDER EXPERIENCE/ENGAGEMENT [4]

Opinions of consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP, and organizations providing services to consumers are surveyed by MSHN at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs, and address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP Participants/SUD Providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services.

[4] Quality-Consumer Satisfaction Survey Policy

The aggregated results of the surveys and/or assessments are collected, analyzed and reported by MSHN in collaboration with the QI Council and Regional Consumer Advisory Council, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines appropriate action for improvements. The findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, accessible on the MSHN website, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

V. SAFETY AND RISK MONITORING

a) Adverse Events[5]

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of these events, adverse events, will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP Participant/SUD Provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes.

MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers.[6] MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of

[5] Quality-Critical Incidents Policy
Quality-Critical Incidents SUD Policy

[6] Quality-Sentinel Events Policy

the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events and/or events requiring immediate notification to MDHHS[7],[8]. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future.

b) Medicaid Event Verification[9]

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed and reported for review at the QI Council meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology

[7] Quality CMHSP Participant Monitoring & Oversight Procedure
[8] Quality Monitoring & Oversight of SUD Service Providers Procedure
[9] Quality- Medicaid Event Verification Policy and Procedure

Report. All CMHSP Participants and MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

VI. CLINICAL QUALITY STANDARDS

a) Utilization Management[10]

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered.
Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

[10]Annual Utilization Management Plan

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contract and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) Practice Guidelines[11]

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research - validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are a locally driven process in

[11] Clinical Practice Guidelines and Evidenced Based Practices Policy

collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Clinical programs will ensure the presence of documented practice skills including motivational interviewing, trauma informed care and positive behavioral supports.

Practice guidelines will be monitored and evaluated through MSHN's site review process to ensure CMHSPs and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

c) Oversight Of "Vulnerable People"

MSHN assures the health and welfare of the region's service recipients through service delivery [12]by establishing standards of care for individuals served.[13][14][15] Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. MSHN monitors population health through data analytics software to identify adverse utilization patterns and to reduce health disparities.

MSHN monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies, as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

[12] Habilitation Supports Waiver Annual Recertification, initial
[13] Home and Community Based Services Monitoring Procedure
[14] Autism Benefit Compliance Monitoring
[15] Case Management Services

d) Cultural Competence[16]

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

e) Autism Benefit [17]

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs the application of the policies, rules and regulations as established. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement Strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the EPSDT state plan and reviews this data monthly to quarterly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for reporting individual-level and systemic-level CMHSP quality improvement efforts.

<u>Autism Benefit Review</u>

Initial eligibility is managed through MSHN in a review of clinical content and then submitted to MDHHS for ABA service approval. Re-evaluations shall address the ongoing eligibility of the autism benefit participants and are updated annually. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

f) Behavior Treatment[18]

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Only techniques approved by the Standards of Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered

[16] Service Delivery-Cultural Competency Policy
[17] Service Delivery-Autism Benefit Compliance Monitoring; Re-Evaluation Eligibility
[18] Quality-Behavior Treatment Plans Policy and Procedure

planning, and supported by current peer- reviewed psychological and psychiatric literature may be used. MSHN also receives CMHSP behavior treatment data regarding consumers on the habilitation supports waiver. This data has been piloted and tracked in the MSHN region and provides sub- assurances within participant safeguards that require additional oversight & monitoring by the Michigan Department of Health and Human Services (MDHHS) for habilitation supports waiver enrollees around use of intrusive and/or restrictive techniques for behavioral control. By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data is analyzed on a quarterly basis by MSHN and is available to MDHHS upon request. CMHSP data is reviewed as part of the CMHSP Quality Program and reported to the MSHN QIC at a defined frequency. MSHN analyzes the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

g) Trauma[19]

MSHN and its Provider Network shall adopt a trauma informed culture including the following: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization. In compliance with the MDHHS Trauma Policy MSHN has delegated the responsibility to the network providers to ensure development of a process for screening and assessing each population for trauma. Providers shall adopt approaches to address secondary trauma for staff and utilize evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment shall be completed to evaluate the extent to which the organizations policies are trauma informed. Organizational strengths and barriers, including an environmental scale to ensure the building and environment does not re-traumatize will be identified and utilized for improvement efforts. The assessment should occur every three years.

