Community MENTAL HEALTH
CLINTON • EATON • INGHAM

PROGRAM & PLANNING COMMITTEE AGENDA

Monday, February 10th, 2025
5:30 p.m.
812 E. Jolly Rd, G11-C
Lansing, MI 48910

Join Zoom Meeting
https://zoom.us/j/94026869514
Meeting ID: 940 2686 9514

***Action Items**

1. Call to Order

2. Previous Meeting Minutes – January 13th, 2025

3. Adoption of Agenda

4. Public Comment on Agenda Items

PROGRAM AND PLANNING COMMITTEE BUSINESS ITEMS:

***5. 2025 CMHA-CEI Quality Improvement Program Plan,**
2024 Quality Improvement Program Plan Effectiveness Report
2025 Mid-State Health Network Quality Assessment and
Performance Improvement Program and the
2024 Annual Effectiveness and Evaluation Report – Elise Magen

***6. New Expense Contract: Trusted Translation – Elise Magen**

***b. CMHA-CEI Consumer Advisory Council Recommended Appointee – Elise Magen**

***7. New Expense Contract: Henry Ford Behavioral Health Hospital – Shana Badgley**

If you need accommodations in order to fully participate in this meeting, please call 517-346-8238. If, however, you are deaf/hard of hearing or deaf/blind, please call Michigan Relay Center, TTY/Voice by dialing 711 or 844-578-6563 *and ask them to forward your message to the above number. Requests must be made no later than 48 hours prior to the meeting. This meeting is open to all members of the public under Michigan's Open Meetings Act.*

***8. New Revenue Contract: Ingham County 911 Central Dispatch (Full-Time Crisis Call Taker Services) – Shana Badgley**

***9. New Expense Contract: Anikare Inc. – Drew Kersjes**

***10. New Expense Contract: Mercy Plus Healthcare – Drew Kersjes**

***11. New Revenue Contract: Ingham County Health Department (ICHD) – Opioid Crisis Response Grant – KC Brown**

12. Unfinished Business
a. Crisis Stabilization Unit Update

13. New Business

14. Public Comment

15. Adjournment

PROGRAM AND PLANNING COMMITTEE
Meeting Minutes
Monday, January 13th, 2025
5:30 p.m.
812 E. Jolly Rd, Atrium
Lansing, MI 48910

Join Zoom Meeting
https://zoom.us/j/94026869514
Meeting ID: 940 2686 9514

Committee Members Present:
Al Platt
Jason White
Tim Hanna
Jeanne Pearl-Wright

Committee Members Excused:
Paul Palmer
Dianne Holman
Raul Gonzales

Staff Present
Darby Vermeulen, Sara Lurie, Drew Kersjes, Emily Ryan, Elise Magen, Jana Baylis, Dr. Jennifer Stanley

Other Board Members Present:
Dwight Washington via Zoom

Public Present:
None

Others Present
None

Call to Order:
The meeting was called to order by Vice Chairperson Al Platt at 5:33 p.m.

Previous Meeting Minutes:
MOVED by Tim Hanna and SUPPORTED by Jason White to approve the Program and Planning Committee meeting minutes of December 9th, 2024.

MOTION CARRIED unanimously.

Adoption of Agenda:
MOVED by Tim Hanna and SUPPORTED by Jason White to adopt the agenda of January 13, 2025.

MOTION CARRIED unanimously.

Public Comment on Agenda Items:
None

BUSINESS ITEMS:
Compliance Policy 1.1.04 Updates
Emily Ryan, Compliance and Privacy Officer, presented this item. She said one of her first orders of business as a new employee in August 2024 was to update the compliance policy. Emily reviewed the substantial changes made to the policy, including the roles of the CEO, Board of Directors, and the Corporate Compliance Officer in compliance matters.

ACTION:
MOVED by Tim Hanna and SUPPORTED by Jason White that the Program and Planning Committee of the CMHA-CEI Board of Directors authorize CMHA-CEI to approve the revised Compliance Policy 1.1.04.

MOTION CARRIED unanimously.

Unfinished Business

a. **Crisis Stabilization Unit Update**

Sara Lurie said that everything closed as planned on December 30th! Sue attended the closing. This is a huge relief! Sara hasn't met with John since returning from vacation for an update on construction; she will be able to give a more detailed report on this Thursday at the full Board meeting.

Sara said a group of employees went to CSU's in Detroit and Grand Rapids to tour the facilities. She has not yet heard an update from this group. Sara said CEI met with Network 180 and discussed service agreements regarding purchasing lab services, food service, etc. Sara said we could potentially contract with Sparrow or McLaren on these items. She went on to say we will probably use our internal staff for custodial needs.

Al Platt wanted the group to introduce themselves to the new Board member from Eaton County, Jeanne Pearl-Wright.

New Business

Sara wanted to take a moment to share the Winter 2025 issue of Adelante Forward magazine, 'A multicultural magazine dedicated to the health, education, and welfare of Mid-Michigan area residents'. CEI has a relationship with Lansing Latino Health Alliance that has led us to creating a relationship with AF magazine. There will be four articles featuring CEI in the magazine this year. This publication will also be handed out at the MLK luncheon next week. The article was put together by Rachel McCoy, CEI's Outreach and Public Relations Specialist, who worked together with Sandra Ruiz, Luis Rodriguez, and Valerie Tijerina who are providing outpatient and community support services for the Hispanic community.

Public Comment
None

The meeting was adjourned at 5:52 p.m. The next regularly scheduled Program and Planning Committee meeting is Monday, February 10th, 2025 at 5:30pm, 812 E. Jolly Rd, Atrium.

Minutes Submitted by:

Darby Vermeulen
Finance Administrative Assistant

Community
MENTAL HEALTH
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Agenda Item: Program and Planning Committee
Agenda Item #P-5

Month, Year: February, 2025

Major Program: All Programs

Agenda Item Title: 2025 CMHA-CEI Quality Improvement Program Plan,
2024 Quality Improvement Program Plan Effectiveness Report
2025 Mid-State Health Network Quality Assessment and Performance Improvement Program and the
2024 Annual Effectiveness and Evaluation Report

SUMMARY OF CONTRACT/PROPOSAL:
As required by contract with MDHHS, CMHA-CEI develops an internal Quality Improvement Program (QIP). CMHA-CEI's QIP aligns with quality standards and expectations of The Michigan Department of Health and Human Services (MDHHS), Mid-State Health Network (MSHN), Certified Community Behavioral Health Clinics (CCBHC), the Balanced Budget Act (BBA), and the Commission on Accreditation of Rehabilitation Facilities (CARF). The QIP plan details the structure, scope, activities and functions of CMHA-CEI's overall Quality Improvement Program. The QIP plan describes core quality improvement activities and functions that are conducted by CMHA-CEI and its network of contracted service providers.

An evaluation of the QIP plan is completed at the end of each fiscal year. The evaluation summarizes activity that occurred around the goals and objectives of the plans and progress made toward achieving the goals and objectives. The evaluation describes the quality improvement activities conducted during the past year related to the goals/objectives, including a description of targeted processes and systems implemented, outcomes of those processes and systems, any performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes implemented, and the quality improvement initiatives taken in response to the findings. Annual evaluation of PIHP and CMHSP Quality Plans is required by contract with MDHHS.

Additionally, as required by contract with MDHHS each Prepaid Inpatient Health Plan (PIHP) is responsible for monitoring quality improvement through their Quality Assessment and Performance Improvement Program (QAPIP). The scope of MSHN's

QAPIP program includes services and programs provided by the CMHSP participants within their region. Performance monitoring covers all important organization functions and aspects of care and service delivery systems.

STAFF RECOMMENDATION:

Staff recommend that the Program and Planning Committee of the CMHA-CEI Board of Directors approve the following resolutions:

- The Program and Planning Committee recommends that the Board of Directors of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the adoption of the 2025 CMHA-CEI Quality Improvement Program Plan and the 2024 Quality Improvement Program Plan Effectiveness Report.
- The Program and Planning Committee recommends that the Board of Directors of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the adoption of the 2025 Mid-State Health Network Quality Assessment and Performance Improvement Program and the 2024 Annual Effectiveness and Evaluation Report

Quality Improvement Program Plan FY2025

Community Mental Health Authority of Clinton, Eaton, and Ingham Counties

10/01/2024 – 09/30/2025

Prepared by: CMHA-CEI Quality Improvement Team – January 2025

Reviewed by: Quality Improvement and Compliance Committee – January 2025

Approved by: Board of Directors –

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SECTION 1: Overview

Introduction and QIP Mandate

Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) is a Community Mental Health Service Provider (CMHSP) within the Mid-State Health Network (MSHN) region. CMHA-CEI's Quality Improvement Program (QIP) Plan assures the agency aligns with current behavioral health standards. The QIP Plan annually demonstrates to consumers and stakeholders that the agency provides evidence-based, quality-centered, and customer-focused behavioral health services.

CMHA-CEI's QIP Plan aligns with quality standards and expectations of the Michigan Department of Health and Human Services (MDHHS), MSHN, the Balanced Budget Act (BBA), the Commission on Accreditation of Rehabilitation Facilities (CARF), and Certified Community Behavioral Health Clinics (CCBHC). The QIP Plan fulfills all obligations and mandates listed below:

- MDHHS has mandated that CMHSPs develop a QIP Plan annually.
- MSHN has delegated the responsibility of the development and implementation of a QIP Plan to each of the CMHSP members within the region per its Quality Assessment and Performance Improvement Plan.
- CARF requires an implemented performance measurement and management plan.
- CCBHCs are required to develop, implement, and maintain a Continuous Quality Improvement (CQI) plan.

Purpose

CMHA-CEI's QIP Plan details the structure, scope, activities, and functions of the CMHA-CEI's overall Quality Improvement Program. The QIP Plan describes core activities and functions that are conducted by CMHA-CEI and its network of contracted service providers. It is the responsibility of CMHA-CEI to ensure that the QIP Plan meets applicable Federal and State laws, contractual requirements, and regulatory standards. The term of the QIP Plan begins 10/01/2024 and ends 09/30/2025. Upon expiration of the term, the QIP Plan shall remain in effect until CMHA-CEI's Board of Directors approves a new QIP Plan.

Mission, Vision, and Clinical Philosophy

Mission

The organization's mission is to fulfill two complementary but distinct roles in realizing its vision:

> **As a behavioral healthcare provider**: Providing, directly and through partnerships, a comprehensive set of person-centered, high quality, and effective behavioral health and developmental disability services to the residents of this community.
>
> **As an advocate, catalyst, thought leader, and convener**: Fostering the transformation of all aspects of community life, eliminating inequities, and promoting the common good for all, especially for persons with mental health needs.

Vision

CMHA-CEI holds this vision of a community:

> A community in which any person with a mental health need has access to a wide range of resources to allow them to seek their desired quality of life and to participate, with dignity, in the life of the community, with its freedoms and responsibilities.
>
> A community defined by justice for persons with mental health needs. Persons with mental health needs include those with a mental illness, an emotional disturbance, a developmental disability, and/or a substance use disorder.

Clinical Philosophy

CMHA-CEI will strive to serve persons with a broad range of mental health and substance abuse needs. Further, the organization has a primary commitment (as per statutory guidance provided by the Michigan Mental Health Code) to persons with serious and persistent mental illness or an impairing personal life crisis, children who are seriously emotionally disturbed, and persons with significant developmental disabilities. These principles apply to the services and supports directly provided by, or contracted through, CMHA-CEI.

Scope of the QIP Plan

The scope of the QIP Plan includes all programs and services provided by CMHA-CEI and its contract providers. It identifies the essential processes and aspects of care required to ensure quality services and supports for consumers. All demographic groups, stakeholders, care settings, and types of services are included in the scope of the QIP Plan.

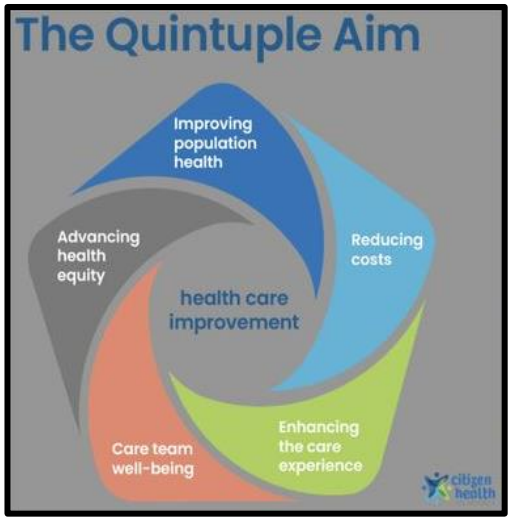
The QIP Plan serves as an ongoing monitoring and evaluation tool that measures CMHA-CEI's plans, processes, and outcomes to influence practice-level decisions for consumer care. It is intended to address multiple objectives including:

- Improve consumer health outcomes (e.g., recommendation for screening and assessments, reduced morbidity and mortality, integration of behavioral and physical health).
- Improve efficiencies of managerial and clinical processes.
- Reduce waste and cost associated with system failures and redundancy.
- Avoid costs associated with process failures, errors, and poor outcomes.
- Implement proactive processes that recognize and solve problems before they occur.
- Ensure that the system of care is reliable and predictable.
- Promote a culture that seeks to continuously improve its quality of care.

CMHA-CEI utilizes the "Quintuple Aim" to help guide us in quality improvement initiatives. The five components of the Health Quintuple Aim are:

1. Improve the patient experience of care:
   Focuses on providing a positive and personalized experience for patients, including improved communication, access to care, and patient engagement.
2. Improve the health of populations:
   Improving the health outcomes of entire populations, rather than just individual patients, achieved through community-based interventions and addressing social determinants of health.

3. Reduce the per capita cost of health care:
   Reducing the amount of money spent on health care for each individual, while still achieving improved health outcomes.
4. Enhance the experience of the workforce:
   Recognizes that the well-being and satisfaction of health care providers is essential to delivering high-quality care. This can be achieved through initiatives such as provider wellness programs, professional development opportunities, and more.
5. Improve Health Equity:
   Ensuring that health care is delivered in a way that is evidence-based, effective, safe, and equitability offered to all populations.



SECTION 2: Organizational Structure

Governance

Michigan Department of Health and Human Services (MDHHS)

The department carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code. It also administers Medicaid Waivers for people with developmental disabilities, severe and persistent mental illness, serious emotional disturbance, and substance use disorders. MDHHS appoints regional Prepaid Inpatient Health Plans (PIHPs) to work with CMHSPs.

Prepaid Inpatient Health Plan (PIHP)

The regional PIHP that partners with CMHA-CEI is the Mid-State Health Network (MSHN). MSHN provides oversight on standards, requirements, and regulations from MDHHS. It is responsible for maintaining high-quality service delivery systems for persons with serious and persistent mental illness, serious emotional disturbance, developmental disabilities, and substance use disorders. MSHN reviews CMHA-CEI's delegated managed care functions, monitors corrective action plan implementation, and provides general guidance.

CMHA-CEI Board of Directors

The Board of Directors is the governing body of CMHA-CEI and has ultimate responsibility for the quality of care and services delivered by the organization. It upholds CMHA-CEI's commitment to continuous quality improvement, including the allocation of resources for organizational performance-related endeavors. The Board of Directors delegates day-to-day operational responsibility and accountability for organizational performance improvement to the Chief Executive Officer. Annually, the Board of Directors reviews and approves the following documents:

- MSHN's Quality Assessment and Performance Improvement Plan (QAPIP)
- MSHN's Evaluation of the QAPIP
- CMHA-CEI's Quality Improvement Program Plan
- CMHA-CEI's Evaluation of the Quality Improvement Program Plan

- Ad hoc reports and position papers related to performance improvement

CMHA-CEI Leadership and Staff

The Chief Executive Officer links the strategic planning and operational functions of the organization. They ensure coordination among agency leadership and the allocation of adequate resources for the QIP Plan.

The CEO has designated the Director of QCSRR as the leader responsible for the daily management of the QIP Plan. The Director of QCSRR has overall responsibility for the implementation of the QIP Plan and provides delegated oversight and leadership.

The Medical Director provides clinical oversight related to the quality and utilization of services through case supervision, participation in Root-Cause Analyses (RCA), review of clinical incidents, and participation in relevant committees.

Additional leadership includes Clinical Directors and Administrative Officers who serve with the CEO, Director of QCSRR, and Medical Director in the Director's Group.

Director's Group

The Director's Group at CMHA-CEI includes employees at the Director and Officer levels. This includes the Chief Executive Officer, Chief Financial Officer, Chief Human Resource Officer, Chief Information Officer, Medical Director, Director of Quality, Customer Service, and Recipient Rights (QCSRR), Director of Adult Mental Health Services (AMHS), Director of Community Services for the Developmentally Disabled (CSDD), Director of Families Forward (FF), and the Director of Integrated Treatment and Recovery Services (ITRS). The Director's Group determines organizational strategy and ensures alignment between performance improvement activities and CMHA-CEI's long-term vision.

Quality Improvement (QI) Team

The QI Team is composed of the Quality Coordinator, Quality Improvement Specialists, and Quality Advisors. It initiates, coordinates, and collaborates on performance improvement projects at CMHA-CEI. Under the guidance of the Director of QCSRR, the QI Team is responsible for:

- Leading the Quality and Compliance Committee (QICC) meetings
- Participating in agency and regional workgroups
- Performance measures and data collection
- Review of clinical records
- Provider monitoring and site visits
- Application for and renewal of accreditation
- Audit preparation
- Developing and implementing plans of correction
- Preparing and submitting the annual QIP Plan and QIP Plan Evaluation

Other CMHA-CEI Staff

All CMHA-CEI staff, volunteers, and interns contribute to quality and performance improvement processes. This occurs in a variety of ways, including program representation at the Quality Improvement and Compliance Committee, collaboration with the QI Team on quality and performance-

improvement activities, incident reporting, and carrying out the agency's mission and vision while providing direct care.

Committees and Advisory Bodies

MDHHS Quality Improvement Council

The Quality Improvement Council (QIC) for MDHHS meets bi-monthly with representation from MDHHS, PIHPs, CMHSPs, and provider organizations. The council directs the development and implementation of the behavioral health managed care programs and serves as the primary point of prioritization and integration of quality improvement activities. CMHA-CEI representation at the MDHHS QIC include the Director of QCSRR and Quality Coordinator.

MSHN Quality Improvement Council

MSHN's Quality Improvement Council was established as a mechanism for oversight and advice related to quality improvement matters. The council is chaired by MSHN's Quality Manager. Council membership includes quality and performance representatives from each of the region's participating CMHSPs. The council reports to the MSHN Operations Council and the MSHN Chief Executive Officer.

Quality Improvement and Compliance Committee (QICC)

The CMHA-CEI QICC provides oversite of the QIP Plan by supporting and guiding the implementation of quality improvement activities. Participants of QICC include the representatives from Quality Improvement, Compliance, Recipient Rights, Clinical Programs, the Medical Director, the CEO, and other staff as applicable. The QICC approves the QIP Plan annually and has the opportunity to review, evaluate, and make suggestions as needed. Other topics covered at QICC include safety and security, system-wide trends, patterns of key indicators, clinical record reviews, agency policies and procedures, and review of agency goals and objectives.

External Meetings and Data Review Committee

The External Meetings and Data Review Committee reviews initiatives, data, and activities that are occurring at External Meetings that CMHA-CEI staff attend. These meetings may be at the PIHP level, MDHHS Workgroups or Committees, or Community Workgroups. Membership includes the Chief Executive Officer, Director of QCSRR, Medical Director, Directors of Clinical Programs, Chief Human Resources Officer, Chief Information Officer, Chief Financial Officer, QI Team, Contracts Manager, Compliance, and other staff as needed. The purpose of this Committee is to ensure uniformity of understanding across departments of happenings that may impact our agency and discuss action plans as needed.

Critical Incident Review Committee (CIRC)

The Critical Incident Review Committee provides oversight of the critical incident and sentinel event processes, which involve the reporting of all unexpected incidents involving the health and safety of the consumers within the CMHA-CEI's service-delivery area. Incidents include consumer deaths, medication errors, behavioral episodes, arrests, and emergency medical treatment. Membership consists of the Director of QCSRR, Medical Director, Compliance Coordinator, Recipient Rights staff, a designee from the QI Team, and representation from all four Clinical Programs, as applicable. The goals of CIRC are to review consumer deaths, assign a cause of death, and review other critical incidents. General incident

report data is reviewed by CIRC for policy review/implementation, patterns, trends, compliance, education/improvement, and presentation to QICC.