VII. PROVIDER STANDARDS

a) Credentialing/Provider Qualifications and Selection

In compliance with MDHHS's Credentialing and Re-Credentialing Processes, MSHN has established written policy and procedures[20] for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[21] also ensure

[19] Service Delivery-Trauma Informed Systems of Care Policy
[20] Provider Network Credentialing/Recredentialing Policy and Procedure
[21] Provider Network Non-Licensed Provider Qualifications

that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. MSHN policies and procedures are established to address the selection, orientation and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) Financial Oversight

MSHN has established written policies and procedures to ensure appropriate financial management. MSHN will conduct a financial oversight review of the SUDSP Network. The review will be based on seven standards used to assure regulatory compliance by reviewing the following: Certified Public Accountant (CPA) Audit, compliance with previous corrective action; financial management policies and procedures; documents to ensure proper segregation of duties; evidence to support the Financial Status Report(FSR) billing; verification of board approved sample financial reports; and evaluation of Risk Management Plan. Information obtained from the review will be used to identify focus areas for improvement efforts, in accordance with the oversight monitoring corrective action process.

c) Provider Monitoring and Follow-Up[22]

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulates required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS. Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP Participant/SUD Provider is also

[22] Quality-Monitoring and Oversight Policy and Procedures

contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. SUD Providers, however, must first obtain written authorization from MSHN in order to subcontract any portion of their agreement with MSHN. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies as necessary CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance are required to provide corrective action, will be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

d) External Reviews

The PIHP is subject to external reviews through MDHHS or an external auditor to ensure compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external auditor to provide relevant evidence to support compliance. In accordance the Medicaid Managed Specialty Supports and Services Program FY21 External Quality Review. All findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives and activities in response to the findings. The improvement plan will be available to MDHHS upon request.

VIII. Quality Assessment and Performance Improvement Program Priorities (QAPIP) FY2021

The QAPIP priorities shall guide quality efforts for FY21. Attachment 1 provides the QAPIP Priorities and Quality Work Plan for FY21. The FY21 QAPIP Priorities include completion of required elements of the QAPIP, growth areas based on external site reviews and the review of effectiveness. QAPIP activities are aligned with the MSHN Strategic Plan Priorities contributing to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals we serve.

An effective performance measurement system allows an organization to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, outcomes, and an evaluation of satisfaction of the services in which an individual receives. MSHN utilizes a balanced score card to monitor organizational performance. Those areas that perform below the standard are included in the annual QAPIP. Figure 1 demonstrates indicators used to monitor the performance of MSHN.

Figure 1. FY21 Performance Measures

Indicator	Committee/ Council Review
Michigan Mission Based Performance Indicator System -	
MSHN will meet or exceed the standard for indicator 1: Percentage of Children/Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC
Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC
Indicator 2 b. Effective April 16, 2020, the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.(No Standard)	QIC/SUD
Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC
MSHN will meet or exceed the standard for indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (>= 95%)	QIC
MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD
MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is <=15%)	QIC
BH-TEDS Data	
MSHN will demonstrate an improvement with the quality of data for the BH-TEDS data. (military fields, living arrangements and employment, LOCUS, Medicaid ID)	QIC

Performance Improvement Projects	
PIP – The degree to which programs implement recovery-oriented practices will demonstrate a 3.50 or above annually. (>=3.50)	QIC
PIP - The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year will demonstrate a statistically significant increase from previous reporting period. (target-38.6%)	QIC
Assessment of Member Experiences	
*MSHN will demonstrate a 100% completion rate of assessments for each representative population served (SUD, MI/SED, IDD inclusive of LTSS) with development of action plan to address findings annually.	QIC
MSHN will demonstrate an 80% rate of satisfaction for each representative population.	QIC
I am involved in my community and organization (RSA-Involvement) (>=3.5)	QIC
Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services) (>=3.5)	QIC
I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment) (>=3.5)	QIC
I am given choices about my treatment and care that I receive (RSA-Choice) (>=3.5)	QIC
Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals) (>=3.5)	QIC
The rate of satisfaction with SUD services and treatment received will meet or exceed 80%.	QIC
The rate of satisfaction with services and treatment received for a mental illness (including LTSS) will meet or exceed 80%.	QIC
The rate of satisfaction with services and treatment received for a Severe Emotional Disturbance will meet or exceed 80%.	QIC
Safety and Risk Monitoring (Event Monitoring and Reporting)	
*MSHN will demonstrate a 100% completion rate of Critical Incident/Event performance summary quarterly.	**QIC**
The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year.(CMHSP)	QIC
The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous year. (CMHSP)	QIC
The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.	QIC
The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC
The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year. (CMHSP)	QIC
The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year. (CMHSP)	QIC
The rate of deaths per 1000 persons served will demonstrate a decrease from previous reporting period.	SUD TX/UM
The rate of accidents requiring emergency medical treatment and/or hospitalization per 1000 persons served will demonstrate a decrease from previous reporting period. (SUD)	SUD TX/UM
The rate of physical illness requiring admissions to hospitals per 1000 persons served will demonstrate a decrease from previous reporting period.	SUD TX/UM
The rate of arrest or convictions per 1000 persons served will demonstrate a decrease from previous reporting period.	SUD TX/UM
The rate of serious challenging behaviors per 1000 persons served, will demonstrate a decrease from previous reporting period.	SUD TX/UM
The rate of medication errors, per 1000 persons, served will demonstrate a decrease from previous reporting period.	SUD TX/UM

Medicaid Event Verification	
MSHN will demonstrate a 90% performance rate in each of the seven attributes verified during the Medicaid Event Verification Reviews.	CC
Medicaid Event Verification review demonstrates improvement of previous year results (94.05%) with the documentation of the service date and time matching the claim date and time of the service. SUD	CC
Joint Metrics	
The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (standard-58%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences).	QIC
The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (standard-70%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences)	QIC
Implementation of Joint Care Management Processes	UMC
Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence	UMC
Performance Based Incentive Payments	
Identification of enrollees who may be eligible for services through the Veteran's Administration. (Narrative Report BH-TEDS and Veteran Services Navigator Data)	ITC/QIC
Increased data sharing with providers (narrative report)	ITC
MSHN will demonstrate an increase over previous reporting period of Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (2018 level Intitation-36.81%; Engagement 22.30%) (informational only)	CLC
Increased participation in patient centered medical homes (narrative)	UM
Priority Measures-	
MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report	QIC
MSHN will demonstrate an increase from previous measurement period (78.5%) in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening	CLC
The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.	CLC
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.	CLC

Priority Measures-	
Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%)	UM
The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%)	UM
The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%)	UM
Member Appeals and Grievance Performance Summary	
Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (standard-95%)	CSC
The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (standard-95%)	CSC
The percentage (rate per 100) of Medicaid second opinion requests regarding inpatient psychiatric hospitalization denials which are resolved in compliance with state and federal timeliness standards, including receiving a written provision of disposition (standard-95%)	CSC
The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)	CSC
Behavior Treatment	
The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.	QIC
The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC
The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC
External Reviews	
MSHN will achieve a 95% percent for individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (standard-95%)	CLC
The QAPIP Plan and Report will be provided to network providers and members upon request.	QIC
MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	CSC
MSHN will communicate practice guidelines to the providers annually.	CLC
MSHN providers will increase compliance with the MDHHS/MSHN credentialing, recredentialing and no-licensed provider staff qualification requirements. (Standard 8)	PNM
MSHN will achieve a status of “Met” on the Performance Improvement Validation Review.	QIC

X. DEFINITIONS/ACRONYMS

BTPRC: Behavior Treatment Plan Review Committee
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CLC: Clinical leadership Committee
Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.
CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.
Contractual Provider refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.
Critical Incident Reporting system (CIRS): Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.
CSC: Customer Services Committee
Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.
EQR: External Quality Review
FC: Finance Committee
ITC: Information Technology Committee
Long Term Services and Supports (LTSS)- Older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(CMS.gov)
MEV: Medicaid Event Verification
MMBPIS: Michigan Mission Based Performance Indicator System
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIP: Performance Improvement Project
PNM: Provider Network Management
Prepaid Inpatient Health Plan (PIHP): In Michigan a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Part 438. Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b also manages the Autism ISPA, Healthy Michigan, Substance Abuse Treatment and Prevention Block Grant and PA2. "
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
QAPI: Quality Assessment Performance Improvement
QAPIP: Quality Assessment and Performance Improvement Plan

QIC: Quality Improvement Council
QM: Quality Manager
Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.
Root Cause Analysis (RCA): Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)
Sentinel Event (SE): Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event
RSA: Recovery Self-Assessment
RAS: Recovery Assessment Scale
Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.
SUD Providers: Refers to Substance Use Disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.
TR: Technical Requirement
UMC: Utilization Management Committee
Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

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Attachment 1 Quality Priorities and Work Plan FY21

Organizational Structure and Leadership	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.18.2021
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP (UM, PNM, CC, Clinical-SUD and CMHSP, IT).	Quality Manager	9.30.2021
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	Deputy Director/Director of Compliance, Quality, Customer Services	1.1.2022
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. (MSHN Quarterly QAPIP Report)	Deputy Director/Director of Compliance, Quality, Customer Services	6.1.2021
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site) Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	Quality Manager/QIC CEO	1.31.2022 10.1.2021
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	Quality Manager/QIC	1.31.2022