Medication and Pharmacy Committee (MAP)

The Medication and Pharmacy Committee facilitates the review of all medication incidents and communication between the contracted pharmacy and clinical programs. Other ongoing objectives of the MAP committee include trend analysis of medication incidents, dissemination of medication information from the contracted pharmacy to clinical programs, response to coordination issues between the contracted pharmacy and clinical programs, and review and development of other medication-specific processes or procedures. Membership of MAP consists of the Medical Director, a designated RN, a designee from the QI Team, representation from all four Clinical Programs, and representation from the contracted pharmacy. Medication incident report data is reviewed by MAP for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

Behavior Treatment Committee (BTC)

The BTC reviews all Behavior Treatment Plans (BTPs) submitted for CMHA-CEI consumers. As part of this review, the committee evaluates the effectiveness of behavior treatment plans and the use of behavioral interventions. A descriptive summary, incident reports, and other BTP data are submitted quarterly for review to CIRC, the PIHP, and MDHHS. The BTC includes:

- CMHA-CEI Medical Director (Chairperson)
- Recipient Rights Specialists (Ex-officio)
- A licensed psychologist
- Designee from the QI Team

Safety Committee

The Safety Committee ensures that the work environment is maintained adequately and that protections from potential hazards are in place. It oversees the development and review of applicable policies, procedures, and emergency response plans. It also monitors state and federal regulatory standards and accreditation standards.

The scope and practice of the Safety Committee includes:

- Building, employee health and safety, and security: monitoring safety and security training, emergency drills, first aid kits/AED equipment, hazard vulnerabilities, etc.
- Transportation and vehicle safety: monitors vehicle condition, accidents, injuries, inspections, safety equipment, staff training, etc.

When trends or patterns in this data are recognized, the committee is responsible for making recommendations to management to resolve safety issues.

Threat Assessment Team (TAT)

The CMHA-CEI Threat Assessment Team identifies possible risks, vulnerabilities, and threats that may come from consumers or members of the public. These individuals may be added to the agency Watch List for monitoring. The TAT reviews:

- Individuals on the Watch List
- New additions to the Watch List
- General safety concerns

Standing members of the TAT consist of the Safety and Security Coordinator, Environmental Safety Compliance Officer, representatives from Clinical Programs, and QI designees. As needed, a representative from Human Resources will be in attendance.

Consumer Advisory Council (CAC)

The primary source of consumer input is through the Consumer Advisory Council. The CAC meets monthly and provides insight and direction to organizational strategy, advocacy, and outreach. It contributes to the monitoring and oversight of consumer and community engagement efforts. The CAC provides meaningful input to the board about policies, processes, and services. This may include:

- Policy and program development
- Performance measures monitoring
- Consumer satisfaction
- Advocacy
- Access and service delivery
- Education
- Other QI projects

Membership to the CAC is open to consumers, guardians, and family members of consumers.

Healthcare Integration Committee

CMHA-CEI is a convener and partner in the implementation of healthcare integration. It provides meaningful and manageable approaches to improve the overall quality of life for those served. The healthcare integration vision is focused on:

- Partnering with Primary Care Physicians
- Treatment Plans
- Population Health

The committee is composed of the CEO, Program Directors, Administrative and Clinical Supervisors, Healthcare Integration staff, and QCSRR staff.

Virus Task Force

The Virus Task Force was formed in March 2020 to monitor the ongoing public health crisis. Today the group is composed of the Medical Director, CEO, Chief Human Resource Officer, Director of QCSRR, Property & Facilities Supervisor, Safety and Security Coordinator, designated RN, and QCSRR Administrative Assistant. The Virus Task Force processes and communicates guidance of the CDC as well as State, and local health departments.

Contract Quality and Home and Community-Based Services (HCBS) Workgroup

The Contract Quality and HCBS Workgroup facilitates review of contracted provider concerns and initiatives. It also serves the agency to assist in development of agency-wide interpretation and support compliance with Home and Community Based Services (HCBS) rules. The workgroup has representation from all clinical programs, Quality team, Compliance staff, Finance staff, and facilities staff.

Zero Suicide Workgroup

In 2023, CMHA-CEI began to implement the Zero Suicide initiative across all programs with the introduction of a workgroup. The workgroup's goal includes a three-year training cycle for staff and a framework for systematic, clinical suicide prevention in behavioral and physical healthcare systems. The workgroup is composed of four subgroups: clinical, training, data & improvement, and communication. Each subgroup meets monthly, and the entire group meets quarterly.

Diversity Advisory Committee (DAC)

CMHA-CEI is committed to recognizing, enhancing, and supporting diversity in all forms. The goals of the DAC are:

- Striving toward a diverse workforce that is reflective of the consumers served
- Promoting regular communications relating to diversity
- Collaborating with community partners in diversity-promoting efforts.

The DAC is facilitated by the agency's Diversity, Equity, Inclusion, and Justice Administrator. Members include the CEO, Chief Human Resources Officer, and representatives from Clinical and Administrative Programs.

MSHN Data Analytics Workgroup (DAW)

The Data Analytics Workgroup is a workgroup facilitated by MSHN that meets to increase the competence and confidence of data analysts throughout the region to use analytic tools. This workgroup connects CMHSPs within the region and provides opportunities to share data and tools. DAW reviews datasets from MDHHS's Care Connect 360 and the Integrated Care Delivery Platform.

SECTION 3: Quality and Performance Improvement and Activities

The Quality Improvement Team is responsible for performing quality improvement functions and ensuring that program improvements are occurring within the organization. QI operates in partnership with stakeholders including consumers, advocates, contract providers, CMHA-CEI staff, and other relevant stakeholders. The QI Team is responsible for implementing and monitoring the QIP Plan.

Michigan Mission-Based Performance Indicators (MMBPIS)

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly and compiled into quarterly reports that are submitted to MDHHS and MSHN for analysis and regional benchmarking. If CMHA-CEI performance is below the identified goal, the QI Team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval. Beginning in 2025, new Performance Measures will be implemented through a new Behavioral

Health Quality Program and will occur through a 3-year rollout. MMBPIS submissions will continue through FY25 and then be replaced by these new Performance Measures.

Behavioral Health Quality Measures

Beginning in 2025, the Bureau of Specialty Behavioral Health Services in MDHHS will begin using new quality reporting measures with a 3-year rollout. The transformed program will be more comprehensive and better defined, with a more rigorous methodology that aligns with other state and national requirements. Measurement years will switch to calendar years from fiscal years. The first year will focus on aligning reporting requirements for PIHPs with CMS Core Set Reporting. By the end of the Year 1 measure roll-out, all required CMS Core Set measures will be available by PIHP. The second year will focus on rolling out stratification of measures, along with adding several key measures. The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures.

CMHA-CEI and MSHN will be responsible for the ACC Indicator rolling out in Year 2. The ACC will measure Access to Care – appointment within 10 (business) days of request. MDHHS will provide an updated Codebook by June 2025 for measure specification. ACC measurement will be implemented by January 2026 with quarterly data submissions beginning in Summer 2026. MDHHS will be responsible for all 30 other Measures rolling out over the 3 year period.

PIHP Required Performance-Improvement Projects (PIP)

MDHHS requires that CMHSPs complete two Performance-Improvement Projects (PIP) per waiver renewal period. One of the PIPs is based upon recommendations put forward by the MDHHS Quality Improvement Council. It is subject to validation by the external quality review organization and requires the use of the External Quality Review (EQR) standard forms. The other initiative is developed by the PIHP based on the identified needs of the individuals served by the region's CMHSPs. The initiatives are data-driven and include annual submissions of performance and tactics for improvement. The current PIP, detailed below, continues through FY25.

Racial or Ethnic Disparities within the Region and Populations Served

The current PIP is to reduce or eliminate racial or ethnic disparities in timely service deliveries for new consumers, with the goal of improving delivery rates among the Black/African American population in particular. The target is to provide a medically necessary service within 14 days of completing an assessment. This PIP was selected because data indicates a disparity between the White population and Black/African American population in access and timeliness of service.

MSHN QIC has recommended an additional PIP related to reducing or eliminating the racial and ethnic disparities in the penetration rate among the Black/African American population. The disparity is measured by the index penetration rate (rate for the White population).

Performance is reviewed as outlined in the performance improvement project description. The summary is submitted to the external quality review organization for a validation review as well as to MDHHS through the QAPIP Annual Report or upon request.

Event Monitoring

Below is a brief summary of monitoring activities at CMHA-CEI:

Behavior Treatment Plans and Interventions

The data on the use of intrusive and restrictive techniques must be evaluated by the CMHSPs and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are incidents that must be reviewed by the BTC. The QI Team has taken a lead role in the facilitation and organization of the BTC. In addition to state reporting requirements for Behavior Treatment Plans, CMHA-CEI reviews behavioral incidents of all consumers and monitors progress at BTC.

Denials, Grievances, and Appeals

The monitoring process for denials, grievances, and appeals focuses on the ability to provide evidence of timeliness of communication. As the capacity for evaluation and analysis increases, CMHA-CEI will approach this monitoring activity in a manner that helps to explore any patterns in occurrence and identify process or policy changes to resolve organizational challenges. Detailed requirements can be found in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. Customer Service Staff are responsible for tracking this data.

Incident Reporting

Incident Reporting requirements and processes are outlined in CMHA-CEI's Incident Reporting Procedure. Critical incident reporting requirements are defined in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. Critical incidents include suicide, non-suicide death, emergency medical treatment due to injury/medication error, hospitalization due to injury/medication error, and arrests. Critical incidents are captured through the organization's incident reporting process and reviewed at CIRC.

A summary of the incident reports filed and reviewed can be found in the attached QIP Plan Evaluation.

Staff Injury/Accident Rate

CMHA-CEI regularly monitors staff injury, accident, and infection data as risk management considerations through the organization's Safety Committee. HR in collaboration with Property and Facilities captures injury and accident information to monitor trends, optimize organizational performance, and decrease liability. Monitoring includes identifying provisions that require corrective action, providing enhanced training/education, and following up on corrective action plans.

Sentinel Event Review

Processes to identify sentinel events, understand the cause, and take necessary action to reduce the probability of future reoccurrence are defined in CMHA-CEI's Sentinel Events Procedure. Sentinel events are reviewed through a Root Cause Analysis (RCA) process that is facilitated by the QI Team. Sentinel events and sentinel event plans of correction are reviewed at CIRC. Sentinel events are reported to MSHN and CARF as needed.

Medicaid Event Verification

CMHA-CEI partners with MSHN to conduct regular audits of billed service events to verify that they are in alignment with the documents submitted. These reviews are conducted twice annually and facilitated by the QI Team.

Chart Review

CMHA-CEI regularly monitors clinical performance by selecting a random sample of both open and closed consumers to ensure organizational and professional standards are upheld as defined in the Clinical Record Review Procedure. The QI Team compiles the aggregate data and meets with the clinical programs to review results quarterly. QCSRR meets with the clinical program to assist in analyzing the data, determine areas of improvement, and develop a plan to address the issues identified.

Provider Monitoring

The QI Team's Quality Advisors are staff designated to provide support, advocacy, and education to contracted service providers as well as internal programs at CMHA-CEI. Annually, the QAs conduct a Quality and Compliance, Recipient Rights, and Home and Community Based Services Review, as applicable, with each contracted AFC home, CLS provider, ABA provider, Hospital, Financial Management Services, and CEI directly-run licensed homes. Site visits are conducted in many ways including on-site as required, regionally with other MSHN CHMSPs, and remotely in combination with other CMHSP reciprocity reviews. A reciprocity review can be used for providers outside of the CEI catchment area as long as it was visited on-site by another CMHSP. More frequent visits are conducted as needed as well if provider issues arise. Plans of correction may be issued to providers that are deemed to be out-of-compliance or in partial compliance. The QAs monitor these plans throughout the year and inform CEI clinical teams, Finance, and or Contracts of any issues that may need a more combined approach to ensure compliance.

Policy and Procedure Review

All agency policies and procedures are reviewed annually. The QI Team oversees and monitors this process through the PolicyStat document management system in collaboration with agency leadership. The QI Team continues to convert program-specific operating guidelines to PolicyStat, with a goal of completion by the end of 2025.

Health Services Advisory Group (HSAG)

Each year, MSHN works with all CMHSPs to validate performance measures and quality for HSAG. The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. The QI Team and IS department work with MSHN throughout the year to prepare for the HSAG review.

MSHN Audit

Every two years, MSHN conducts a full monitoring and evaluation process of CMHA-CEI. This process consists of the utilization of uniform standards and measures to assess compliance with federal and state regulations, and PIHP contractual requirements. During the interim year, MSHN's review process focuses on any elements from the previous year's findings in which compliance standards were considered to be partially or not fully met. The QI Team works with the clinical and administrative programs to meet the standards MSHN monitors. The QI Team also facilitates the audit and plan of

correction processes. In 2024, an interim review was conducted. Results from this review can be found in the FY2024 QIP Plan Evaluation. The next MSHN audit will take place in June 2025.

MDHHS Audits

Each year, MDHHS conducts a full monitoring and evaluation process of the following waiver programs:

- Serious Emotional Disturbance Waiver (SEDW)
- Children's Waiver Program (CWP)
- Habilitation Support Waiver (HSW)
- State Plan Amendment /(i) SPA (1915i)

The QI Team works with the administrative and clinical programs to meet the standards MDHHS has set for these waivers. The QI Team also facilitates the audit and plan of correction processes. MDHHS conducts a 90-day follow-up to assess the implementation of the submitted corrective action plan. The 2024 audit included a review of SEDW, CWP, 1915i, and HSW. The next review will be in 2025.

Quantitative and Qualitative Assessment of Experience

CMHA-CEI is committed to providing the highest quality of care and services. Central to this commitment is regularly soliciting feedback from consumers, providers, and stakeholders.

Consumer Satisfaction Survey

As part of CMHA-CEI's quality improvement efforts, satisfaction surveys are administered annually to active consumers. Results are used to gauge the level of satisfaction among consumers, determine ways to improve the quality of practice, and address identified areas of need. The purpose of the survey is to measure the quality of CEI services and summarize the level of satisfaction with the CMH service system.

In 2024, the Youth Satisfaction Survey for Families (YSSF) and Mental Health Statistics Improvement Program (MHSIP) adult satisfaction survey were distributed to all CMHA-CEI consumers who were receiving services within the reporting period. While the CMHSPs in the region are responsible for administering the survey, the PIHP collects and maintains the data and survey findings. Results of recent satisfaction survey efforts can be found in the attached FY2024 QIP Plan Evaluation.

CMHA-CEI also works with MSHN to complete the CCBHC Patient Experience Survey using the results from the YSSF and MHSIP surveys. These surveys evaluate consumer responses in the following areas.

MHSIP Domains:

- General Satisfaction
- Access
- Quality and Appropriateness
- Participation in Treatment Planning
- Outcome of Services
- Functioning
- Social Connectedness

YSSF Domains:

- Cultural Sensitivity
- Access
- Appropriateness
- Participation in Treatment
- Outcome of Services
- Social Functioning
- Social Connectedness

Stakeholder Survey

Every two years, CMHA-CEI is required by MDHHS to conduct an assessment of the mental health needs of our community. The assessment must involve public and private providers, school systems, and other key community partners and stakeholders. Stakeholders are asked to share the trends and needs they identify that may be related to, or indicative of, mental health needs in our community. CMHA-CEI leadership reviews the survey results to develop priority needs and planned actions for the agency. CMHA-CEI evaluated stakeholder concerns over the year from a survey that was conducted in 2024. Priority needs identified during the 2024 survey included access to care, training of Direct Care Staff, Recruitment and Retention of staff, strain on crisis services, and access to housing and resources for adults with serious and persistent mental illness. CMHA-CEI will conduct another stakeholder survey in 2026.

Trauma Self-Assessment

An agency trauma workgroup was formed to expand efforts to combat the negative impact of trauma for consumers and secondary trauma for staff. Every three years the Trauma Self-Assessment is sent to all agency staff. It is encouraged that staff from all departments participate to capture broad organizational representation in the results. Results are analyzed by the QI Team and sent to agency leadership and appropriate committees or workgroups. Analysis of the results identifies where programs and supports are needed, helps to target information and training, and allows the agency to measure progress. The most recent Trauma Self-Assessment results from 2024 can be found in the attached QIP Plan Evaluation. The next Trauma Self-Assessment will be conducted in 2027.

National Core Indicators (NCI) Survey

The NCI Survey is an annual collaboration between participating states, the Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. The NCI survey aims to assess family and adult consumer perceptions of satisfaction with their community mental health system and services. A random sample of consumers is selected to participate each year by NCI. Once the sample has been selected, the QI Team obtains consent and completes pre-survey information for each consumer before the NCI-conducted interview. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritizing quality improvement initiatives. Details about CMHA-CEI's participation in each year's NCI Survey can be found in the attached FY2024 QIP Plan Evaluation.

Organizational Performance Initiatives

The QI Team strives to improve quality throughout the agency. Additional projects the QI Team works on are listed below:

CARF

CARF is the accrediting body for all administrative units, case management, Assertive Community Treatment, and SUD programs. The QI Team applies for reaccreditation through CARF every three years. After application, CARF will survey the agency to ensure continued conformance to the current version of the Behavioral Health Standards Manual. The survey involves observation of services, interviews with persons served and other stakeholders, and review of documentation. In 2023, CARF conducted a digitally enabled site survey and granted CMHA-CEI the standard three-year accreditation. Corrective Action Plans from the survey findings can be seen in the attached QIP Plan Evaluation. The next CARF survey will be conducted in 2026.

Internal Research Approvals

CMHA-CEI promotes research in mental illness, developmental disabilities, and substance abuse, recognizing its importance for improving diagnosis, treatment, and prevention. Any research involving consumers must be approved by the Research Review Committee (RRC). Research must receive the prior written approval of the Chief Executive Officer. The activity of the Research Review Committee is facilitated by the QI Team.

Data Reporting through ICDP/CC360

CMHA-CEI has access to Medicaid claims data through two sources: the Integrated Care Delivery Platform (ICDP) and Care Connect 360 (CC360). ICDP is a tool utilized by MSHN, while CC360 is the tool utilized by MDHHS. Through both resources, the QI Team reviews data as required by MSHN, MDHHS, and by request of the clinical programs. The data may be utilized by the QI Team to facilitate collaboration with community partners, review and develop performance measures, and participate in the MSHN PIP processes.

Care Alerts

CMHA-CEI reviews Care Alerts as identified in ICDP. ICDP provides specific details identifying individuals who have an active Care Alert, which can be exported and reviewed for follow-up. This follow-up may include reviewing services provided to the individual, coordinating with the primary clinician, or creating a systemic action plan.

Annual Submission to MDHHS

Each year, the QI Team submits required data to MDHHS. This data includes estimated workforce changes for the fiscal year, a summary of service requests, and waiting list information as well as community data. Every other year, the annual submission includes a stakeholder survey as well as priority needs and planned actions. The last annual submission was submitted in FY24 and was based on the planned actions made in response to the stakeholder survey conducted in 2023. In FY25, the submission to MDHHS will include an updated stakeholder survey.

State Recertification

The QI Team submits required documentation every three years to MDHHS to recertify CMHA-CEI as a CMHSP, as required in Administrative Rule 330.2801. Information prepared for submission includes

accreditation information for CMHA-CEI and applicable contract providers, lists of all contracts with other agencies or organizations that provide mental health services under the auspices of CMHA-CEI including services provided, and identification of any changes to CMHA-CEI's provider network. CMHA-CEI was approved for renewal certification on April 23, 2024. It is effective until April 23, 2027.

State Reporting

The QI Team regularly assists the agency in compiling and submitting reports to MSHN or MDHHS, as needed. Examples include the biannual credentialing report for MSHN and the annual "Special Education to the Community" report for MDHHS.

HCBS Support for the Agency

CMHA-CEI Quality Advisors act as independent verifiers to ensure that internal oversight of the HCBS Final Rule and MDHHS/MSHN plans of correction are as conflict-free as possible. Efforts include coordination/communication with MSHN/MDHHS on survey processes, supporting provider plan development related to ongoing HCBS compliance and HCBS Plans of Corrections as needed, monitoring plan of correction follow-up, on-site verification annually or more if needed, providing guidance to CEI clinical programs to ensure internal compliance, and ongoing support of HCBS education and documentation improvement processes.

Environmental Modifications

Environmental Modifications is a Medicaid Covered Service that CMHA-CEI has a higher level of review of due to the higher cost and involvement of contract staff. The QI Team provides input for all requests received for environmental modifications through participation in the Environmental Modifications Workgroup. The workgroup includes staff from CSDD, waiver programs, Property and Facilities, Finance, and others as needed.

Enrollee Rights and Responsibilities

CMHA-CEI is committed to treating members in a manner that acknowledges their rights and responsibilities. CMHA-CEI ensures that a recipient of mental health services has all of the rights guaranteed by state and federal law, in addition to those guaranteed by P.A. 258, 1974, Chapter 7 and 7A. MDHHS routinely conducts site reviews; the CMHA-CEI Recipient Rights Office submits annual reports to MDHHS as required by Chapter 7 of the Michigan Mental Health Code. Additionally, procedures have been established to address any complaints and appeals through the CMHA-CEI Corporate Compliance unit.

Utilization Management

Utilization Management monitors the agency's resources by conducting regular reviews and collecting and analysis of data. CMHA-CEI and MSHN have Utilization Management Plans that are followed. These plans address practices related to retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, and other aspects of utilization management as deemed appropriate by directors.

Healthcare Integration Initiatives

CMHA-CEI's healthcare integration vision is to be a convener and partner in the implementation of healthcare integration by providing meaningful and manageable approaches in achieving outcomes and

improving the overall quality of life for those we serve. Through the Healthcare Integration Committee, there are three workgroups to help drive healthcare integration initiatives:

1. Primary Care Provider Status and use of the Continuity of Care Document
2. Treatment Planning
3. Population Health

CMHA-CEI works with several community health partners to provide Behavioral Health Consultants (BHCs). BHCs are integrated members of the medical team who address health behaviors and behavioral health. Goals of Healthcare Integration Programs include functional restoration and patient activation.

CCBHC Continuous Quality Improvement Plan

CCBHC is a model of care that provides quality, accessible treatment to consumers using data and evidence-based practices. In 2018, CMHA-CEI was awarded a two-year federal grant to expand services for individuals with a diagnosis of Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder, or Co-Occurring Disorders who are uninsured, underinsured, or have commercial insurance. In 2020, CMHA-CEI was additionally awarded a two-year expansion CCBHC grant through April 2022. In April 2022, CMHA-CEI was awarded full certification of its Certified Community Behavioral Health Clinic through the Michigan Department of Health and Human Services. The certification is valid for two years.

Continuous Quality Improvement (CQI) plans are required to be developed, implemented, and maintained annually for CCBHCs and focus on improved patterns of care delivery, including reductions in emergency department use, rehospitalization, and repeated crisis episodes.

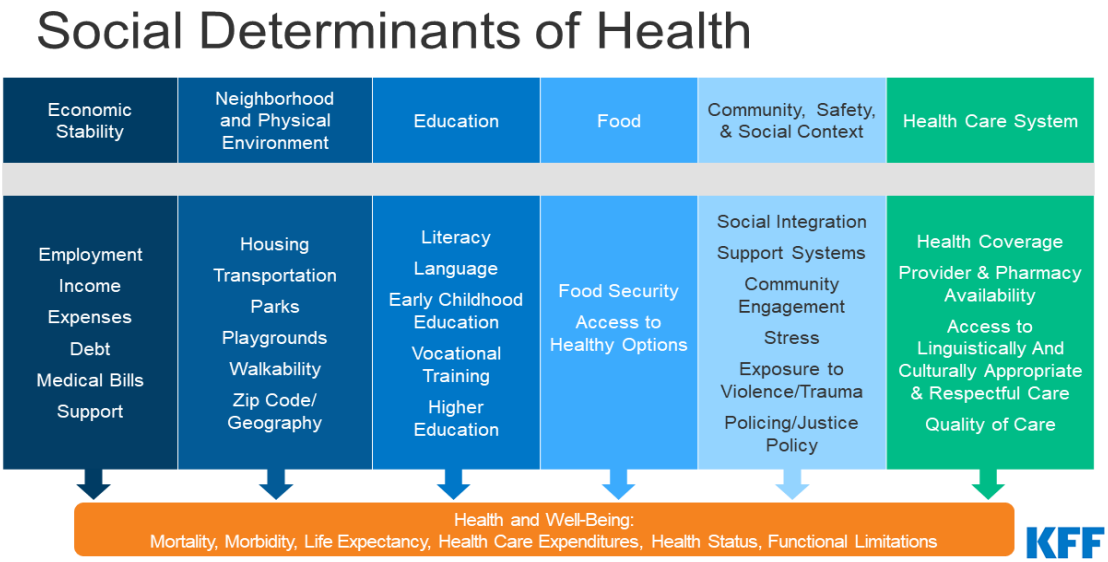
The CQI plan report tracks:

1. Deaths by suicide or suicide attempts of people receiving services;
2. Fatal and non-fatal overdoses;
3. All-cause mortality among people receiving CCBHC services;
4. 30-day hospital readmissions for psychiatric or substance use reasons

The CQI plan also reports on the quality measures collected by CCBHC, including:

1. Time to Initial Evaluation
2. Preventative Care Screenings: Adult BMI Screening and Follow-up
3. Weight Assessment for Children/Adolescents
4. Tobacco Screening and Cessation
5. Alcohol Screening and Brief Counseling
6. Suicide Risk Assessment: Adult and Child
7. Screening for Clinical Depression and Follow-up
8. Depression Remission at Twelve Months

The CQI plan reports data on health disparities and utilizes Performance Improvement Projects to track and improve outcomes. The CQI plan report also reviews Social Determinants of Health (SDOH) and how CMHA-CEI can assist in improving the health and well-being of those served. SDOH are described below:



SECTION 4: Additional Agency Plans Monitored by QI

Risk Assessment Plan

An agency-wide Risk Management Plan is reviewed and updated annually with assistance from the QI Team. The Risk Management Plan informs the agency by increasing awareness for identifying and minimizing risk. Ongoing monitoring of action steps identified in the Risk Assessment are completed by agency leadership and the QI Team.

Accessibility Plan

An agency-wide Accessibility Plan is also reviewed and updated annually with assistance from the QI Team. This plan identifies physical and organizational barriers and provides the status of planned actions to address those barriers. An assessment and management control tool was developed for the plan. The tool assesses organizational accessibility barriers, defines accountability, and monitors progress. Ongoing monitoring of planned actions identified in the Accessibility Plan is completed by agency leadership and the QI Team.

Needs Assessment

In 2023, CMHA-CEI created a formal agency Needs Assessment to fulfill state and federal requirements. The Needs Assessment utilizes state and local data, input from individuals served and community stakeholders, and service delivery data to help address service needs and priorities for CMHA-CEI. The Needs Assessment is updated annually and demonstrates CMHA-CEI's ongoing commitment to quality services and outcomes.

SECTION 5: Evaluation of QIP Plan Effectiveness

An evaluation of the QIP Plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives. The evaluation describes the quality improvement activities conducted during the past year related to the following goals and objectives.

SECTION 6: QIP Plan Goals and Objectives

FY 2024 Goals Review

FY 2024 Goal	**Progress**
Continue to work with the Information Systems Department on updating the Incident Reporting System for updated MDHHS report and explore Incident Reporting Software options.	Potential systems have been identified and discussions regarding implementation have been initiated.
Integrate CMHA-CEI Operating Guidelines into Policy Stat software.	There are currently 44 Operating Guidelines active in PolicyStat and over 400 additional Operating Guidelines are under review with programs.
Continue to utilize available data for quality process improvement and begin looking at disparities (data through chart reviews, audits, SmartCare reports, ICDP).	The QI Team created a performance indicator data dashboard that is regularly shared with AMHS. Prior to clinical chart reviews, the QI Team meets with program leadership to identify areas of concern with results reviewed quarterly. The QI Team collaborates with regional CMHSPs to develop interventions to address access to service disparities.
Develop updated Priority Needs for the agency.	The QI Team completed the annual submission, which includes priority needs and planned actions.
Improve and expand on the data gathered for the annual Needs Assessment and Social Determinants of Health report.	The QI Team expanded information captured within the annual Needs Assessment to fulfill CCBHC requirements.

FY 2025 Goals

- Complete successful rollout of Crisis Stabilization Center: Obtain applicable accreditation and work with clinical programs on reviewing MSHN, CCBHC, and MDHHS standards with regularly occurring chart reviews scheduled annually.
- Integrate remaining program Operating Guidelines into PolicyStat and train additional staff on using the PolicyStat system.
- Develop a data dashboard to share agency-wide and with specific clinical programs: Use performance indicator, satisfaction survey, healthcare integration, care coordination, and other applicable data for use by program supervisors to implement needed changes and interventions.
- Continue to develop and improve agency needs assessment: Explore opportunities to expand data collected and focus groups.

REFERENCES:

- Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program Contract FY25:
    - Attachment P7.9.1 Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans
- MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY25:
    - Attachment C6.3.2.1 Local Dispute Resolution Process
    - Attachment C6.5.1.1 Reporting Requirements
    - Attachment C6.8.1.1 Quality Improvement Programs for CMHSPs
    - Attachment C6.8.3.1 Standards for Behavior Treatment Plan Review Committees
    - Attachment C7.6.1 Compliance Examination Guidelines
- Mid-State Health Network Quality Assessment and Performance Improvement Plan (QAPIP)
- MSHN Quality Policy, Medicaid Event Verification
- MDHHS Certified Community Behavioral Health Clinic (CCBHC) Handbook
- Mid-State Health Network Utilization Management Plan
- CMHA-CEI Policies and Procedures Manual
- CMHA-CEI Utilization Management Plan
- CMHA-CEI Needs Assessment
- CMHA-CEI Risk Assessment Plan
- CMHA-CEI Accessibility Plan

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2024

Prepared By: MSHN Quality Manager – November 20, 2024
Reviewed and Approved By: Quality Improvement Council – November/December 2024
Reviewed By: MSHN Leadership - December 11, 2024
Reviewed By: MSHN Operations Council - December 16, 2024
Reviewed and Approved By: MSHN Board – January 7, 2025

Contents

I. Introduction

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 MSHN 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. Effective 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 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 Behavioral Health, 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. Effective October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes a review of the components of the QAPIP to ensure alignment with the contract requirements, a review of the status of the QAPIP Workplan and impact on the desired outcome, and a committee/council annual review with accomplishments and goals for the upcoming year. The QAPIP Plan and associated QAPIP Work Plan was effective. Recommendations for the Annual QAPIP Plan, which include a description of each activity and a work plan for the upcoming year, are included in the FY24 QAPIP Plan. The Board of Directors will receive the Annual QAPIP Report and approve the Annual QAPIP Plan for FY24. The measurement period for this annual QAPIP Evaluation is October 1, 2023, through September 30, 2024. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Performance Measurement and QAPIP Work Plan FY24 Review

MSHN monitors longitudinal performance through an analysis of regional trends. Performance is compared to the previous measurement period or other specifically identified targets. A status of "met" or "not met" is received. When minimum performance standards or requirements are "not met", CMHSP Participants/SUD Providers participate in a quality improvement process. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. *Indicates data that has not been finalized. Based on performance and the performance measurement requirements, a recommendation is made to "continue", "discontinue", or "modify". Considerations for recommendations are based on changes in requirements and performance.

a) Michigan Mission Based Performance Indicator System

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance through The Michigan Mission Based Performance Indicator System (MMBPIS).

Goal: MSHN will meet or exceed the MMBPIS Standards for Access (Indicators 1, 2, 3, and 4) and Outcomes (Indicator 10) as required by MDHHS.

Status: Partially Effective

MSHN exceeded the State Average Performance on 12 of the 18 indicators as demonstrated in the MMBPIS PIHP Final Report FY24Q3. Figure one demonstrates the status of each indicator.

Data collected at key points of access and service delivery (Figure 2) indicated the main reasons for not meeting the standard. The reasons were prioritized, and interventions were implemented during FY24 to address the priority areas. FY24 data was analyzed to determine effectiveness of the interventions and to make recommendations for FY25.

1. Causal Factor-No appointment available within 14 days with any staff

Interventions (FY24):

- Rebuild the Workforce and increase staffing levels.
    - Develop internal processes for staff coverage
    - Utilize peers for increased engagement
    - Recruitment
        - billboards, commercials, job fairs, outreach to colleges, interns.
    - Financial incentives
        - Paying for Masters-additional education.
        - Paid Internships
        - Incentives for staff referrals

Effectiveness:

- Financial incentives were the most effective in rebuilding and increasing the workforce thereby reducing the percentage of appointments that were not available within 14 days for both Indicator 2 and Indicator 3.

2. Causal Factor-Consumer No showed/Canceled appointment

Interventions (FY24):

- Appointment reminders
    - Staff phone calls
    - Automated phone calls and text messages

Effectiveness:

- Interventions were not effective in decreasing the rate of no shows or cancelations. The overall rate for no shows/cancelations for both Indicator 2 and 3 increased during FY24.
- Individual CMHSP data indicates that those who utilize staff to make reminder calls or engage in warm handoffs had a decreased rate of no shows/cancelations of appointments.

Recommendations for FY25:

- Continue the use of financial incentives to obtain and retain adequate staffing levels. This will be removed from the QAPIP Workplan. Adequate staffing levels will continue to be monitored through the Network Adequacy Assessment.
- Complete additional data analysis to identify population groups that have a high rate of no shows/cancelations. This includes data collection and analysis of the social determinants of health.
- Increase the use of practices for warm hand offs, staff/peers making direct phone calls to individuals for access and engagement in services and to identify any barriers, utilization of the teachback method to ensure understanding of next steps in treatment.

Figure 1. MSHN MMBPIS Performance Data

	Population	Standard	FY23	FY24Q1	FY24Q2	FY24Q3	FY24 YTD	Status
Indicator 1: Percentage who received a Prescreen within 3 hours of request.	Children	≥95%	98.40%	98.58%	98.63%	*98.22%	98.48%	Met
	Adults	≥95%	99.45%	*99.67%	*99.33%	*99.67%	99.56%	Met
Indicator 2: Percentage of new persons who have completed Bio-psychosocial Assessment within 14 Days. (Cumulative)	MI Child	>62.0%	59.81%	*60.43%	*65.52%	*69.02%	64.76%	Met
	MI Adults	>62.0%	62.82%	*64.31%	*64.59%	*67.02%	65.26%	Met
	DD Child	>62.0%	44.27%	*43.51%	*56.63%	47.51%	49.29%	Not Met
	DD Adult	>62.0%	56.47%	*67.83%	*73.33%	*65.09%	68.71%	Met
	Total	>62.0%	60.70%	*61.79%	*64.60%	*66.21%	64.13%	Met
Indicator 2e: Percentage of new persons receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service. (Cumulative)	SUD	>75.3%		*72.40%	*74.17%	*73.30%	73.29%	Not Met
Indicator 3: Percentage of new persons who had a medically necessary service within 14 days. (Cumulative)	MI Child	>72.9%	58.83%	58.28%	58.59%	62.21%	59.58%	Not Met
	MI Adults	>72.9%	62.26%	58.09%	67.71%	68.21%	64.51%	Not Met
	DD Child	>72.9%	81.09%	*76.05%	*80.97%	*81.43%	79.59%	Met
	DD Adult	>72.9%	62.50%	65.74%	67.01%	70.71%	67.76%	Not Met
	Total	>72.9%	62.54%	59.72%	65.56%	67.52%	64.13%	Not Met
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit	Children	≥95%	97.83%	*94.67%	*97.37%	*100%	97.22%	Met
	Adults	≥95%	95.76%	*95.20%	*95.99%	*97.16%	96.14%	Met
	MSHN SUD	≥95%	97.48%	95.02%	*98.05%	91.91%	95.16%	Met
Indicator 10: Percentage who had a Re-admission to Psychiatric Unit within 30 Days	Children	≤15%	8.81%	*9.36%	*8.84%	*6.38%	8.25%	Met
	Adults	≤15%	12.31%	*10.73%	*10.95%	*12.79%	11.52%	Met

*Exceeded the Michigan State Performance. Red font indicates performance below the standard.

b) Access-Priority Populations

Goal: MSHN will demonstrate an increase in percentage of individuals identified as a priority population (pregnant with a substance use disorder, or pregnant injecting drug user) who have been screened and referred within the required time frame, based on the recommended level of care.

Status: Effective

Goal	Baseline	FY23	FY24	Status
MSHN will demonstrate an increase in percentage of individuals identified as a priority population (pregnant with a substance use disorder, or pregnant injecting drug user) who have been screened and referred within the required time frame, based on the recommended level of care.	**42%**	**35%**	**56%**	**Met/Continue**

Improvement Strategies				
Barrier/Causal Factors	**Intervention**	**Intervention Start Date**	**Who**	**Evaluation Process**
Appointment date and time does not match the admission date and time. Providers not following the correct process for documentation.	Access training was provided for the provider network	5/2023	MSHN/UM	Continued ongoing training needed.
Data Fields are blank (Admission Date/Time, Appointment Date/Time, Time from Request to Appointment)	• Access training was provided for the provider network. • Exploring additional documentation fields to explain the reasons for no appointment scheduled. • Re-opened ITR with PCE to properly pull appointment date from the LOC determination when there is no admission. • Reviewed LOC Determinations that have blank "Appointment Date" cells on the report and manually entered date that provider offered appointment and determined compliance.	5/2023 7/2023 3/2024 4/2024	MSHN/UM MSHN/IT MSHN/SUD Care Navigator	PCE was able to amend the report to include the Appointment Date when there was no Admission Date, which was previously hindering this report.
Improve access timeliness for pregnant individuals seeking SUD services	MSHN will be centralizing Access for Withdrawal Management, Residential and Recovery Housing services.	10/1/2024	MSHN/UM	Ongoing monitoring of the admission timeliness report before and after implementation date.

Recommendations for FY25:

- MSHN will be centralizing Access for Withdrawal Management, Residential and Recovery Housing services.

c) Performance Based Incentive Payment Measures

Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Data is currently available only through CY24Q1.

Goal: MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers

Status: Partially Effective

6

Recommendations for FY25:

- Identify Causal factors and develop improvement strategies.
- Develop an organizational plan to address disparities for both SUD providers and CMHSP Participants.

Attachment 3 FY24 Q1-Q2 Integrated Health Quarterly Report

Figure 4. MSHN Performance Based Incentive Payment Measures Performance

Strategic Priority	Joint Metrics	Standard	CY22	CY23	CY24Q1	Status/ Recommendations
Better Care	J.2 a. The percentage of discharges for adults (18 years or older) 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 Data Source CC360	58%	*70%	*69%	*68%	Met/Continue
Better Care	J.2 b. The percentage of discharges for children (6-17 years) 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 Data Source CC360	70%	*88%	*85%	*85%	Met/Continue
Better Care	J.2 c. Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	0 Disparity exist	0 Disparity exist	1 Disparity exist	1 Disparity exist	Not Met/Continue
Better Care	J.3 a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence	100%	*43%	*38%	*39%	Not Met/Continue
Better Care	J.3 b. Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	0 Disparity exist	2 Disparity exist	2 Disparity exist	2 Disparity exist	Not Met/Continue

d) Certified Community Behavioral Health Clinics

The Certified Community Behavior Health Clinics review data quarterly to identify any areas of improvement needed and to share best practice with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures. MDHHS has provided the finalized performance data for FY23. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect

360 to monitor performance throughout the year. The data in the table below is obtained from CC360 and is only available through March 31, 2024.

The clinics that perform below the standard are responsible for analyzing their organizations data and developing improvement strategies. If the causal factors are related to a system issue and a regional response is required by the lead entity, improvement strategies are developed and monitored for effectiveness. During FY24 a regional improvement strategy was not required. Regional monitoring will continue. The CCBHC program has implemented new performance measures beginning 10/1/2024. The performance year will transition to a calendar year beginning 1/1/2025 through 12/31/2025. A statewide metric workgroup has been initiated by the clinics for the new performance measures. The purpose will be clearly identified and is expected to include the provision of clarification and utilization of consistent definitions and interpretations for the data elements of new and ongoing performance measures.

Goal: CCBHC will meet the standard for the CCBHC performance measures.

Status: Partially Met/Continue

Recommendations for FY25

- MSHN, as the lead entity (LE), will complete the following:
  - Will receive CCBHC metrics template quarterly from each clinic quarterly.
  - Will review metric templates for completeness and accuracy
  - Will ensure improvement strategies are developed based on clinic and LE performance.
  - Will establish/develop an efficient method to view performance by clinic, comparing to Michigan CCBHC standards and to provide validated detail clinic data as requested to each clinic.