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	*To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	Quality Manager	1.31.2022 Annually
*The Practice Guidelines MSHN will communicate practice guidelines to the providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact, and post to MSHN Website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	Quality Manager- QIC, CLC, UM, CLC, ITC, CSC, SUDP, FC, OC	As needed, minimum annually
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Recovery Survey Assessments, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC and PAC quarterly for feedback.	Customer Services Specialist; Quality Manager; Director of Compliance, Customer Services, Quality, MEV; Director of Utilization and Care Management	December, February, April, June, August, October
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Director of Compliance, Customer Services, Quality, MEV; CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly

MMBPIS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	CMHSPs to upload detail data utilizing MSHN template quarterly through REMI.	CMHSP Participants	Q1-3.15.2021; Q2-6.15.2021; Q3-9.15.2021; Q4-12.15.2021
	MSHN submit MMBPIS to MDHHS quarterly.	Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021
	MSHN to complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations), and present/provide to relevant committees/councils and providers quarterly.	Quality Manager QIC, Medical Directors, Tx/UM, PAC, RCAC, SUDP.	Q1 April; Q2 July; Q3 October; Q4 January
	CMHSPs to develop and submit improvement plans quarterly.	CMHSP Participants	Q1 April; Q2 July; Q3 October; Q4 January
	SUD Providers to develop improvements quarterly	SUDPs	FY21 Q3
	MSHN will develop or have available documentation for education and training of performance indicator requirements.	Quality Manager	Annually through QIC/PAC/SUD Provider Meeting
	MSHN to complete primary source verification of submitted records during the DMC review.	QAPI	Biennially with follows ups based on findings

BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will improve the quality of BH-TEDS data.	MSHN will identify areas of discrepancy for the BH-TEDS data for FY21Q1. Veterans data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	CIO-ITC	2.28.21
	Causal factors will be determined based on review BH-TEDS data.	Quality Manager- QIC; IT Project Manager- CMHSP participants	3.31.21
	Narrative completed comparing BH-TEDS (veteran's military fields) and VSN Report for FY21 Q1Q2 data.	CIO, Quality Manager- QIC; IT Project Manager- ITC	6.30.21
	Action steps developed to address incomplete data, discrepancies. Veterans data (military fields), Employment data-minimum wage, Living arrangements.	CIO, Quality Manager- QIC; IT Project Manager- ITC	7.31.21
	MSHN QIC will monitor progress through quarterly performance reports.	Quality Manager- QIC; IT Project Manager- ITC	FY21 Q4, FY22 Q1
Performance Improvement Projects	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
Will engage in two performance improvement projects during the waiver renewal period.	To complete the Annual Recovery Self-Assessment-Provider/Administrator Summary Report	Quality Manager/QIC/CLC/RCAC	Annually/May
	To complete the Diabetes Monitoring Performance Report quarterly and complete the Annual Submission to HSAG.	Quality Manager/Data Coordinator, QIC, Regional Medical Directors	Quarterly-December, March, June, September