Figure 5. CCBHC Quality Bonus Payment Measures Performance

CCBHC Quality Bonus Payments	Standard	FY23	FY24Q2/CY24Q1 3.31.2024	Status/ Recommendations
Follow-Up After Hospitalization for Mental Illness. 30 days (FUH -Adults)	58%	Michigan CCBHC: 69.8% CEI: 62% Right Door: 61% SCCMHA: 70%	Michigan CCBHC: 70% CEI: 64% Lifeways: 77% Right Door: 78% SCCMHA: 71%	Met
Follow-Up After Hospitalization for Mental Illness (FUH-Child/Adolescents) MSHN.	70%	Michigan CCBHC: 81.5% CEI: 69% Right Door: 73% SCCMHA: 77%	Michigan: 82% CEI: 92% Lifeways: 81% The Right Door: 100% SCCMHA: 80%	Met
Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN. Standard 58.5%	58.5%	Michigan CCBHC: 54.9% CEI: 59% Right Door: 95% SCCMHA: 57%	Michigan CCBHC: 58% CEI: 61% Lifeways: 63% The Right Door: 78% SCCMHA: 56%	Partially Met
Initiation of Alcohol and Other Drug Dependence Treatment MSHN.	25%	Michigan CCBHC: 41.2% CEI: 52% Right Door: 33% SCCMHA: 49%	Michigan CCBHC: 42% CEI: 43% Lifeways: 24% The Right Door: 41% SCCMHA: 43%	Partially Met

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CCBHC Quality Bonus Payments	Standard	FY23	FY24Q4/CY24Q3 9.30.2024	Status/ Recommendations
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN. Standard 12.5%	12.5%	Michigan CCBHC: 63.9% CEI: 89% Right Door: 83% SCCMHA: 21%	Michigan CCBHC: Not Available CEI: 83% Lifeways: 19% The Right Door: 86% SCCMHA: 86%	Met
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN. Standard 23.9%	23.9%	Michigan CCBHC: 78.1% CEI: 76% Lifeways: 38% Right Door: 69% SCCMHA: 74%	Michigan CCBHC: Not Available CEI: 73% Lifeways: 33% Right Door: 67% SCCMHA: 84%	Met

e) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. MSHN has approved the two Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region for CY22 through CY25.

Goal: Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment without a decline in performance for the White population? Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

STUDY INDICATORS:

Indicator 1: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:** Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid State Health Network region and are determined eligible for ongoing services.

Indicator 2: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:** Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services.

Indicator 3: The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

A comparison of the percentage of compliance between the black and white populations for each time period with a two-proportion z-test. This is used to determine if the difference in rates are statistically significant.

DATA ANALYSIS**:**

Indicator 1

CY23- When comparing the percentage of compliance for the black population between the baseline and remeasurement period 1 with a two-proportion z-test, the difference in compliance between the two time periods was significant because the p-value is less than 0.05.

CY24Q2-When comparing the percentage of compliance for the black population between remeasurement period 1 and remeasurement period 2 with a two-proportion z-test, the difference in compliance between the two time periods was not significant because the p-value is greater than 0.05.

Indicator 1 Title: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Rate (%)	Mandated Goal if applicable	*p* Value
01/01/2021–12/31/2021	*Baseline*	852	1310	65.04%	N/A for baseline	Reference
01/01/2023–12/31/2023	Remeasurement 1	890	1491	59.69%	Increase	P value .00407
01/01/2024–6/30/2024 YTD	Remeasurement 2	674	1047	64.37%	Increase	P value .77047

Indicator 2

CY23-When comparing the percentage of compliance for the black population between the baseline and remeasurement period 1 with a two-proportion z-test, the difference in compliance between the two time periods was significant because the p-value is less than 0.05.

CY24Q2-When comparing the percentage of compliance for the black population between remeasurement period 1 and remeasurement period 2 with a two-proportion z-test, the difference in compliance between the two time periods was not significant because the p-value is greater than 0.05.

Figure 3: MSHN Indicator 2 Data

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Indicator 2 Title: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal, if applicable	*p* Value
01/01/2021-12/31/2021	*Baseline*	5655	8138	69.49%	N/A for baseline	Reference
01/01/2023 - 12/31/2023	Remeasurement 1	6084	9665	62.95%	≥69.49%	P value .0169
01/01/2024–6/30/2024 YTD	Remeasurement 2	4572	6539	70.02%	≥69.49%	p value .5018

Indicator 3

CY21-When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

CY23-When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

CY24Q2- When comparing the percentage of compliance between the black and white populations for each time period with a two-proportion z-test, the difference in compliance between the two populations was significant because the p-value is less than 0.05.

Figure 4: Indicator 3 Data

Indicator 3 Title: The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.								
Time Period	Indicator Measurement	White Numerator	White Denominator	Percentage	Black Numerator	Black Denominator	Percentage	p-Value (Goal p value <0.500)
01/01/2021 - 12/31/2021	Baseline	5655	8138	69.49%	852	1310	65.04%	.00139
01/01/2023 - 12/31/2023	Remeasurement 1	6084	9665	62.95%	890	1491	59.69%	.01687
01/01/2024 - 6/30/2024	Remeasurement 2	4572	6530	70.02%	674	1047	64.37%	.00028

FINDINGS: MSHN did not eliminate the disparity between the black or African Americans and the white population groups for CY24Q2. The rate of access to services for Index/White population group demonstrated a downward trend from the baseline year as indicated in the Figure 1 for CY23. The rates in CY24Q2 for both population groups have improved since CY23. The black/African American rate continues to be below the baseline rate, however, did demonstrate a significant increase in CY24Q2. The area within MSHN that has the largest Black/African American population group is CEI, Saginaw, Lifeways, and CMCMH. Interventions focused primarily in those areas will have the largest impact on the overall regional performance.

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Performance Improvement Project Two:

Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate of those who are eligible for Medicaid services?

STUDY INDICATORS:

Indicator 1: The percentage of individuals who are black/African American and eligible for Medicaid and have received a PIHP managed service.

Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service. (CMHSPs Combined)

Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Indicator 2: The percentage of individuals who are white and eligible for Medicaid and have received a PIHP managed service.

Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service. (CMHSPs Combined)

Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Figure

Measurement Period	Indicators-Race	# Total Medicaid Enrollees	# Medicaid Enrollees Served	Penetration Rate	Disparity Rate
CY21Q2	African American / Black	62829	3973	6.32%	1.85%
	White	328506	26852	8.17%	
CY21 (Baseline)	African American / Black	70267	5236	7.45%	2.05%
	White	373783	35532	9.51%	
CY22Q2	African American / Black	70208	4131	5.88%	1.70%
	White	374973	28420	7.58%	
CY22	African American / Black	72377	5241	7.24%	1.80%
	White	385878	34891	9.04%	
CY23Q2	African American / Black	70385	4099	5.82%	1.76%
	White	368396	27947	7.59%	
CY23	African American / Black	74833	5500	7.35%	1.71%
	White	391423	35448	9.06%	
CY24Q2	African American / Black	66557	4373	6.57%	1.46%
	White	339843	27283	8.03%	

Figure

Test	Test Question	Test Result
Test 1	Was there disparity between the Minority rate and White rate in Year 1?	Disparity in year 1: the Minority rate was significantly lower than the White rate.
Test 2	Was there disparity between the Minority rate and White rate in Year 2?	Disparity in year 2: the Minority rate was significantly lower than the White rate.
Test 3.1	Did the Minority rate increase, stay the same, or decrease from Year 1 to Year 2?	No change in Minority rate from year 1 to year 2: there was no significant change in the Minority rate.
Test 3.2	Did the White rate increase, stay the same, or decrease from Year 1 to Year 2?	Decrease from year 1 to year 2: the White rate significantly decreased.
Test 3.3	Did the disparity between the Minority rate and the White rate decrease, stay the same, or increase from Year 1 to Year 2?	Disparity decreased significantly from year 1 to year 2

STATUS: Indicator 1 (African American or Black) and Indicator 2 (White) have both rates have increased from previous measurement period (CY24Q2). However, when compared to the baseline year (CY21Q2) both rates have decreased. The number of Medicaid eligible has increased at a higher rate than those who have received a service.

RECOMMENDATIONS: Complete additional analysis to determine areas of focus. Complete statistical testing to determine significance related to the penetration rate and change over time.

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Improvement Strategies					
Barrier		**Interventions**			
Priority Ranking	**Barrier Description**	**Initiation Date (MM/YY)**	**Description**	**Status**	**Member, Provider, System**
1	No shows-lack of appointment follow up	10/1/2024 8/31/2024 10/1/2024	• Implement appointment reminder system **completed by a staff person/peer.** • Implement/modify process for coordination between providers (warm hand off) • **Provide training for Teach back method.** • **Implement Teach back method for coordination including resolution of barriers. Including barriers specifically related to race and ethnicity.**	Revised Continued **New** **New**	Provider Provider **System** **Provider**
2	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in limited available appointments within 14 days.	10/1/2022	• Recruit of student interns and recent graduates from colleges and universities with diverse student populations.	Continued	Provider Intervention
		10/1/2022	• Utilization of external contractors to provide services.	Continued	Provider Intervention
3	Minority Groups are not aware of services offered	8/1/2024	• Identify and engage with partner organizations that predominantly serve communities of color. (examples: faith- based/religious groups, community recreation centers, tribal organizations, etc.)	Continue, revise the timeline	Provider
	Minority Groups are not aware of services offered	8/1/2024	• Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	Continue, revise the timeline	Provider
4	**Ratio established by MDHHS for Wrap-around and Homebased Services staffing not met.**	**CY25**	• **Develop action steps to increase network adequacy for children services.**	**New**	**System/Provider**
5	Insufficient data to identify Social Determinants of Health (SDOH) such as inadequate Housing, food insecurity, transportation needs, employment/income challenges	**CY26**	• MSHN will work with partner CMHSPs to develop a standardized a process for collecting and sharing data related to social determinants of health including the use of SDOH z codes on service encounters.	**Continue, revise timeline.**	**System**

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments, and other data were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Customer Services Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials. The tools used for each population group are listed below. The individuals who have received treatment for a substance use disorder utilized the MHSIP for the first time this year. An electronic version of the tool was developed in survey monkey. The tools, instructions, and a link for the data submission was made available through the MSHN website.

- Mental Health Statistics Improvement Program (MHSIP)-Adults receiving treatment for a Mental Health Diagnosis, an Intellectual Developmental Disability, a substance use disorder, and or receiving long term supports or services.
- Youth Satisfaction Survey (YSS) Youth receiving treatment for a Severe Emotional Disturbance (SED), an Intellectual Developmental Disability, and or receiving long term supports and services
- Provider Network Survey-Organizations who contract with MSHN (every other year)
- Committee/Council Survey-Provider representatives on MSHN committees/councils (every other year)
- National Core Indicator Survey-Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints-All individuals receiving services.

Goal: MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and

- Assess issues of quality, availability, accessibility of care,
- take specific action as needed, identifying sources of dissatisfaction,
- outline systematic action steps,
- evaluate the effects of improvement activities and,
  communicate results to providers, recipients, and the Governing Body

Status: Effective. MSHN Met the standard by obtaining an 80% or higher

Goal: MSHN will adhere to the timeliness standards for Appeal and Grievance Reporting

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Status: Effective. MSHN Met the Standard

Recommendations for FY25:

- Provide /update instructions and tools on the MSHN website for all surveys.
- Update process and instructions to include the submission of template on the MSHN website.

- Develop electronic version of the tool and establish process for data distribution once completed.
- Explore the use of an external contractor to complete the analysis of the survey data and annual report.

Attachment 4 MSHN Experience of Care Executive Summary 2024

Strategic Priority	Goal-Stakeholder Feedback	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services.	80%	95%	90%	87%	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services.	80%	87%	81%	82%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services.	80%	83%	80%	80%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.	80%	83%	80%	85%	Met/Continue
Strategic Priority	**Goal-Stakeholder Feedback**	**Standard**	**FY22**	**FY23**	**FY24**	**Status/ Recommendations**
Better Care	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.	95%	96.71%	98.85%	97.25%	Met/Continue
Better Care	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.	95%	95.12%	100%	100%	Met/Continue

g) Adverse Event Monitoring

Goal:
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy.

Goal: Improve timeliness of remediation response in the CIRS-CRM

Status: The QAPIP was partially effective.
MSHN completed four of the six objectives on the work plan.

Recommendations for FY25:

- Monitor performance indicators including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence quarterly.
- Increase the rate of critical incidents submitted within the required time frame.
- Increase the rate of remediations completed within the required time frame.

    - Develop training documents and complete training outlining the requirements of reporting critical, sentinel, immediately reportable, and news media events.
    - Validate / reconcile reported data through the CRM.
    - Establish electronic process for submission of sentinel events/ immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated service. (CRM)
    - Monitor timeliness of submissions and remediation response in the CIRS-CRM through development of dashboard in REMI
    - Track CIRS changes and barriers through the CIRS Process Improvement Report.

Attachment 5 MSHN Critical Incident Performance Report FY24 Q3

	Goal-Event Monitoring and Reporting	Standard	FY22	FY23	FY24Q3	Status/ Recommendations
Better Care	The rate of critical incidents per 1000 persons served will demonstrate a decrease from the previous year. (CMHSP) (excluding deaths)	Track and Trend	8.561	9.550	8.848	Continue
Better Care	The rate, per 1000 persons served, of unexpected deaths will demonstrate a decrease from previous year. (CMHSP) (Accidental, Homicide, Suicide)	Track and Trend		1.109	.395	Continue
Better Care	The rate of natural cause deaths, including the leading causes of death.	Track and Trend		5.915	4.112	Continue
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	Track and Trend	0.91%	0.77 %	.74%	Continue

h) Behavior Treatment

Goal: MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis.
Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX

Goal: MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans.
Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX

Status: MSHN did not meet each standard.

Recommendations:

Attachment 6 MSHN Behavior Treatment Review Data FY24 Q3

Strategic Priority	Behavior Treatment	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	Track and Trend	0.91%	0.77 %	.74%	Continue

i) Clinical Practice Guidelines

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 are monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT 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.

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.

Status: MSHN did not meet the standard.

Attachment 6 MSHN Behavior Treatment Review Data FY24 Q3
Attachment 7 ACT Utilization FY24 Q2

Strategic Priority	FY24 Goal-Clinical Practice Guidelines	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	95%	72.2%	88%	50%	Not Met/Continue
Better Care	MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer	(85%/96 minutes-100%/120 minutes).	2/7	1/8	1/8	Not Met/Continue

	MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS					

III. Provider Monitoring

a) Credentialing and Re-credentialing

MSHN has established written policy and procedures[1] in compliance with MDHHS's Credentialing and Re-Credentialing policy 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 three (3) years thereafter. MSHN written policies and procedures[2] also ensure 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, 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 compliance with federal, state, and local regulations and requirements through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. In addition, MSHN has established an increased monitoring process that focuses on timeliness not decision making and recredentialing as reported bi-annually by CMHs. Any CMH that does not meet 90% compliance is subject to increased morning.

FY24 Q1-Q2, three of the twelve CMHSPs scored under 90% and were required to submit plans of correction as well as put on increased monitoring plans (quarterly). At the time of this report, a summary of the full FY24 credentialing was not available as reporting was not due to MSHN and MDHHS until after the report due date.

The CMHSPs have been making adjustments to their current systems to ensure compliance with requirements without making significant costly changes. It was recommended by MSHN for CMHSPs to find interim ways to meet compliance that aligned with the implementation of the MDHHS Universal credentialing system expected in FY25. MDHHS created the system as a result of legislation requiring MDHHS to have a universal system for PIHPs/CMHSPs. The system will house all documentation required as outlined in the MDHHS Credentialing and Re-credentialing policy for licensed providers and provider network organizations.

Implementation and Next Steps: The MDHHS training and implementation plan for the MSHN region begins October 2025. In FY25, MSHN will assist CMHSPs in the implementation of the new system and will plan to conduct credentialing reviews directly from the Universal Credentialing system in FY26.

[1] Provider Network Credentialing/Recredentialing Policy and Procedure
[2] Provider Network Non-Licensed Provider Qualifications

Status: Effective.

Recommendations:

- Discontinue the goal as indicated below.
- Implement the Universal Credentialing System.

Strategic Priority	Goal-Staff Qualifications	FY22	FY24	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. FY22 MDHHS Review, FY24 MDHHS Review	88%	95%	Met/Discontinue

b) Verification of Services

Status: MSHN did meet the goal as indicated below for the CMHSP Providers FY24. MSHN did not meet the goal for the SUD Providers.

Recommendations for FY25:

Goal: SUD-Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. 90% Standard

Goal: CMHSP- Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed. 90% Standard

- SUD Lunch and Learn which included overview of the MEV SUD Guide,
- SUD MEV Guide has been added to the website, sent out in the Constant Contact, and linked in the checklist that providers receive prior to the review.
- Presented to the SUD Residential workgroup and discussed requirements, documentation suggestions, and how to prepare for the review i.e., documentation required.
- Recommendations to all providers during the review process and within the final reports
- Created a CMH MEV Guide which has been provided to CMHs via MSHN committees, added to the MSHN website, and linked in the CMH Review checklists.
- Met with the MSHN Compliance Committee in FY23Q3 to discuss the attribute compliance and make recommendations for improvement.
- Met with QIC and discussed this specific attribute and provided recommendations for improvement that CMHs could implement.
- Make recommendations to all CMHs during the review process and within the final reports.

Strategic Priority	Goal-Medicaid Event Verification	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.	90%	CMHSP: 86.21% SUD: 87.57%	CMHSP: 86.65% SUD: 75.68%	CMHSP: 91.6% SUD: 85.65%	CMHSP-Met/Discontinue SUD-Not Met Continue

c) Customer Services

Strategic Priority	Goal-Stakeholder Feedback	Standard	FY22	FY23	FY24	Status/ Recommendations
Better Care	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.	95%	96.71%	98.85%	97.25%	Met/Continue
Better Care	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.	95%	95.12%	100%	100%	Met/Continue

Status: Effective

Recommendations for FY25:

- Continue to monitor goals for effectiveness.

d) Utilization Management

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.

Status: Partially Effective

Recommendations for FY25:

Goals	Standard	FY23	FY24	Status/ Recommendation
Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	100%	100.00%	97.0%	Not Met-Continue
Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	100%	68.2%	N/A	Not Met/Continue
The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	<=15%	13.64%	12.51%	Met
Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices	> 90%		98.46%(Q3)	Met/ Discontinue
Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	<= 5%	1.0%	0.01%	Met/Discontinue

e) Long Term Supports and Services for Vulnerable Adults

MSHN ensures that long term supports, and services are consistently provided in a manner that supports community integration and considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. MSHN assesses the quality and appropriateness of care furnished and community integration by monitoring population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's treatment plan and during transitions between care settings. In addition to the behavior treatment data, and adverse event data, MSHN monitors key priority measures as approved by Operations Council.

MSHN encourages community integration to occur more than once per week. Community integration is discussed with individuals at a minimum during the time of the person-centered planning to ensure their wants and desires are noted during the planning process. Documentation of community integration has been seen regularly during oversight reviews. Currently, there is not a systemic issue related to community integration as evidenced by the site review results.

Status: Effective

Recommendations for FY25

Strategic Priority		Standard	FY22	FY23	FY24	Status/ Recommendations
Better Value		100%	78%	81%	86%	Met/Continue

f) Provider Monitoring and External Reviews

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. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

IV. FY24 MDHHS 1915(c) Waiver and 1915(i) State Plan (iSPA) Review Summary

Overview

The Michigan Department of Health and Human Services (MDHHS) conducted a review of the Mid-State Health Network region May 28, 2024-July 31, 2024. The review was specific to the Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Severe Emotional Disturbance Waiver (SEDW), and 1915(i) State Plan (iSPA). The review included an administrative review, samples of clinical records, and staff qualification file reviews. MDHHS also conducted interviews with individuals and their families.

MDHHS completed a review of 149 clinical records and a review of staff files for those staff working with the 149 beneficiaries selected for clinical review. MDHHS reviewed a total of 868 staff files which included 236 professional staff and 632 aide-level staff.

MDHHS sent the final report to MSHN on August 28, 2024, and requested a plan of correction for any findings identified. CMHSPs have provided individual and systemic plans of correction which were combined into a regional document and submitted to MDHHS. Once approved, MDHHS will conduct a 90-day review to ensure implementation of the plans of correction.

Elements of the administrative review:

- Critical Incidents-CMH and PIHP policies, procedures and implementation
- Contracting Policy- CMH and PIHP policies and procedures that guide contracting processes with new providers or providers who are expanding service array to ensure they do not require heightened scrutiny (due to isolating/institutional elements).
- Parity Plan- Verification that the region (i.e. PIHP/CMHP) has adhered to the Parity Plan that was approved by MDHHS.

Results: No findings. 100% Compliant.