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
*MSHN will demonstrate an 80% or above for assess consumer experience and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, communicating results. *Member assessment of experiences will represent all served (including LTSS), and address the issues of the quality, availability, and accessibility of care.	MSHN in collaboration with CMHSPs and SUDPs will identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction)	Quality Manager-QIC/SUDP	March, April
	MSHN to complete an Annual Member Experience Report to include trends, causal sources of dissatisfaction, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July
MSHN will assess the recovery environment	MSHN to complete the Annual RAS Report to include trends, causal factors, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
MSHN will ensure Events (Sentinel/Critical/Risk) as specified in the PIHP Contract, are monitored, and submitted to MDHHS.	To submit Critical Events to MSHN monthly	CMHSPs	26th of each month
	To submit Critical Events to MDHHS monthly	Quality Manager	The last day of each month
	To submit Critical Events to MSHN Quarterly	SUDPs	January 15, April 15, July 15, October 14
	To submit Sentinel Events to MSHN Quarterly or sooner based on event notification requirements	CMHSPs / SUDP	January 15, April 15, July 15, October 15
	To submit Sentinel Events to MDHHS 2x annually	Quality Manager	Q1-Q2 April 30, Q3-Q4 October 30
MSHN Will complete oversight through primary source verification of critical incidents and sentinel events; review of the process for follow up of recommendations and consistency with MSHN/MDHHS requirements.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will ensure appropriate follow up will occur for all events dependent on the type and severity of the event and may including a root cause analysis, mortality review, immediate notification to MDHHS.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed
MSHN will ensure Individuals will have the appropriate credentials for review of scope of care.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed
CMHSP Participants and SUD Treatment Providers will achieve established targets as applicable. Trends, patterns, strengths, and opportunities for improvement identified. 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. *MSHN will demonstrate a 100% completion rate of the Critical Incident Review System performance reports quarterly.	To complete the CIRS Performance Reports (including standards, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. To distribute the Performance Reports to relevant committees/councils/providers for review and follow up.	Quality Manager (QIC relevant committees	Quarterly (Q4 January, Q3 April, Q2 July, Q3 October)
Medicaid Event Verification	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
Will verify delivery of services billed to Medicaid	To complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	See annual schedule for each provider
MSHN will identify trends, patterns, strengths and opportunities for improvement.	To complete The MEV Annual Methodology Report and review with QIC and Compliance Committee annually.	Director of Compliance/Quality/ Customer Services, MEV auditor	1.31.2022
The MEV Methodology Report will be submitted to MDHHS annually as required.	To submit the Annual MEV Methodology Report to MDHHS.	Director of Compliance/ Quality/Customer Services,	12.31.2021

Utilization Management Plan	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	To complete/review the MSHN Utilization Management Plan annually.	Director of Utilization and Care Management	12.1.2021
MSHN will identify trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services.	MSHN to complete performance summary quarterly reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations), identifying CMHSPs/SUDSPs requiring improvement and present/provide to relevant committees/councils.	Director of Utilization and Care Management	Quarterly/annually See UM Reporting Schedule
MSHN will utilize uniform screening tools and admission criteria	To utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	Director of Utilization and Care Management	Quarterly/Annually
*MSHN will achieve full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews. Development of new timeliness standard to be reviewed quarterly.	QAPI Customer Service Specialist	Biennial Full Review with follow up annually as needed. Quarterly
*MSHN will achieve full compliance with the appeal resolution notice contact as required by MDHHS.	Refresher training will be conducted Oversight of compliance during Delegated Managed Care Reviews.	Customer Service Specialist QAPI	1.25.2020 Biennial Full Review with follow up annually as needed.

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN adopts practice guidelines that are nationally, or mutually accepted by MDHHS and MSHN.	The QAPIP Plan and related policies/procedure will include a process for adoption, evaluating and communicating practice guidelines.	Chief Behavioral Health Officer-CLC and RMD	Annually
MSHN will communicate and disseminate practice guidelines to providers and members upon request. *MSHN will communicate the practice guidelines to providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact. Upload clinical practice guidelines, including MDHHS specified guidelines to the MSHN website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually
CMHSPs will adhere to the standards within the accepted practice guidelines.	To provide oversight during DMC Review to ensure providers adhere to practice guidelines as appropriate to the population served.	QAPI	Biennially with follows ups based on findings
*MSHN will meet the standards for PCP/IPOS development for those receiving services, specifically the Autism Benefit, SEDW Waiver, CWP Waiver, and HSW	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. e following elements will be incorporated into the planning process and document: • Choice voucher/self-determination arrangements offered • Assessed needs in IPOS • Strategies adequately address health and safety and primary care coordination • Goals are measurable and include amount, scope and duration • Prior authorization of services corresponds to services in IPOS • IPOS is reviewed and updated no less than annually • Include guardian in PCP process • Category/intensity of Care (CWP)	Director of Compliance, Quality and Customer Services; Waiver Manager, Waiver Coordinator	2.17.2021