MDHHS reviewed clinical records for individuals enrolled in the CWP, HSW, SED, iSPA. Record reviews standards encompassing the following elements:

- Person centered planning

- Plan of service and documentation requirements
- Behavior Treatment Plans
- Waiver Participant Health and Welfare

Areas for regional improvement are identified in this summary as standards that had findings in 50% or more of the records reviewed. Findings that were repeat findings (i.e. findings identified by MDHHS during the 2022 review) are identified with a red asterisk (*).

Areas for Regional Improvement –

Areas for regional improvement are identified in this summary as standards that had findings in 50% or more of the records reviewed. Findings that were repeat findings (i.e. findings identified by MDHHS during the 2022 review) are identified with a red asterisk (*).

CWP Clinical Records

- **P.1.2:** The IPOS addresses all service needs reflected in the assessments. (6/12; 50%)*
- **P.1.4:** The IPOS is developed in accordance with the policies and procedures established by MDHHS. (7/12; 58%)*
- **P.4.2:** Services and supports are provided as specified in the IPOS, including type, amount, scope duration and frequency. (9/12; 75%) *

HSW Clinical Records

- **P.2.8:** Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (8/13; 62%)*
- **P.5.1:** Specific Services and supports that align with the individual's assessed needs, including measurable goals/objectives, with amt/scope/duration and time frame of services for implementing. (33/38; 87%) *
- **P.5.2**: Services and treatment identified in the IPOS are provided as specified in the plan. (19/38; 50%)*
- **B.2:** Behavioral treatment plans are developed in accordance with the technical requirement for Behavior Treatment Plan Review Committee. (8/12; 67%) *

One urgent health and safety issue was identified and required a plan of correction to be submitted to MDHHS prior to the final report. An update to the plan of correction was submitted to MDHHS with the regional CAPs in September 2024.

SEDW Clinical Records

- **P.3.4:** The IPOS is developed in accordance with policies/procedures established by MDHHS. Plans contain measurable goals/objectives and time frames. Prior authorizations of services correspond to services identified in the plan. (15/23; 65%) *
- **P.6.1:** Services and supports are provided as specified in the IPOS including type amount scope duration and frequency. (19/23; 83%)*

iSPA Clinical Records

- **P.1.B.2:** Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (65/76; 86%)

- **P.1 B.3:** Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objectives, the type, amount scope duration, frequency and timeframe for implementing. (51/76; 67%
- **B.2:** Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. (6/6; 100%)

38% demonstrated a decrease (16)

62% increased or maintained compliance (26)

Recommendations for FY25:

- MSHN will provide monitoring and oversight to ensure corrective action plans are implemented and effective.
- Region wide quality improvement efforts will be explored to increase efficiencies and improve compliance with standards.

V. External Quality Review Summary

Overview

The Michigan Department of Health and Human Services (MDHHS) contracts with Health Services Advisory Group (HSAG) to compete federally required Medicaid Quality Reviews (EQR) of Pre-Paid Inpatient Health Plans (PIHPs) to ensure compliance with federal and state Medicaid requirements.

In FY24, HSAG conducted four reviews:

- Encounter Data Validation
- Network Adequacy Validation
- Performance Measure Validation
- Compliance

In addition, HSAG requested a progress update for areas where they made recommendations during FY23 reviews.

Encounter Data Validation (EDV) April – July

In FY24, MDHHS introduced a new review of PIHPs. The EDV is expected to be conducted every three years. The goal of the review was to evaluate MDHHS' encounter data completeness and accuracy through a review of records. The study population included members continuously enrolled in the same PIHP that had at least one visit covered by Medicaid during the review period. The review period was 10/1/22 – 9/30/23.

Initially, the case selection for each region included 411 encounters. As there were some barriers and challenges identified, the case selection size was ultimately changed to 308. Documentation for the 308 encounters was required to be submitted along with documentation for the next encounter the individual had with the same provider.

MSHN submitted all documentation within the timeframe requested (7/3/24). On 9/20/24, HSAG requested follow up documentation for the review and requested it be submitted by 9/27/24.

The final report summarizing the review is expected sometime in early FY25. A date was not provided by MDHHS or HSAG.

Network Adequacy Validation (NAV) May – August

In FY24, MDHHS introduced the NAV review to PIHPs. The review is expected to take place annually in concert with the Performance Measure Validation (PMV) review. The focus of the review included network adequacy data collection, integration, calculation, accuracy, and reporting of indicators for each required standard.

Additionally, the review included an Information Systems and Capabilities Assessment (ISCA) which included network adequacy elements and PMV review elements. During the virtual review, MSHN was provided the opportunity to show live/real-time processes used for data integration and processes for calculating time and distance.

In August 2024, MSHN received a Logic Review Report from HSAG indicating that the time and distance standard review was approved. If findings are identified via the ISCA, they will be included in an aggregate report. The NAV audit aggregate report is expected in December 2024.

Performance Measure Validation (PMV) May - August

The PMV review is conducted annually and includes validation of performance measures, an Information Systems Capabilities Assessment (ISCA), and a review of source code/programming language used to generate required performance indicator rates.

All source code reviews specific to each performance indicator were found to be approved by HSAG for all CMHs and MSHN. MSHN and HSAG reviewed a total of 310 records in the FY24 review. Of the records reviewed there were no repeat findings for five of the six recommendations/findings listed by HSAG in the

Findings:

Weakness #1: One case identified in indicator #10 for Tuscola did not involve a member who was a Medicaid beneficiary for at least one month during the reporting period. [**Quality**]

> **Why the weakness exists:** Enrollment system information indicated that the member had a Family Planning Program waiver (Plan First) and was not eligible for Medicaid. **MSHN** confirmed that the member should be removed from indicator #10 and that, based on its review of all other reported indicator #10 cases, this was an isolated issue.
>
> **Recommendation:** Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.

Weakness #2: Two cases for CMHA-CEI in indicators #2 and #3 were identified as having the incorrect populations listed in the member-level detail file. [**Quality**]

> **Why the weakness exists: MSHN** confirmed that this was due to the population designations changing after the original report was run and before the final report was submitted with final rates to MDHHS. **MSHN** indicated that it plans to put a remediation plan in place to crosswalk the initial report with the final report to identify any changes in population designations before submission. No other cases were identified with this issue.

Recommendation: Although this finding did not have a significant impact on the indicator #2 and #3 total rates, HSAG recommends that **MSHN** proceed with its outlined remediation plan. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #2 and #3 data. This should include implementing another level of validation for reviewing a statistically significant sample of cases each quarter to confirm that their associated population designations are accurately reported.

Weakness #3: HSAG identified one case in indicator #3 for Lifeways that should have been reported as out of compliance rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that crisis transportation should not have been captured as an ongoing covered service and removed the case from indicator #3. **MSHN** also indicated that it will be working with PCE to update its programming logic to ensure that crisis transportation is not counted as an ongoing covered service. MSHN confirmed that this **w**as an isolated issue after it reviewed all other reported indicator #3 cases.

Recommendation: Although **MSHN confirmed** that this was an isolated issue, HSAG recommends that **MSHN** implement the programming logic updates and also perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #3 data.

Weakness #4: HSAG identified one case in indicator #4a for Lifeways that should have been reported as an exception rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that the case should not have been reported as incompliance for indicator #4a due to the follow-up appointment not being documented in the out-of-network area of the REMI system, and therefore it was not captured as an exception for indicator #4a. **MSHN confirmed that this w**as an isolated issue after it reviewed of all other reported indicator #4a cases.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #4a data. Retraining on how to appropriately document various scenarios in the REMI system should be provided if found necessary.

Weakness #5: MSHN's indicator #2 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a nonemergency request for service.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #6: MSHN's indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN's indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

Recommendations FY25:

- Review a statistically significant sample prior to submission of those CMHSPs that had findings during the HSAG review.
    - TBHS-Medicaid eligibility,
    - CEI - Associated population designations are accurately reported
    - Lifeways-Accurate disposition, exceptions are coded correctly for Indicator 4.
- Ensure completion of the CMHSP/SUD Provider corrective action plans related to internal review of primary source verification.

Compliance Review May - September

HSAG conducts compliance reviews over a three-year cycle. FY24 was Year 1 of the new cycle. The focus of the review included ensuring compliance with the areas of

- Member Right and Member Information
- Availability of Services
- Assurance of Adequate Capacity and Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services

MSHN is expected to receive a final report and request for a plan of correction for any findings identified in December 2024.

Performance Improvement Projects Validation Report

1. HSAG evaluates the technical structure of the PIP to ensure that Region 5—Mid-State Health Network referred to as MSHN in this report, designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depend on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG

evaluates how well MSHN improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).
The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related
to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

MSHN Validation Rating 1 Design and Implementation

- Percentage of Evaluation Elements Met 100%
- Percentage of Critical Elements Met 100%
- MSHN Validation resulted in a *High Confidence* rating.
  MSHN met 100 percent of the requirements for the data analysis and implementation of improvement
  strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.
  MSHN

Validation Rating 2 Outcomes

- Percentage of Evaluation Elements Met 33%
- Percentage of Critical Elements Met 100%
- MSHN Validation resulted in a *No Confidence* rating.
  MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the first remeasurement period.

HSAG Recommendations

- The performance indicators have not yet achieved the goals for the PIP. MSHN should consider evidence-based intervention efforts and the risk factors in quality of care for each subgroup, independently.
- MSHN should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions for both subgroups.
- MSHN should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

VI. Quality Priorities and Work Plan FY24

Goal-Organizational Structure and Leadership	Objectives/Activities	Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will complete and submit a Board approved QAPIP Plan, Evaluation and Workplan with list of members of the Governing Body. *42 CFR §438.330(a)(1) Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN QAPIP Evaluation. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations. • Submit to MDHHS via FTP site.	Quality Manager	10/31/2024 10/31/2024 9/30/2024 2/28/2024	Complete/Continue Complete/Continue Complete/Continue Complete/Continue
MSHN Board of Directors will review QAPIP Progress Reports describing performance improvement projects, actions, and results of actions.	• Establish an organizational process to monitor the status of the quality workplan and key performance indicators used to monitor clinical outcomes and process implementation. • Development of standard templates for use in organizational performance improvement projects and QI plan. • Include standard agenda items specific to the organizational performance and improvement activity (QAPIP). (Balanced Scorecard Review, Quarterly Department Reports)	Quality Manager Quality Manager Deputy Director	6/30/2024 6/30/2024 6/30/2024	In Progress/Continue In Progress/Continue Complete/Discontinue
MSHN will have an adequate organizational structure with clear administration and evaluation of the	• Evaluate the committee/structure to ensure responsibilities align with the strategic priorities.	Committee/ Council Leads	9/30/2024	Complete/Ongoing

QAPIP *Contract Schedule A—1(K)(2)(a). QAPIPs for Specialty PIHPs, Section I*	• Review committee charters to ensure effectiveness in carrying out the defined responsibilities. • Complete committee/council survey of effectiveness		10/30/2024 8/30/2024	Complete/Ongoing Complete/Next survey in 2026
MSHN will include the role of recipients of service in the QAPIP. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I*	• Recipients will provide feedback and have membership in select regional committees for the purpose of advocacy, project/policy planning and development, project implementation and evaluation. • Recipients will complete an assessment/survey of services and experiences of care. • Document member feedback in meeting minutes or other documents to ensure follow up. (QAPIP Description, Organizational Chart, Charter Membership).	Customer Services Manager Quality Manager Customer Services Manager	9/30/2024 8/30/2024	Complete/Ongoing Complete/Ongoing Complete/Ongoing
MSHN will have mechanisms or procedures for adopting and communicating process and outcome improvement. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I*	• Utilize the regional committee structure for communication and distribute policies/procedures, reports through. ○ Committee/councils, ○ MSHN Constant Contact, ○ Email. ○ Website ○ Post to the MSHN Website.	Committee/ Council Leads	Monthly	Complete/Ongoing
MSHN will have active participation of Network providers and members in the QAPIP processes. *Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IV*	• Document discussion and source of feedback to ensure follow up.	Committee/ Council Leads	9/30/2024	Complete/Ongoing

MSHN will provide and/or make available to consumers & stakeholders, including providers and the general public, the QAPIP Report, QAPIP Plan and other quality reports. *Contract Schedule A—1(K)(3)(a*	• Distribute the completed Board approved QAPIP Effectiveness Review (Report) and QAPIP Plan through ○ Committee/councils, ○ MSHN Constant Contact, ○ Email. ○ Website ○ Post to the MSHN Website. • Ensure CMHSP contractors have opportunity to receive the QAPIP. (DMC-check websites) • Provide to members upon request. • Distribute QAPIP progress reports which include but are not limited to Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	Quality Manager	Annually Annually As needed. Quarterly	Complete/Ongoing
Performance Measurement and Quality reports are made available to stakeholders and general public. *Contract Schedule A—1(K)(3)(a)*	• 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.	Leadership	Quarterly	Complete/Ongoing

Goal-MDHHS Performance Measures	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers.	• Review/Identify regional key performance indicators. • Monitor performance and review progress.	Quality Manager and Assigned Measure Stewards	Annually Quarterly	In Progress/Continue Include the revised BH Quality Program Performance Measures for Year 1.
MSHN will evaluate the impact and effectiveness of the QAPIP • Performance of the measures, • Outcomes and trended results • Results of efforts to support community integration for members receiving LTSS. • Analysis of improvements in healthcare and services as a result of the QI activities. • Trends in service delivery and health outcomes over time including monitoring of progress	• Establish a standardized process for MSHN committee/council to monitor the impact of intervention (quality improvement) on assigned performance areas. • Establish standard process for quality improvement in collaboration with committee/councils to analyze outliers and develop/identify regional improvement strategies used to identify barriers and interventions.	Quality Manager	Quarterly	In Progress/Continue-Develop a standard template for all committees and councils to use
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions in collaboration with committee. • Monitor the effectiveness of interventions.	Quality Manager	Annually Annually Quarterly	Completed/Continue In Progress/Continue-Develop a standardized template In Progress/Continue

Goal-Performance Improvement Projects	• Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions.	SUD Care Navigator	Quarterly	Complete/Continue
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/ African American population and the white population.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit PIP 1 to HSAG as required for validation. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 6/30/2024 2/28/2024 2/28/2025	In Progress/Continue with revisions
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 2/28/2024 2/28/2025	In Progress/Continue with revisions

Goal-Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and • Assess issues of quality, availability, accessibility of care, • take specific action as needed, identifying sources of dissatisfaction, • outline systematic action steps, • evaluate the effects of improvement activities and, • communicate results to providers, recipients, and the Governing Body. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(A-D)*	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS)	Quality Manager	6/30/2024	Complete/Continue
	• Implement MHSIP for individuals receiving SUD services.	Quality Manager	6/30/2024	Complete/Discontinue
	• Complete member experience annual report with causal factors, interventions, feedback provided from relevant committees/councils, and an evaluation of impact of the interventions to improve satisfaction.	Quality Manager	9/30/2024	Complete/Continue
	• Identify sources of dissatisfaction and document Provider Network action steps for improvement in the QIC action plan	Quality Manager	8/30/2024	In Progress/Continue
	• Establish a QI Team to streamline surveys and processes. Identify sources of feedback to include in the regional assessment of member experiences. Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	Quality Manager	3/31/2024	Complete/Discontinue
	• Complete an RFP for administration and analysis by an external vendor.	Quality Manager	6/30/2024	Not Started/On Hold

MSHN will adhere to the timeliness standards for Appeal and Grievance Reporting	• Implement a corrective action plan process for FY24 reporting when CMHSPs do not meet the 95% timeliness standard for Appeal and Grievance reporting	Customer Services Manager	1/31/2024	Completed/Discontinue
Goal- Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy. *42 CFR § 441.302(h)* *42 CFR §438.330(b)(5)(ii)* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII*	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events.	Quality Manager	4/2024	In Progress/Continue
	• Validate / reconcile reported data through the CRM.	Quality Manager	Quarterly	On Hold
	• Establish electronic process for submission of sentinel events/ immediate notification, remediation documentations, and written analysis for those deaths that occurred within one year of discharge from state operated service.	Quality Manager	9/2024	In Progress/Continue
	• Implement the use of the Root Cause Analysis template with standardized elements.	Quality Manager	9/2024	Complete/Discontinue
	• Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. • Complete CIRS Process Improvement Report.	Quality Manager	Quarterly	Complete/Continue with revisions
Improve timeliness of remediation response in the CIRS-CRM	• Develop dashboard for tracking and monitoring submission timelines and remediation timelines.	Quality Manager	9/2024	Not Started/Continue

Goal-Medicaid Event Verification	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status of Objectives /Recommendation
MSHN will address and verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors. *Contract Schedule A—1(K)(2)(a),QAPIPs for Specialty PIHPs, Section XII(A,B*	• Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	Annually	Completed/Continue
	• Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement, and actions taken.	Chief Compliance and Quality officer	12/31/2023 12/31/2024	In Progress/Continue (Due to MDHHS 12/31/2024)
Goal-Utilization Management Plan	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements: • Procedures to evaluate medical necessity, criteria used, information sources, and process to review and approve provision of medical services. • Mechanisms to identify and correct under and over utilization. • Prospective, concurrent and retrospective procedures are established and include required components. *42 CFR §438.330(b)(3)*	• MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	Chief Population Health Officer	Quarterly/ Annually	In Progress/Continue
	• Review tools for determining medical necessity for community living supports; recommend regional best practice	Chief Population Health Officer	April 2024	In Progress/Continue
	• Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals. • Develop and monitor reports and identify any areas where improvement is needed. • Integrate standard assessment tools into REMI- MichiCANS implementation.	Chief Population Health Officer Chief Information Officer	January 2024 Quarterly	In Progress/Continue

Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices.	• Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	Chief Population Health Officer	Annually	Completed/Continue
	• Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	Chief Population Health Officer	Annually	Completed/Continue
Goal-Oversight of "Vulnerable People"/Long Term Supports and Services	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including 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. *42 CFR 438.330 (b)(5)(i)* *42 CFR 438.330 (b)(4)*	• Develop process and identify report to monitor aggregate data on the quality and appropriateness of care for those receiving LTSS. • Establish process and identify report to monitor aggregate data for assessment of care between care settings. • Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings. • Include information in the QAPIP description, workplan, evaluation.	CBHO	Annually/ Quarterly	Complete/ Ongoing
Individuals receiving LTSS will be offered opportunities to participate in the community.	• MSHN clinical team will review community integration during regional site reviews, implementing quality improvement when evidence of community integration is not found, and monitor for	Waiver staff	Annually	Complete/Ongoing

	effectiveness to ensure community integration is occurring.			
Goal-Practice Guidelines	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will demonstrate an increase in fidelity to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	• Monitor utilization summary of the average. • Recommend improvement strategies where adverse utilization trends are detected.	Chief Population Health Officer	Quarterly	In Progress/Continue
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	• Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies. • Develop report to monitor, analyze, and improve the amount/scope and duration of services received by individuals enrolled in waivers and those not enrolled in waiver programs/services.	Quality Manager Chief Population Health Officer	6/30/2024 1/2024	In Progress/Continue
Goal-Behavior Treatment (Include under other areas. As indicated below)	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
(Event monitoring) MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI	Quality Manager	9/30/2024	Complete/Discontinue
	• MSHN will reach out to State Workgroup about training opportunities (including Direct Care Workers) • CMHSPs will share details of their training platforms with others (internal training, contracted trainers, etc.)	Waiver Administrator	10/2024	Complete/Ongoing

	• Regional BTR Workgroup will work together to provide/offer training opportunities for those working in direct care roles			
(Clinical Practice Guidelines) MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• BTR Workgroup members will share documentation and processes for consistent monitoring and tracking purposes. • CMHSPs will identify ways to incorporate standards into their EMR. • CMHSPs will share progress on EMR development of BTP standards. • MSHN will continue to review BTP charts through the DMC Review and the MDHHS 2024 Site Review. • MSHN will offer individual trainings as needed/requested. • MSHN will make regional BTPRC Training recording accessible to providers and stakeholders	Waiver Administrator	10/2024	Complete/Ongoing
Goal-Provider Monitoring	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
MSHN will monitor the provider network including affiliates or subcontractors to which it has delegated managed care functions, including service and support provision, following up to ensure adherence to the required functions.	• Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	Compliance Administrator	Annually	Complete/Ongoing
	• Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site	Functional Area Leads	9/30/2023	In Progress/Continue

	reviews, and submission of evidence for the follow up reviews.			
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	• Implement corrective action plans for areas not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps and assigned leads.	Compliance Administrator	9/30/2024	In Progress/Continue
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	• Verify Medicaid Eligibility and data accuracy through primary source verification.	Quality Manager	Quarterly	Complete/Discontinue
	• Validate data collection process, both administrative and manual.	Quality Manager	Annually	Complete/Continue
	• Develop / modify ongoing training documents.	Quality Manager	Annually	Complete/Continue
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	• Provide technical assistance to CMHSPs related to standards. • Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	Waiver Staff	9/30/2023	In Progress/Continue
Goal-Provider Qualifications	**Objectives/Activities**	**Assessment/Assigned Lead**	**Frequency/ Due Date**	**Status of Objectives /Recommendation**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements	• Will evaluate the MDHHS credentialing report for CMHSP timeliness in decision making and credentialing activities.	Compliance Administrator	Biannually	Complete/Ongoing
	• Will complete additional monitoring for those CMHSP who demonstrate a compliance rate of =<90% based on the credentialing report.	Compliance Administrator	Quarterly	Complete/Ongoing

	• Will complete primary source verification and review of the credentialing/recredentialing policy and procedure during the DMC review.	Compliance Administrator	Annually	Not Completed/Interim year. Transitioning to the MDHHS Universal Credentialing System
	• Will complete primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	Waiver Staff	Annually	In Progress/Ongoing

VII. MSHN Council Annual Reports FY24

Team Name: Mid-State Health Network Operations Council
Team Leader: Joe Sedlock, MSHN Chief Executive Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Board has created the Operations Council to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[3]

A. Past Year Accomplishments. FY23

- Reviewed and approved the FY22 Operations Council Annual Report
- Supported the forming of the 1915(i) Workgroup
- Reviewed and approved the FY22 QAPIP Annual Report
- Reviewed and approved the FY23 QAPIP Plan
- Supported MSHN position to appeal citations for the use of service ranges language in plans of service.
- Encouraged and supported MSHN in approaching MDHHS to offer to work together on special populations issues.
- Discussed and reviewed the Operating Agreement in regard to the local funds for OHH and BHH.
- Planned for the FY2024-2025 Strategic Plan Process

[3] Article III, Section 3.2, MSHN/CMHSP Operating Agreement

- Requested MSHN/region to look for opportunities to do more advocacy with MDHHS regarding how the state determines State Hospital placement.
- Supported the proposal to MSHNs Board of Directors to extend the Provider Staffing Crisis Stabilization Program thru the end of FY23.
- Supported MSHN and SWMBH collaboration in dialogue with MDHHS to assist with improving access for Children in Child Welfare.
- Reviewed and supported the Service Authorization Denial Summary and Procedure
- Reviewed MSHN Strategic Plan
- Examined Regional Savings Estimates-CMHSP regional partners to take a closer watch on current budget and expenditures. May need to develop regional strategy and/or regional cost containment plans.
- Discussed and reviewed the CFAP resolution
- Collaboration on issues raised by DHHS regarding Children's Access Issues
- Reviewed the FY22 Network Adequacy Addendum report
- Reviewed and approved FY24 ABA Contract
- Reviewed and approved FY24 Financial Management Services Contract
- Reviewed and approved the MSHN/CMHSP FY24 Medicaid Subcontract
- Reviewed and approved FY24 MSHN Training Grid
- Reviewed the FY23 budget amendment and the FY24 budget
- Monthly reviews of MDHHS disenrollment reports
- Supported MSHN to advocate with MDHHS to correct technological problems in the Customer Relationship Management (CRM) system and EGrAMS.
- Reviewed and approved the Ops Council Charter annual review
- Reviewed BCBS and Medicare Advantage services for Crisis Stabilization, Urgent Care and Mobile Crisis to encourage CMHSPs to consider participating.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Relating to conflict free access and planning, advocate for system reform changes that comply with the federal rule that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Work with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Ensure effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.

As a region and as individual entities: address, reduce, and eliminate health disparities.
Address funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements
Monitor and expand Behavioral Health Homes, Opioid Health Homes and Certified Community Behavioral Health Clinics in the MSHN region
Continue to educate MDHHS and other stakeholders on the governmental (non-commercial) nature of the public behavioral health system and work to avoid shaping the system to function like a private health plan
Work with MDHHS to establish a practical vision for use of the State CRM and work toward implementation

Team Name: Finance Council

Team Leader: Leslie Thomas, Chief Financial Officer

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- FY 2022 Audits received unqualified opinions and clean Compliance Examinations.
- FY 2022 Fully funded Internal Service Fund and Savings of $47.8 M – both together total 14.4% of the 15% target which is an accomplishment.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
•FY 2023 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2023 and February 2024. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2024 and compliance exams by June 2024. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material

aspects with relevant contractual requirements.
•Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2023 Final Reports due to MDHHS March 31, 2024, are received from the CMHSPs to the PIHP. The goal for FY 2023 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
•Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
•Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
•If applicable, develop regional and local cost containment strategies to align projected revenue and expenses.

Team Name: Information Technology Council
Team Leader: Steven Grulke, MSHN CIO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Representation from each CMHSP Participant at all Meetings.
    - There was a 95% attendance rate during FY23 ITC Meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
    - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: Mental health, substance use, and crisis records. (M, A, Q transactions).
- Several initiatives that ITC assisted with during FY23 are:
    - COB changes in 2023
    - MCG Indicia Upgrades

  - Foster Care Served Numbers for CMHSA advocacy to MDHHS
  - CRM Module Implementation
  - MDHHS Medicaid Redetermination – ongoing
  - Detailed files for updated EQI
  - Withdrawal Management BH-TEDS Adjustments – MDHHS
  - Addition of the 'TF' Modifier in EHRs for mild to moderate CCBHC designation
  - EVV advocacy along with CMHSA
- Facilitate health information exchange (HIE) processes:
  - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway. MSHN is ahead of all other pilots in this implementation.
- Goals Established by Operations Council:
  - Improvements with balanced scorecard reporting
  - Continue trending COVID-19 and telehealth reports (ended in May with emergency orders)
- Meet external quality review requirements:
  - Health Services Advisory Group (HSAG) conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with 1 compliance finding.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Representation from each CMHSP Participant at all Meetings
Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
Collaborate to develop systems or processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
Work on outcome measure data management activities as needed.
Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
Meet IT audit requirements (e.g., EQRO).

Team Name: Quality Improvement Council
Team Leader: Sandy Gettel Quality Manager
Report Period Covered: 10.01.2022-9.30.2023
Purpose of Council or Committee:

The Quality Improvement Council has been established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council will be comprised of the Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by each respective CMHSP Participant Chief Executive Officer/Executive Director, consumer representatives appointed through an application process, and a MSHN SUD staff representing Substance Use Disorder services as needed. The Quality Improvement Council will be chaired by the Quality Manager. All CMHSP Participants will be equally represented on this council.

Annual Evaluation Process

A. Past Year Accomplishments FY23 (10.1.2022 through 9.30.2023)

- Completed and submit a MSHN Board approved QAPIP Plan and Report to MDHHS by the required due date (February 28th, 2023)
- Approved the Quality policies and procedures ensuring they are in compliance with regulatory requirements and have been communicated to the providers.
- Developed regional guidelines for training documentation consistent with MDHHS
- Completed Member Experience Annual Survey
- Achieved the performance standards for each areas within the QAPIP, participating in quality improvement efforts as identified:
    - Behavior Treatment Review-Provide Data to BTPR Workgroup
    - Michigan Mission Based Performance Indicator System (MMBPIS)-Collaborated with MDHHS for recommended revisions and standards for Indicator 2, 3 and other indicators. Executed a targeted remediation based on external results of primary source verification. Developed process for Medicaid eligibility verification prior to submission. Added validation step prior to submission.
    - Develop standardized elements/form for mortality reviews and root cause analysis.
    - Achieve a Performance Improvement Project Validation from the External Quality Reviewers

B. Upcoming Year's Goals FY24 (10.1.2023 through 9.30.2024)

Goal	Objectives/Activities	Frequency/ Due Date
Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2024	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN regional report. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations	Annually 2/28/2024

Improve health outcomes for those served in the region.	• Review regional key performance indicators. • Review regional performance (BSC/Dashboard) • Develop/identify regional improvement strategies used to identify barriers and interventions. • Analyze outliers and establish process for quality improvement in collaboration with committee/councils. • Monitor the effectiveness of interventions	Annually Quarterly Annually- Annually Quarterly
Establish effective quality improvement programs for CCBHC, health homes.	• Identify regional key performance indicators. • Develop/modify data platforms/reports for performance monitoring. • Establish performance monitoring schedule. • Develop/identify regional improvement strategies.	Annually Annually Annually Annually
Adhere to critical incident and event notification reporting requirements by developing an efficient and effective critical incident monitoring system	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. • Validate / reconcile reported data through the CRM. • Improve timeliness of remediation response in the CIRS-CRM • Develop dashboard for tracking and monitoring timelines. • Establish electronic process for submission of sentinel events/ immediate notification, and remediation documentations.	Annually Quarterly Quarterly 2/28/2024 4/30/2024
Achieve full compliance for the MDHHS Review.	• Ensure corrective action plans are implemented to address deficiencies.	Annually
Improve member experience of care	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS) • Identify sources of dissatisfaction • Increase response rate-streamline surveys and process. • Outline actions step for follow up. • Evaluate the effects of activities implemented to improve satisfaction. • Complete an RFP for administration and analysis by an external vendor.	Annually Annually Annually Annually Annually 6/30/2024
Achieve full compliance for the HSAG External Quality Review - Compliance	• Ensure corrective action plans and recommendations are implemented to address deficiencies.	Annually

Achieve Reportable Status for the HSAG External Quality Review – Performance Measure Validation	• Verify Medicaid Eligibility and data accuracy through primary source verification. • Validate data collection process, both administrative and manual. • Develop / modify ongoing training documents.	Quarterly Annually Annually
Achieve 100% Validation Status for the HSAG External Quality Review- Performance Improvement Project	Implement 2 PIPs • Validate data • Utilize quality tools to identify barriers and root causes • Implement interventions • Evaluate the effectiveness of interventions	 Annually Annually Annually Quarterly

VIII. MSHN Advisory Councils FY24 Annual Reports

Team Name: Consumer Advisory Council
Team Leader: Todd Koopmans, Chairperson; Dan Dedloff, MSHN Staff Liaison
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed the changes to the FY23 MSHN Consumer Handbook
- Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
- Reviewed and provided feedback on the MSHN Satisfaction Survey results
- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the 2023 MSHN Delegated Managed Care Reviews
- Reviewed and provided feedback on the 2024/2025 MSHN Strategic Plan
- Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
- Reviewed and provided feedback on the MSHN Website Redesign
- Reviewed and provided feedback on MSHN Adverse Benefit Determination Training

- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Integrated Care
- Education and discussion on Michigan Medicaid Autism Benefit
- Education and discussion on HCBS Rule Updates
- Education and discussion on Conflict Free Access and Planning
- Collaboration with the Healthy Democracy Healthy People
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Charter
- Discussion and feedback on MSHN Council/Committee Survey Results
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities.
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation, and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom and added an in-person meeting option.
- Explore system improvements for services directed to youth

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Provide input on regional educational opportunities for stakeholders
Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
Review regional survey results, including SUD Satisfaction Survey and external quality reviews
Annual review and provide feedback on the QAPIP
Annual review and feedback on the Compliance Plan
Review of the MSHN FY24 Consumer Handbook
Review and advise the MSHN Board relative to strategic planning and advocacy efforts
Provide group advocacy within the region for consumer-related issues
Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
Explore ways to get more consumers involved in the RCAC and local consumer councils

Public Behavioral Health System Redesign Advocacy
Improve access to peer support specialists through CMHSPs

IX. MSHN Oversight Policy Board FY24 Annual Report

Team Name: Substance Use Disorder (SUD) Oversight Policy Board
Team Leader: Chairperson Steve Glaser, SUD Board Member
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Received updates and presentations on the following:
    - MSHN SUD Strategic Plan
    - MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY22 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY23 Budget Overview
- Received PA2 Funding reports – receipts & expenditures by County
- Received Quarterly Reports on Prevention and Treatment Goals and Progress
- Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
- Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Received written updates from Deputy Director including state and federal activities related to SUD
- Received updates on MDHHS State Opioid Response Site Visit Results
- Shared prevention and treatment strategies within region

- Received information and education on opioid settlement and strategies
- Provided input on the FY24-26 MSHN SUD Strategic Plan
-

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Approve use of PA2 funds for prevention and treatment services in each county
Improve communications with MSHN Leadership, Board Members and local coalitions
Orient new SUD OPB members as reappointments occur
Increase communication with local counties/coalitions regarding use of state and local opioid settlement funding
Monitor SUD spending to ensure it occurs consistent with PA 500
Revise and sign new Intergovernmental Agreement

X. MSHN Committee FY24 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, MSHN Chief Behavioral Health Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Address workforce shortage.
- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Address Wraparound services as appropriate.
- Complete appeal of service range issue with MDHHS and waiver versus non-waiver service use.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Regional input into Conflict Free Access and Planning.
Review and address need for increasing access to children's services, including acute care.
Review, report, and increase use of CRM/OPEN Beds.
Address crisis resources uniformly across the region.
Address implementation of 988/MiCAL.
Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation, as appropriate.
Advocate for crossover multi-discipline process for ICSS.
Convert region to use of the CANS.
Address Inpatient Access issues and emergency department boarding.
MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).
Establish and/or work with providers to increase specialized housing options within the region.
Continue advocacy around conflict free access and planning consistent with MSHN Board adopted resolution.

Team Name: Regional Medical Directors Committee (RMDC)
Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
As created by the MSHN Operations Council (OC), the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Review and input into the behavioral health home initiative.
- Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
- Addressed controlled substance prescription law and shared feedback with MDHHS.
- Reviewed planned updates and gave feedback to PCE prescriber module.
- Input into Population health and Integrated Care Plan and Quarterly Reports.

- Addressed staffing status for psychiatry.
- Continued input into Conflict Free Access and Planning discussion.
- Discussed DEI initiative.
- Reviewed critical incident report.
- Reviewed telemedicine bulletin MMP 23-10 and processes.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.
- Review RMDC survey responses.
- Reviewed possibility of writing standards regarding nurse practitioners and physician's assistants.
- Reviewed issue of worker burnout.
- Reviewed and provided input into clinical care pathways relating to the CMH work when someone goes to the emergency room.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address youth access to CMH services.
Continued input into behavior treatment processes.
Ongoing input into population health and integrated care.
Return to OpenBeds process conversation and define further.
Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with CLC.
Improve collaboration with MDHHS around processes related to CMH functions (i.e., determination of hospitalization).

Team Name: Utilization Management Committee
Team Leader: Skye Pletcher, Chief Population Health Officer, MSHN
Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.

- Advocacy and appeal with MDHHS for the use of service ranges in person centered plans for waiver and non-waiver services.
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate.
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >95% adherence to medical necessity criteria

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
NEW - Regional input into Conflict Free Access and Planning.
NEW - Address inpatient access issues and emergency department boarding.
NEW – Review regional process for addressing in-region COFR arrangements
NEW – Implementation of MichiCANS and MiCAS
CONTINUE - Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
CONTINUE - Recommend improvement strategies where adverse utilization trends are detected.
CONTINUE - Recommend opportunities for replication where best practice is identified.
CONTINUE - Address succession planning for UMC members relative to skill set needed by committee members.
CONTINUE - Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals.

Team Name: Regional Compliance Committee
Team Leader: Kim Zimmerman, Chief Quality and Compliance Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2022 Annual Compliance Summary Report

- Reviewed and updated the committee charter.
- Reviewed HSAG Compliance Site Review Findings – Developed plan of correction for findings specific to compliance standards
- Reviewed Compliance Section for Managed Care Program Annual Report (MCPAR)
- Provided feedback on MEV site review process and updates.
- Reviewed proposed revisions to the 42 CFR Part 2 to ensure regional compliance.
- Consensus on use of signatures within the Electronic Health Records
- Reviewed results council/committee surveys- implemented changes based on feedback.
- Provided feedback on 2024-2025 MSHN Strategic Plan
- Updated Privacy Notice to ensure compliance with federal and state standards and developed consistent distribution processes.
- Medicaid Policy Updates: Telehealth compliance and end of public health emergency
- Reviewed the revised FY2023 OIG Quarterly Report changes, guidance documents, fraud referral form, and submission requirements.
- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings.
- Provided consultation on local compliance related matters.
- Reviewed and provided feedback on MSHN compliance policies and procedures.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Identify compliance related educational opportunities including those aimed at training compliance officers
Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies

Team Name: Provider Network Committee
Team Leader: Leslie Thomas, MSHN CFO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures.
- Established regionally approved and executed CRU agreement with FHPCC.
- Continued to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies.
- Established and continued with an intra-regional provider performance monitoring protocol for ABA/Autism provider network; continued regional provider performance monitoring for Fiscal Intermediary and Inpatient Psychiatric Services.
- Establish relevant key performance indicators for the PNMC scorecard.
- Continued to monitor and refine regional provider directory to ensure compliance with managed care rules.
- Reviewed, revised, and issued regional contracts for Autism/ABA, Inpatient Psychiatric, and Fiscal Intermediary Services.
- Improved and continued coordination with regional recipient rights officers to support contract revisions.
- Continued implementation of statewide training reciprocity plan within the MSHN region.
- Development and continued support of regional training coordinators workgroup to support implementation.
- Completed and rolled out regional web-based provider application.
- Provided input into PCE Provider Management Module enhancements.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
Develop an action plan to address repeat findings related to provider credentialing and recredentialing

process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
Establish relevant key performance indicators for the PNMC scorecard;
Monitor and implement Electronic Visit Verification as required by MDHHS;
Initiatives to support reciprocity: •Contracting: ✓ Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation Procurement: ✓ Fully implement the use of a regional web-based provider application; ✓ Publish provider selection processes on MSHN web; •Monitoring: ✓ Fully implement specialized residential reciprocity provider monitoring plan; ✓ Training: ✓ All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
Develop and implement regionally approved process for credentialing/re-credentialing reciprocity
Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services

Team Name: Customer Services Committee
Team Leader: Dan Dedloff, Customer Service & Rights Manager
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Customer Services Committee was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Chief Compliance and Quality Officer and will report through the Quality Improvement Council (QIC).

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY23 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY23 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook

- Reviewed, analyzed and reported regional customer service information for:
  - Grievances
  - Appeals
  - Medicaid Fair Hearings
  - Recipient Rights
- Defined what would be considered a cultural competency request (CCR) to support network adequacy.
- Reviewed the FY22 HSAG Compliance Review results and collaborated to develop the HSAG corrective action plan.
- Reviewed and provided feedback on the Mid-State Health Network (MSHN) 2024/2025 Strategic Plan.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
Continue reporting and monitoring Customer Service information
Continue to explore regional Customer Service process improvements
Continue to develop, where applicable, MSHN standardized regional forms
Continue to identify Educational Material/Brochures/Forms for standardization across the region
Complete the bi-annual review, update, and approval of the MSHN Customer Service Policies and Procedure.
Develop and distribute an Adverse Benefit Determination Frequently Asked Questions document.

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Leader: Shelly Milligan (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:

REACH is an advisory body of community stakeholders established for the following purposes:

- Ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs.
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI).
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma.
- Address stigma and bias that may impact health outcomes.

Annual Evaluation Process:

A. Past Years Accomplishments. FY23

- REACH assisted with review of "Better Equity" strategic priority as MSHN updated its FY24-25 MSHN Strategic Plan.
- REACH assisted with review of MSHN's updates to its FY24-26 SUD strategic plan, in particular, the goals related to reducing health disparities was shared with REACH for their review.
- REACH participated in preparation and planning for MSHN's *Equity Upstream* Spring Lecture series. Several REACH members participated in various capacities in the actual trainings.
- REACH was part of preparation and planning for MSHN's *Equity Upstream* Learning Collaborative (LC) and continues to support direction and strategies related to LC activities.
- REACH members are and will be assisting with mechanisms to engage community members in seeking feedback from impacted minority communities who are underrepresented in our treatment population.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
1. Increase data sharing around equity activities and reducing health disparities
2. Support community engagement to inform Learning Collaborative activities
3. Review LC Action Plans relative to impacting health disparities
4. Support for IDEA Workgroup's internal review of MSHN policies, hiring, etc.