Oversight of "Vulnerable People"	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
Will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes. This includes members with special health care needs, members with long-term services and supports. This will include assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.	MSHN will analyze performance measures-Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	Director of Utilization Management, Chief Behavioral Health Officer, HCBS Manager, Autism Coordinator	Annually/Quarterly
	To complete clinical record reviews during the delegated managed care review.	QAPI, Autism Coordinator, HCBS Manager	Biennial Full Review with follow up annually as needed.
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. Behavior Treatment Data to include intrusive or restrictive techniques, and/or emergency physical intervention and 911 call to law enforcement, will be reviewed quarterly. Oversight will occur during Delegated Managed Care Site Reviews. *MSHN will demonstrate an increase in fidelity to the MDHHS Behavioral Treatment Standards for all IPOSs reviewed during the reporting period.	To develop/update the BTPR regional template, project description, policy and procedure.	BTPR Work Group, QIC, CLC, Quality Manager, Autism Coordinator	Annually
	To complete Behavior Treatment Performance Reports (including barriers, improvement efforts, recommendations and status of recommendations) quarterly.	Quality Manager/BTPR Work Group/CLC/QIC	Q1-February Q2- May Q3- August Q4-November
	CMHSPs to upload BTPR Regional Template for CMHSP data submissions	CMHSP	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021
	CMHSPs to develop action steps based on performance.	CMHSP Participants	Quarterly
	MSHN to develop/provide education and training in coordination with the CMHSP.	HCBS Manager, Autism and Waiver Coordinators	Annually
	MSHN to complete primary source verification of reported events during the DMC Review.		Biennial Full Review with annual follow up as needed

Autism Waiver Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will ensure CMHSP participants are in compliance with the Autism Benefit.	To complete performance reports. To identify patterns, trends, and identification of improvement recommendations and actions steps as needed.	Autism Coordinator	Quarterly
*MSHN will have oversight of the Autism Benefit program requirements and corrective action related to the MDHHS Site Review.	To complete the DMC Site Review Report, ensuring ABA Treatment plans are developed in coordination with the IPOS goals and best practice standards.	Autism Coordinator	Biennial Full Review with follow up to occur in the off year.
Credentialing, Provider Qualification and Selection	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**
*The PIHP shall have written credentialing policies/ procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.	To provide communication, training, and technical assistance on policy and procedures. Resources developed to support compliance with requirements and made available on MSHN website. Revised process to include additional monitoring and reporting based on repeat non-compliance with credentialing and recredentialing requirements. Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review. REMI Provider Portal implemented to assist with document management for SUD Organizational provider qualifications.	QAPI Managers Provider Network Management Committee Contract Specialist Director of Provider Network Autism Coordinator Waiver Manager	Biennial Full Review with follow up to occur in the off year. Regional results reported quarterly via Provider Network Report.
*The PIHP complies (ensures all delegates performing credentialing functions comply) with all initial (including provisional) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool.			
*Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.			
*All providers (non-licensed and licensed) will demonstrate an increase in compliance with staff qualifications, training, credentialing and recredentialing requirements.			

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
CMHSP will ensure subcontractors are in compliance with MSHN standards and requirements.	To complete annual Delegated Managed Care (DMC) Site Review Reports and Corrective Action Plans.	CMHSP (as delegate) Contract Specialist QAPI	Biennially. Interim year review includes review of new standards and evaluation of required corrective action implementation.
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards and regulations.	To complete annual DMC Site Review Reports and Corrective Action Plans.	QAPI-Subject Matter Experts	
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards related to Financial Management regulations.	CMHSP participants are not subject to additional fiscal oversight by MSHN as they are required to obtain a Certified Public Accounting Firm Financial Audit and Compliance Examination. In addition, CMHSPs receiving Federal Funds meeting the 2 Code of Federal Regulations (CFR) 200 threshold must also obtain a Single Audit. MSHN does however review the CMHSP audits to identify adverse opinions. CMHSP Compliance Examination results are included in MSHN's Compliance Examination report. Any findings must be addressed by the PIHP and remedied. SUD Providers are subject to Fiscal Monitoring and Oversight by MSHN Finance Staff to ensure Sub-recipient requirements are met	Financial Specialist	

External Reviews	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date
MSHN will coordinate external site reviews between external body and the provider network. MSHN will receive full compliance on external site reviews.	Completion of the MDHHS Waiver Review Follow Up MDHHS Autism Review Completion of Health Services Advisory Group (HSAG) Compliance Review, Performance Measure Validation Review, Performance Improvement Project Validation Review.	Quality Manager-QIC; Directors of Utilization and Care Management UMC, Customer Services-Compliance-Quality CCC, Provider Network PNMC, Customer Services Specialist-CSC; Waiver Manager, Waiver Coordinators; CBHO; CIO	Annually
MSHN will coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	MDHHS Waiver Review MDHHS Autism Review HSAG Compliance Review	Quality Manager-QIC; HCBS Waiver Manager, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services-Compliance- Quality; CIO	Annually
MSHN will monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MDHHS 1915 (c) Waiver Final Report MDHHS Autism Review HSAG Compliance Review	Quality Manager-QIC; Waiver Managers, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services- Compliance- Quality, Customer Services Specialist; CIO	Biennial Full Review with follow up to occur in the off year.