X. MSHN Workgroups FY24 Annual Reports

Team Name: Autism Benefit Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the Autism Benefit Workgroup: The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The Autism Benefit Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Developed a monitoring system to address timely service delivery.
- Encouraged attendance and participation in Michigan Autism Council and Autism Alliance of Michigan meetings.
- Served as advocates for the region while working to inform and collaborate with newly formed MDHHS autism section.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 3		
Goal	Objectives/Activities	Frequency/Due Date
Improve and develop solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carryout treatment).	1. Outreach to providers within the state to increase opportunities for autism benefit enrollees to participate in medically necessary services. 2. Share list of available providers with the region as well as regional results of ongoing monitoring of current providers. 3. CMHSP representatives will connect with available providers in consideration of additional contracts.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Adjust to code changes and new policy language.	1. Become aware of and understand the changes that are implemented by MDHHS. 2. Advocate for stabilization of policy to support quality service delivery. 3. Inform network and stakeholders when policy changes are proposed and initiated.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Ensure regional representation at quarterly MSHN Autism Workgroups.	1. MSHN to continue to send workgroup meeting invitations and	Frequency: throughout the fiscal year.

	agendas in a timely manner to encourage attendance. 2. Follow-up with CMHSPs that do not have consistent representation at quarterly workgroup meetings.	Due date: 9/30/2024

Team Name: Children's Waiver Program (CWP) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the CWP Workgroup: The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed two separate CWP 101 trainings (10.04.2022 and 10.18.2022), with virtual options, in partnership with MDHHS (141 attendees total).
- Ensured full implementation of corrective action plan related to MDHHS and MSHN CWP findings.
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Demonstrated continued improvement on DMC reviews as evidenced by increased compliance scores (FY21 average chart review score 93.98%; FY23 average chart review score 98.53%).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 2
Goal
Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite.
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are

adequately informed and have the resources available to enroll and maintain a youth in the CWP.

Team Name: Home and Community-Based Services (HCBS) Workgroup
Team Leader: Kara Hart, Home & Community Based Services Waiver Administrator
Report Period Home and Community-Based Services (HCBS) Workgroup**:** 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The HCBS Workgroup was established to initiate and oversee the coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Administrator (Adults), Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Waiver Administrator chairs the HCBS Workgroup, and the Waiver Coordinators facilitate. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed site visits and data cleanup regarding the 2020 HCBS Final Rule Survey Data.
- Surveyed, assessed, and remediated, when necessary, individuals/providers for HCBS Compliance.
- Facilitated discussion on the expectations and concerns relating to the MDHHS Community Transition Program (MCTP) releasing individuals into HS facilities.
- Provided information regarding HCBS Final Rule and their intersection with the BTP process.
- Allowed for the discussion of complex cases and the barriers to placing individuals of high needs.
- Provided updates regarding HCBS sites determined to be Heightened Scrutiny.
- Provided ongoing updates regarding MDHHS role changes and structural shifts as it relates to HCBS.
- Provided support, guidance, and reminders regarding the WSA.
- Reviewed best practice strategies to address potential barriers to attaining full HCBS resolution.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Establish a monitoring process to ensure HCBS settings within the Mid-State Health Network region maintain positive HCBS compliance status.
Continue to remediate and validate HCBS survey responses and provisional approval data as it becomes available from MDHHS.
Work to resolve identified conflicts between HCBS compliance and licensing (LARA) recommendations to ensure site and case compliance with MDHHS guidelines and expectations.

Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process.

Team Name: Habilitative Supports Waiver Workgroup
Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSP's are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Identified potential candidates for enrollment in the HSW to increase slot allocation.
- Distributed monthly HSW reports and monthly overdue and coming due data.
- Tracking and reporting on reason for and number of HSW recertification pend backs from both MHSN and MDHHS.
- Worked through continued challenges related to monitoring initial HSW applications and recertifications for restrictive and intrusive technique and/or Behavior Treatment Plans.
- Received information provided by MDHHS and successfully implemented changes.
- Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Ensure full implementation of corrective action related to MDHHS and MSHN HSW findings.
Demonstrate improvement on DMC review scores for HSW program specific standards and clinical charts.
Achieve a minimum 95% utilization of allocated HSW slots for the region.
Eliminate monthly unsubmitted/past due HSW recertifications based on established due dates from MSHN and MDHHS.
Increase the timeliness of responses to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS.
Ensure transition, as appropriate, from HSW to 1915(i) for all cases that are being disenrolled or going into inactive status.
Prepare for the upcoming MDHHS Home and Community Based Waiver Review set to occur in 2024.

Team Name: Serious Emotional Disturbance Waiver (SEDW) Workgroup

Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Increased overall enrollments by six percent (from August 2022-August 2023). This included one CMHSP that did not have enrollees, adding one enrollee. Eleven out of 12 CMHSPs now have enrollees.
- Completed two separate SEDW 101 trainings (10.03.2022 and 10.17.2022), with virtual options, in partnership with MDHHS (154 attendees total).
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Completed full implementation of corrective action plan related to MDHHS and MSHN SEDW findings.
- Held regional Wraparound consultation with Heather Valentiny (MDHHS) on July 6, 2023 (35 attendees).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite, as appropriate.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Review and respond to system changes as influenced by Michigan Intensive Child and Adolescent Service Array (MICAS).
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.

XI. Definitions/Acronyms

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.

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.

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. (42 CFR §438.208(c)(1)(2)) MDHHS CQS – identify the Home and Community Based Services Waiver. MI-Choice to be recipients of LTSS.

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.

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

Stakeholder: A person, group, or organization that has an interest in an organization, including consumers, 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.

Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

Acronyms

ABA: Applied Behavioral Analysis
BTPRC: Behavior Treatment Plan Review Committee
BHH: Behavioral Health Home
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CCBHC: Certified Community Behavioral Health Clinic
CLC: Clinical leadership Committee
COFR: County of Financial Responsibility
CSC: Customer Services Committee
CMS: Center for Medicare/Medicaid Services
CQS: Comprehensive Quality Strategy
CWP: Child Waiver Program
EQR: External Quality Review
FC: Finance Committee
HCBS: Home and Community Based Standards
HSAG: Health Services Advisory Group
HSW: Habilitation Supports Waiver
ITC: Information Technology Committee
MEV: Medicaid Event Verification
MHSIP: Mental Health Statistics Improvement Program
MMBPIS: Michigan Mission Based Performance Indicator System
OHH: Opioid Health Home
PNMC: Provider Network Management Committee
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver

UMC: Utilization Management Committee
YSS: Youth Satisfaction Survey

XII. Attachments

Attachment 01 MSHN QAPIP Communication

Attachment 1 MMBPIS FY2024 Performance Summary

Attachment 2 FY24 PBIP Narrative

Attachment 3 FY24 Q2 Integrated Health Quarterly Report

Attachment 4 MSHN Experience of Care Executive Summary

Attachment 5 MSHN Critical Incident Performance Report 4 Q3

Attachment 6 MSHN Behavior Treatment Review Data Fy24 Q3

Attachment 7 ACT Utilization FY24 Q2

MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2025

Prepared By: MSHN Quality Manager – November 20, 2024

Reviewed and Approved By: Quality Improvement Council – November/December 2024

Reviewed By: MSHN Leadership - December 11, 2024

Reviewed By: MSHN Operations Council - December 16, 2024

Reviewed and Approved By: MSHN Board – January 7, 2025

Contents

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.

Effective 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 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 Behavioral Health, 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. Effective October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The mission of Mid State Health Network (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.

The Midstate Health Network utilizes the National Healthcare Reform Framework the "Quintuple Aim". For MSHN, the quintuple aim includes five strategic priorities: "Better Health", "Better Care", "Better Value", "Better Provider Systems", and "Better Equity". 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.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) provides a comprehensive program and structure for quality improvement in alignment with the MSHN Strategic Plan through performance monitoring. Additionally, the MSHN QAPIP aligns with the quality assessment and performance improvement program interventions as identified in the Michigan Department of Health and Human Services (MDHHS) Comprehensive Quality Strategy (CQS). Responsibilities of the quality management program are outlined in the QAPIP Plan. (42 CFR 438.330(a)(1))

II. SCOPE OF PLAN

The scope of MSHN's QAPIP includes services and programs provided by the CMHSP participants, substance use disorder providers and their respective provider networks including Certified Community Behavioral Health Clinics, Behavioral Health Home, and Opioid Health Home.

The performance monitoring through the QAPIP, covers all important organizational functions, 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.

III. PHILOSOPHICAL FRAMEWORK

MSHN utilizes 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 methods.
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

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 provider network through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency, 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.

IV. ORGANIZATIONAL STRUCTURE AND LEADERSHIP

Governance

Board of Directors

The MSHN's Board of Directors set policy related to quality management and approves the overall QAPIP and QAPIP Plan. MSHN's Board of Directors receives quarterly progress reports of the QAPIP through the Balanced Score Card and MSHN Department Reports, which describe the performance improvement projects undertaken, the actions taken, and the results of those actions. Additionally, the Board of Directors receives an Annual Quality Assessment and Performance Improvement Program Report evaluating the effectiveness of the quality management program, which include recommendations for improvement initiatives in the upcoming year. After review and approval of the Annual Quality Assessment and Performance Improvement Program, the QAPIP Plan and Report, inclusive of a list of the Board of Directors' is submitted to the Michigan Department of Health and Human Services (MDHHS) as required by February 28 of the respective year.[1]

Structure

Communication Of Process and Outcomes

The MSHN quality structure identifies clear linkages and reporting structures. The MSHN Quality Improvement Council (QIC), in coordination with the CMHSP Participants and SUD Providers through regional committees and councils, is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements. Consumers and stakeholders receive reports on key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects through the Operations Council, Consumer Advisory Council meetings. Final performance and quality reports are available to the stakeholders and the general public through the MSHN website, as requested. The Board of Directors receives periodic and an annual report on the status of organizational performance. [2]

Chief Executive Officer

The MSHN's Board of Directors employs the Chief Executive Officer (CEO). The MSHN CEO is the designated senior official with responsibility for the implementation of the QAPIP. The MSHN 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. Additionally, the CEO allocates resources for the quality management program, links the strategic planning and operational functions of the organization with the quality management functions, and assures coordination occurs among members of the Operations Council to maintain quality and consumer safety.

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 ensuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

The CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council, and a member of the MDHHS Quality Improvement Council. The Quality Manager under the direction of the Chief Compliance and Quality Officer, and in collaboration with the MSHN Quality Improvement Council is

[1] Contract Schedule A-1(k)(20(a) QAPIP for Specialty PIHPs Section I

[2] Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I

responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan.[3]

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization, eligibility decisions, performance improvement projects and is available to provide additional input as required for the regional QAPIP. The MSHN Medical Director leads the Regional Medicaid Directors Committee, is an ad hoc member of the MSHN Quality Improvement Council, demonstrating 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.

Stakeholders

MSHN and the CMHSP Participants/ SUD Providers strive to involve 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; PIHP Quality Improvement Council; PIHP Customer Services Committee; 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.

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 in 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 recipients of services in quality improvement activities,

Provider Network

The structure of the QAPIP allows each contracted behavioral health network provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. MSHN will provide oversight and monitoring of providers 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)

[3] Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section III

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP plan 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.

The MSHN Provider Network staff have the opportunity to participate in and to support the QAPIP through the following activities:

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

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, committees/councils, and the MSHN website. MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy regarding related managed care operational decisions.

Regional Committees and Councils

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. 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 report annually on the progress of accomplishments and goals.

Operations Council (OC)

The OC was established to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible. 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.

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. The RMDC was established to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the

OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

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.

Quality Improvement Council

The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Primary and/or secondary consumer representatives are appointed through an application process. Substance Use Disorder (SUD) Treatment Providers are represented on the Council by MSHN SUD Staff on an as needed basis. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

Finance Council (FC)

The FC will make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The FC may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Information Technology Council (ITC)

The ITC was established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO.

Clinical Leadership Committee (CLC)

The CLC was established to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Utilization Management Committee (UMC)

The UMC was established to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Compliance Committee (CC)

The CC was established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Customer Services Committee (CSC)

The CSC was established to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support the development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Provider Network Management Committee (PNMC)

PNMC was established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is specific to a Level of Care (LOC) and functional area including, Women's Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

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.

Regional Equity Advisory Committee for Health (REACH)

To address MSHN's strategic priority of better equity, MSHN has established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners from historically marginalized populations with lived experience. REACH goals are 1) to ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs; 2) to inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI); 3) to incorporate a trauma-informed perspective that accounts for historical and racialized trauma; 4) to address stigma and bias that may impact health outcomes.[4]

[4] Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IV

V. PERFORMANCE MANAGEMENT[5]

Performance Management is defined as "a forward-looking process used to set goals and regularly check progress toward achieving those goals. In practice, an organization sets goals, looks at the actual data from its performance measures, and acts on results to improve the performance toward its goals."[6] MSHN utilizes a Dashboard and Balanced Score Card (BSC) to provide a comprehensive view of the organizational performance.

a) Establishing Performance Measures

Performance Measures are chosen by MSHN leadership in collaboration with MSHN committees, councils, and work groups based on the needs of the organization, with consideration given to the following three factors:

Focus Area: Clinical, high volume or high-risk services; continuity and coordination of care, or

Non-Clinical include but are not limited to appeals, grievance, trends, and patterns of substantiated member rights complaints as well as access to, and availability of services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. Qualitative and quantitative assessment; internal performance.

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 measures align with the MDHHS Behavioral Health Quality Program[i], and MSHN strategic priorities of Better Health, Better Care, Better Value, Better Provider System, and Better Equity Attachment 2 MDHHS Standardized Performance Measures 2025

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

- growth areas identified from key performance indicators
- stakeholder feedback from providers and member experience of care assessments and surveys
- oversight and monitoring reviews from external and internal reviews and processes.

b) Data Collection, Analysis, and Reporting

The purpose of data collection is to monitor performance, identify growth areas, and monitor the effectiveness of interventions. Data must be systematically aggregated and analyzed to become actionable information. Data is used for clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), and is the basis for identifying performance improvement projects. A description of the measure is written and may include, but is not limited to the following:

[5] QAPIPs for Specialty PIHPs, Section V, Section VI

[6] (U.S. Department of Health & Human Services, Health Resources & Services Administration. Performance Measurment and Management, 2011)

- Baseline
- Standard/Target/Goal
- Data collection timeframe, and remeasurement periods
- Frequency of data analysis
- Population/sample
- Data source
- Consistent data collection techniques.
- Strategies to minimize inter-rater reliability concerns and maximize data validity.
- Measure Steward

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 are compared to established performance targets and/or externally derived benchmarks when available. Performance targets are set through established contract requirements and/or externally derived benchmarks. If there is no set performance target, baseline data should be considered prior to setting a target.

Baseline data is data that is collected for a period of time, typically up to one year, prior to establishing a performance target. Historical data, when available may be used for baseline. 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.).

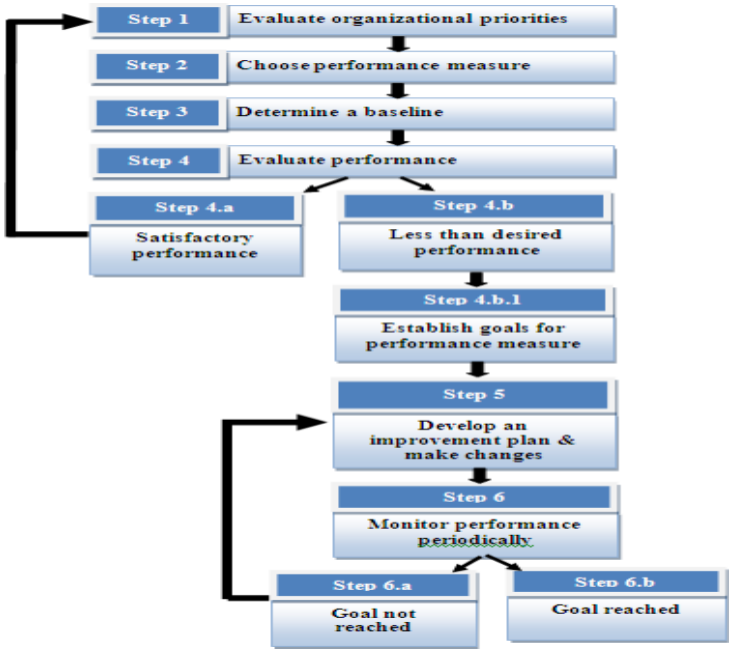
Once the baseline has been collected for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks when available, and deemed to be within acceptable standards, it is up to the monitoring committee or team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

Targets may be defined by a set percentage for achievement to meet the outcome being measured or a percentage increase/decrease change to be achieved. When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

- *Minimum or Acceptable Level:* Performance standards can be considered "minimum" or "acceptable" levels of success.
- *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.
- *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 from the continuous quality improvement (CQI) perspective.

The data is reviewed at the established intervals by the appropriate council, committee, or workgroup, in collaboration with QIC. The data is analyzed for undesirable patterns, trends, or variations in performance. In some instances, it may be necessary to complete further data collection and analysis to isolate the causes of poor performance or excessive variability, proceeding with performance improvement action steps until the performance target is met.

Process Map of Performance Management Pathway (defined by HRSA)



Additionally, if a sampling method is used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level are included in the project/study description. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

c) Quality Improvement

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

- Goal Statement-What do we hope to achieve
- Causal factors that caused the variance (directly and/orindirectly)
- Interventions with dates of implementation to correct the variance.
- Review of effectiveness of the intervention. Any other actions that will be taken to correct undesirablevariation

The plan will be reviewed by the designated MSHN content expert to ensure sufficient action planning. Regional trends are identified and discussed at the relevant committee/council for regional planning efforts and coordination.

In some instances, in lieu of provider level improvement plans, region wide quality improvement efforts may be developed based on the patterns and trends identified through data analysis, Region-wide efforts will follow the process established above and be reviewed for effectiveness at established intervals within the assigned MSHN council, committees, workgroups.

Improvements are achieved by taking action based on 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 Plan Do Study Act (PDSA) promotes process integrity:

- Plan-Develop a step-by-step action plan, limiting the number of variables impacted.
- Do-Implement the action plan, preferably on a small or pilot scale initially, and

- Study-Analyze the data to check for expected results.
- Act-Modify or develop interventions to obtain expected result.

The PDSA cycle is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic (1 year) reassessment of performance to ensure 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.

VI. PERFORMANCE MEASUREMENT[7]

An effective performance measurement system allows an organization to evaluate the safety, accessibility, quality and appropriateness, effectiveness, clinical outcomes and an evaluation of member experience of the services in which an individual receives. MSHN utilizes a balanced score card to monitor organizational performance. Organizational performance includes but are not limited to MDHHS required metrics. Areas that perform below the standard are included in the annual QAPIP Work Plan.

a) Michigan Mission Based Performance Indicator System (MMBPIS)[8]

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in 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 using standardized performance indicators and participate in the MDHHS Behavioral Health Quality Program which includes the Michigan Mission Based Performance Improvement System (MMBPIS).

b) Performance Improvement Projects[9]

MDHHS requires the PIHP to complete a minimum of two performance improvement projects (PIP) per waiver renewal period. The QIC chooses performance improvement projects based on the methodology described

[7] 42 CFR §438.330(b)(2) 42 CFR §438.330(c).
Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section V
Contract Schedule E—Reporting Requirements

[8] Quality-Michigan Mission Based Performance Indicator System

[9] Quality-Performance Improvement

in Section VI Performance Management of this document which includes but is not limited to the analysis of data, analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Once chosen, a recommendation is made to the MSHN Operations Council for approval. The PIP is presented to relevant committees and councils for collaboration during the duration of the PIP. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is approved by MDHHS and subject to validation by the external quality review (EQR) organization, requiring the use of the EQR's form. In alignment with the MDHHS Comprehensive Quality Strategy, MDHHS has elected the focus of the PIP topic for FY22-FY25 to include the reduction of existing racial or ethnic disparities in access to healthcare or health outcomes. Performance is reviewed as outlined in the performance improvement project description to ensure significant improvement is sustained over time. The summary is submitted to the external quality review organization for a validation review, and to MDHHS through the QAPIP Annual Report.

MSHN has approved the following Performance Improvement Projects to address access to services for the historically marginalized groups within the MSHN region.

PIP #1: Study Topic - Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.
Study Question - Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

PIP #2: Study Topic - The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.
Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate?

c) Performance Based Incentive Payment Measures[10]

The Performance Bonus Incentive Program has been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy. Awards will be made to Contractors according to criteria established by the State. Criteria for Performance Bonus awards will include, but is not limited to, assessment of performance in quality of care, access to care and administrative functions. Each year, the State will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.[11] Attachment 2. MDHHS Standardized Performance Measures

VII. STAKEHOLDER EXPERIENCE OF CARE [12]

MSHN values the opinions of consumers, their families, and other stakeholders as essential to identify ways to improve processes and outcomes. ISurveys 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

[10] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/Mental-Health/Reporting-Requirements/PBIP_FY25.pdf?rev=7e0a3d26492a47b4a9f8d4fe51092527&hash=D02E2D8EFB0BEFF53B3EBB9067EF016F

[11] MDHHS PIHP Medicaid Contract FY24 Section 8.D

[12] Quality-Consumer Satisfaction Survey Policy

assessment tool. The tools vary in accordance with service population needs, 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.

Surveys used to assess stakeholder and member experiences include but are not limited to the following:

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Illness, Substance Use Diagnosis, and/or receiving Long Term Supports and Services (LTSS).
- Youth Satisfaction Survey (YSS)- Youth with a Severe Emotional Disturbance and/or receiving Long Term Supports and Services (LTSS)
- Provider Network Survey-Organizations who contract with MSHN
- Committee/Council Survey-Provider representatives on MSHN committees/ councils
- National Core Indicator Survey-Individuals receiving LTSS

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by MSHN to the QI Council, Regional Consumer Advisory Council, Substance Use Disorder Providers and other relevant committees/councils. Regional benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council outlines systemic actions steps to follow up on the findings. The findings are incorporated into program improvement action plans as appropriate. The CMHSP participants/SUD providers take action on individual cases, as appropriate, identifying and investigating sources of dissatisfaction and determining appropriate follow-up.

An evaluation of the regional activities to improve satisfaction is included in the annual PIHP QAPIP Report and presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants, SUD Providers and is accessible on the MSHN website. Findings are shared with stakeholders on a local level through advisory councils, staff/provider meetings and printed materials.[13]

VIII. ADVERSE EVENTS

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant a PIHP review. These include MDHHS defined Immediately reportable events, sentinel events, critical incidents, and risk events. A subset of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System.

MSHN ensures that the MSHN Provider Network has a system in place to prevent, detect, remediate these events and utilize staff with appropriate credentials for the scope of care, for review and/or follow up within the required timeframes. The following bullets outline the responsibilities of both the MSHN region and the MSHN Provider Network.

- MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS PIHP FY25 contract and the Critical Incident Reporting and Event Notification Policy. Beginning in FY23 the reporting system transitioned to the Behavioral Health (BH) Customer Relationship Management System (CRM) from the MPHI PIHP Warehouse.
- MSHN delegates the responsibility for reporting, reviewing and the follow-up of critical incidents and sentinel events to the MSHN Provider Network.

[13] Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section X(A-D)

- MSHN delegates the responsibility for reporting, reviewing and the follow-up of other events that put people at risk of harm to the CMHSP Participants.
- The MSHN Provider Network is responsible for reviewing critical incidents to determine if the incident is sentinel. A determination of a sentinel event must be made within three days of the discovery of the critical incident, by an appropriately qualified and credentialed staff.
- The MSHN Provider Network is responsible to commence a root cause analysis within 2 business days of the identification of the sentinel event.
- The MSHN Provider Network, based on the root cause analysis/ investigation, will develop and implement either a plan of action to address immediate safety issues, 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. [14]
- The MSHN Provider Network is responsible to report immediately reportable events (IRE).
- The CMHSP Participants monitor risk events and include actions taken by individuals receiving services as defined by MDHHS, that may cause harm to self or others and have had two or more unscheduled admissions to a medical hospital within 12 months.
- MSHN is responsible for reporting immediately reportable events to MDHHS within 48 hours of notification/discovery of the event.
- MSHN provides oversight and monitoring of the MSHN Provider Network processes for reporting sentinel events, critical events, events requiring immediate notification to MDHHS, and monitoring of risk events. In addition, a quarterly analysis of the events, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction is reviewed with the relevant committees and councils.
    - Risk Events required to be reviewed include the following: Harm to self, harm to others, and two or more unscheduled admissions to a medical hospital (not due to planned surgery or natural course of a chronic illness) within a 12 month period.
    - Critical Events required to be reviewed and reported include the following: suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries, illness, medication errors, and serious challenging behaviors, 911 calls made by staff for assistance with a behavioral crisis, and physical management for required populations as defined by MDHHS. [15] Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management and/or falls.
    - Immediately Reportable Events(IRE) are required to be reported within 48 hours to MDHHS and include the following: any death that occurs as a result of staff action or inaction, subject to a recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation to the PIHP.
    - Sentinel Events include but are not limited to incidents that result in the following: Unexpected deaths, permanent harm, severe temporary harm and intervention required to sustain life. (The Joint Commission 2022)

[14] Quality-Sentinel Events

[15] Quality-Critical Incidents

IX. BEHAVIOR TREATMENT[16]

MSHN delegates the responsibility for the collection and evaluation of data, and the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders to each local CMHSP Behavior Treatment Review Committee. Behavior treatment data is reviewed as part of each CMHSP Quality Program. Only those (restrictive and/or intrusive) techniques that are permitted by the Behavior Treatment Technical Requirements and have been approved during the person-centered planning process may be used with individuals receiving services. Data is collected, reviewed, and reported to MSHN 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. Data shall include numbers of interventions and the length of time the interventions were used per person. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long term supports and services.

MSHN provides oversight through analysis of the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data during the delegated managed care site reviews to ensure accurate reporting and adherence to the Behavioral Treatment Standards by each CMHSP. MSHN conducts clinical chart reviews for those with recommended restrictive and/or intrusive interventions, in addition to the annual review of BTPRC policy and procedures. The clinical chart reviews address each of the behavior treatment standards and overall compliance is determined based on implementation of those standards. This data is available to MDHHS upon request. [17]

X. CLINICAL QUALITY STANDARDS

a) Utilization Management [18] -

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

[16] Quality-Behavior Treatment Plan Review Committee

[17] Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section IX

[18] Utilization Management Plan

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.

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) Integrated Care

MSHN has developed a population health and integrated care plan to establish regional guidance and best practices related to population health and integrated care strategies. Integrated care initiatives are used to improve the health of individuals within the MSHN region. The integrated care initiatives are monitored through population health analysis and a core set of performance measures designed to measure the health outcomes of individuals and the effectiveness of services requirements within various models of care. A continuous quality improvement (CQI) plan is implemented in accordance with each integrated care program requirement. Currently MSHN participates in the following initiatives:

- Certified Behavioral Health Clinics (CCBHC)
- Behavioral Health Homes (BHH)
- Substance Use Disorder Health Homes (SUDHH)
- Complex Care Management

c) Value Based Purchasing

MSHN utilizes a value-based purchasing model in coordination with the CMHSP participants and SUD Providers to provide cost effective, and high-quality care. This is completed through incentivizing positive clinical outcomes utilizing the most effective service model.

d) Practice Guidelines[19]

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, 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 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 and focused care, positive behavioral supports, and appropriate behavior treatment planning principles and processes.

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices are 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. [20]

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 MDHHS and Regional practice guidelines adopted for use are available on the MSHN website: Practice Guidelines - Mid-State Health Network.

e) Long Term Supports and Services/ Home and Community Based Standards

MSHN ensures that individuals needs are assessed and long term supports and services are included in the individual's plan of service and 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 are acknowledged, and actions taken as appropriate. As indicated in the 1115 Waiver, LTSS include the following services: Respite, CLS (Community Living Supports), PDN (Private Duty Nursing), Supported/Integrated Employment, Out of Home Non-Vocational Habilitation, Good and Services, Environmental Modifications, Supports Coordination, Enhanced Pharmacy, PERS (Personal Emergency Response System), Community Transition Services, Enhanced Medical Equipment and Supplies, Family Training, Non-Family training, Specialty Therapies (Music, Art, Message), Children Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services, Fiscal Intermediary Services, and Prevocational Services. MSHN assesses the quality and appropriateness of care furnished, assessment of care during the

[19] Service Delivery-Clinical Practice Guidelines and Evidence Based Practices

[20] 42 CFR §438.236(b)(1-4). QAPIPs for Specialty PIHPs, Section XI. 42 CFR §438.236(c)
Contract Schedule A—1(K)(5)(a). Contract Schedule A—1(K)(2)©.42 CFR §438.330(b)(4)(5)(i)

transition between care settings, and community integration through coordinated specialized foster care home visits with CMH staff, documented individual review results in the MSHN EMR, aggregated reports on outcomes of site reviews, individual feedback on member experiences (satisfaction surveys, appeals and grievance data), adverse events (sentinel, critical, and risk), and clinical chart reviews to ensure opportunities for community integration are occurring, and services are being provided as indicated in the individual plan of service. MSHN monitors systemic patterns through population health using data analytics software to identify adverse utilization patterns and to reduce health disparities. [21]

f) Cultural Competence

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.

With MSHN's added strategic priority of "better equity," MSHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities.

XI. PROVIDER NETWORK OVERSIGHT

a) Provider Qualifications [22] [23] [24]

MSHN has established written policy and procedures, in accordance with MDHHS's Credentialing and Re-Credentialing Policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur prior to providing services, and minimally every three (3) years thereafter. MSHN written policies and procedures also ensure 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, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors the CMHSP Participant and compliance with federal, state, local regulations and requirements through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. In addition, MSHN has established an increased monitoring process that focuses on timeliness not decision making and recredentialing as reported bi-annually by the CMHSPs. Any CMHSP that does not meet 90% compliance is subject to increased monitoring.

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.

[21] QAPIPs for Specialty PIHPs, Section XVI42 CFR §438.330(e)(2)Contract Schedule A—1(K)(3)(a)

[22] Provider Network-Provider Network Credentialing/Re-Credentialing

[23] Provider Network-Non-licensed Provider Qualifications

[24] Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section XII(A-B)

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) Medicaid Event Verification [25]

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.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review. 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 Report. [26]

c) Financial Oversight

MSHN has established written policies and procedures to ensure appropriate financial management. MSHN will conduct a financial oversight review of the SUD provider network. The review will be based on eight 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.

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.

d) Provider Monitoring and Follow-Up[27][28]

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 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

[25] Quality-Medicaid Event Verification

[26] Contract Schedule A—1(K)(2)(a). QAPIPs for Specialty PIHPs, Section XII(A-B)

[27] Quality-CMHSP Participant Monitoring & Oversight

[28] Quality-Monitoring & Oversight of SUD Service Providers

requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to ensure that the MSHN Provider Network supports 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. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination. [29]

e) External Reviews[30]

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance with the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year and submitted to MDHHS annually by February 28. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. [31]

XII. ANNUAL REVIEW of EFFECTIVENESS [32]

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes

- The performance on the measures on which it is required to report.
- The outcomes and trended results of each PIP.
- The results of any efforts to support community integration for members using LTSS.
- The annual effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for members as a result of QAPI activities and interventions carried out by the PIHP.
- The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring progress on performance goals and objectives.

XIII. QAPIP PRIORITIES FY2025

The QAPIP priorities shall guide quality efforts for FY25. The QAPIP Priorities include improvement areas based on the QAPIP review of effectiveness which include key performance indicators that have not met the standard, findings from the External Quality Reviews, findings from the Federal Compliance Review, and recommendations from the annual compliance review for delegated functions. QAPIP activities are aligned with the MSHN Strategic Plan contributing to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals we serve.

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[29] QAPIPs for Specialty PIHPs, Section XV

[30] Quality-External Quality Review

[31] Contract Schedule A-K.2.b

[32] 42 CFR §438.330(e)(2). Contract Schedule A—1(K)(3)(a)

Attachment 1 provides the QAPIP Priorities and Quality Work Plan for FY25.

Attachment 2 MSHN Governing Board

XIV. DEFINITIONS/ACRONYMS

BTPRC: Behavior Treatment Plan Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

BHH: Behavioral Health Home

CCBHC: Certified Community Behavioral Health Clinic

CMHSP: CMHSP is a program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay. (Michigan Mental Health Code 330.1100a, 330.1206).

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) providing administrative type services including CMHSP participants who hold retained functions contracts.

Critical Incident: Critical Incidents are defined as the following events: 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.

CIRS: Critical Incident Reporting System includes a system for reporting required events to MDHHS. Currently the Behavioral Health Customer Relations Management includes the critical incident reporting system for MDHHS.

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.

Delegation: An agreement between Contractor and an individual, provider, CMHSP or other organization to perform certain functions that otherwise would be the responsibility of Contractor to perform. Contractor oversees and is accountable for any functions or responsibilities that are delegated to other entities whether the functions are provided by Contractor or other entities.

EQR: External Quality Review is conducted quarterly by CMS and MDHHS.

LTSS: Long Term Supports and Services are provided to 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.(42 CFR §438.208(c)(1)(2)) MDHHS identify the Home and Community Based Services Waiver. MI-Choice as recipients of LTSS.

CQS: Comprehensive Quality Strategy provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

Limited English Proficiency (LEP): Means being limited in ability or unable to speak, read and/or write the English language well enough to understand and be understood without the aid of an interpreter

MEV: Medicaid Event Verification is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS CQS: Michigan Department of Health and Human Services Comprehensive Quality Strategy

MDHHS: Michigan Department of Health and Services

OHH-Opioid Health Home

PIP: Performance Improvement Projects must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes.

PIHP: Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.

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 subcontractors.

QAPI: Quality Assessment Performance Improvement

QM/QA/QI: Quality Manager/Assurance/Improvement

QAPIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

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): 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): A sentinel event 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. Include but are not limited to incidents that result in the following: Unexpected deaths, permanent harm, severe temporary harm and intervention required to sustain life. (The Joint Commission 2022)

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 (SUD) providers directly contracted with MSHN to provide SUD treatment and prevention services.

Veteran Navigator (VN): The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, physical inability to care for themselves.

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Evaluation of Quality Improvement Program Plan Effectiveness FY2024
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

Table of Contents

Overview

An evaluation of the QIP plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives.

Performance Indicators

Michigan Mission-Based Performance Indicators (MMBPIS)

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly and compiled into quarterly reports that are submitted to MDHHS and MSHN for analysis and regional benchmarking. If CMHA-CEI performance is below the identified goal, the QI Team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval.

Indicator #1:

- The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95% or greater.
- Two sub-populations: Children and Adults.

Indicator #2a:

- The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. No standard, higher is better.
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

Indicator #3:

- Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. No standard, higher is better.
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

Indicator #4a:

- The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95% or greater.
- Two sub-populations: Children and Adults.

Indicators #5 and #6:

- The total number of persons receiving a face-to-face assessment with professionals that result in decisions to deny CMHSP services and total number of persons receiving mental health service following a second opinion.
- Submitted as a count of full population records.

Indicator #10:

- The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less.
- Two sub-populations: Children and Adults.

Changes in PI reporting standards were adopted beginning FY20 Q3, which eliminated exceptions, exclusions, and the 95% standard for Indicators 2 and 3. Beginning in 2025, new Performance Measures will be implemented through a new Behavioral Health Quality Program through a 3-year rollout. MMBPIS submissions will continue through the end of FY25 and then be replaced by these new Performance Measures. MMBPIS measures may continue to be used internally depending on the timeliness and usability of state-reported new measure data.

New Behavioral Health Quality Program

Beginning in 2025, the Bureau of Specialty Behavioral Health Services in MDHHS will begin using new quality reporting measures with a 3-year rollout. The transformed program will be more comprehensive and better defined, with a more rigorous methodology that aligns with other state and national requirements. Measurement years will switch to calendar years from fiscal years.

The first year will focus on aligning reporting requirements for PIHPs with CMS Core Set Reporting. By the end of the Year 1 measure roll-out, all required CMS Core Set measures will be available by PIHP. The second year will focus on rolling out stratification of measures, along with adding several key measures. The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures.

CMHA-CEI and MSHN will be responsible for the ACC Indicator rolling out in Year 2. The ACC will measure Access to Care – appointment within 10 (business) days of request. MDHHS will provide an updated Codebook by June 2025 for measure specification. ACC measurement will be implemented by January 2026 with quarterly data submissions beginning in Summer 2026. MDHHS will be responsible for all 30

other Measures rolling out over the 3 year period, shown below:

Year	Source	Behavioral Health Quality Measure	Program	Domain	Responsibility
Year 1 (2025)	ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH	MDDHS
	AMM	Antidepressant Medication Management			
	FUH	Follow-up After Hospitalization for Mental Illness*		Access	
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics		MH	
	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
	FUA	Follow-up After Emergency Department Visit for Substance Use*		Access	
	FUM	Follow-up After Emergency Department Visit for Mental Illness*			
	IET	Initiation and Engagement into Substance Use Disorder Treatment		SUD	
Year 2 (2026)	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions	MDHHS
	HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			
	OUD	Use of Pharmacotherapy for Opioid Use Disorder		SUD	
	SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia		MH	
	ACC	**Access to Care—appointment within 10 days of request**	**Final Rule**	**Access**	**CMHA-CEI**
Year 3 (2027)	CAHPS	How people rated their health plan	QRS	Patient Experience	MDHHS
		Getting care quickly			
		Getting needed care			
		How well doctors communicate			
		Health plan customer service			
	HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home and Community Based Services	
		Community Inclusion and Empowerment			
		Transportation to Medical Appointments			
		Physical Safety			
		Personal Safety and Respect			
		Staff are Reliable and Helpful			
		Staff Listen and Communicate Well			
		Unmet Needs Composite Measure			
	MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS		
	MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update			
		Social Needs Screening- Tool TBD.	CCBHC	Social Needs	
	MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD	
	CDF	Screening for Depression and Follow-up Plan*	BHCS	MH	

FY24 MMBPIS Data

Regionally, MSHN demonstrated performance above the State of Michigan average on 12 out of 18 indicators in FY24 Quarter 3. This is a slight decrease from FY24 Quarter 2, where MSHN performed above the State average for 13 of the 18 reported indicators. MSHN performed above the State average for 12 of the 18 indicators in FY24 Quarter 1. This data is sourced from the most recent MMBPIS PIHP Consultative Report FY24 Q3.

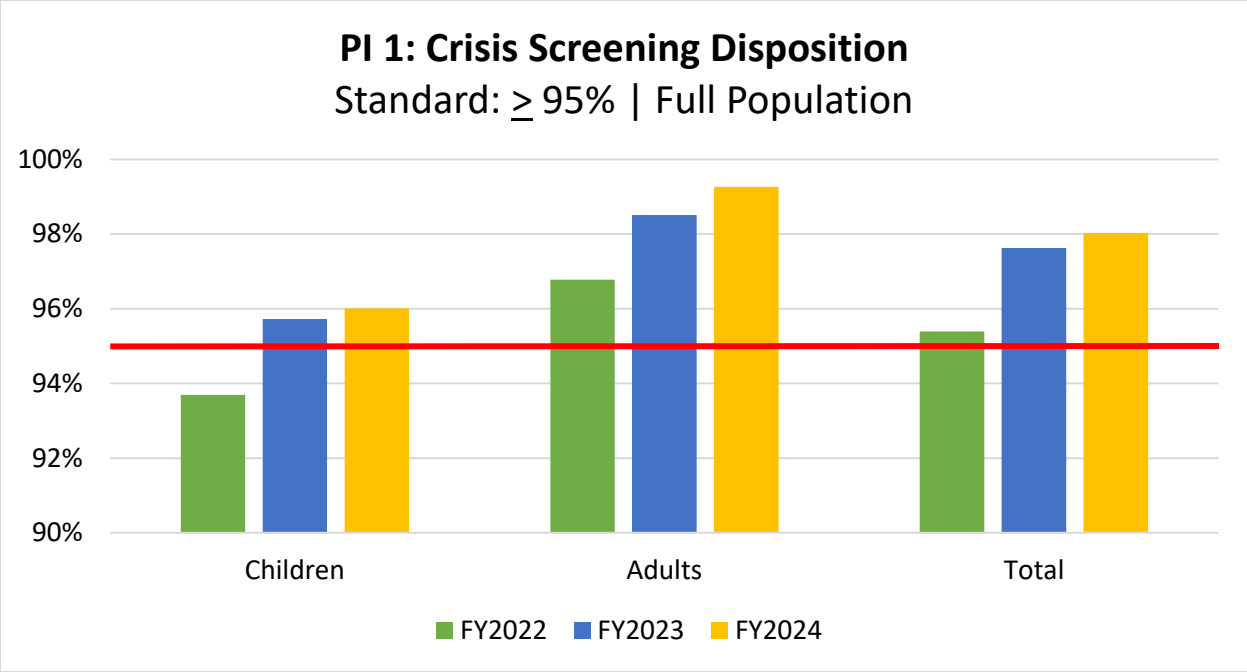
CMHA-CEI saw improvements in Performance Indicators 1, 3, and 10 from FY23 to FY24. There was continued compliance with PI 4a from FY23 to FY24 despite a slight decrease in performance. There was also a slight decrease in PI 2a from FY23 to FY24, but the indicator remains in good standing with improved performance from FY22.

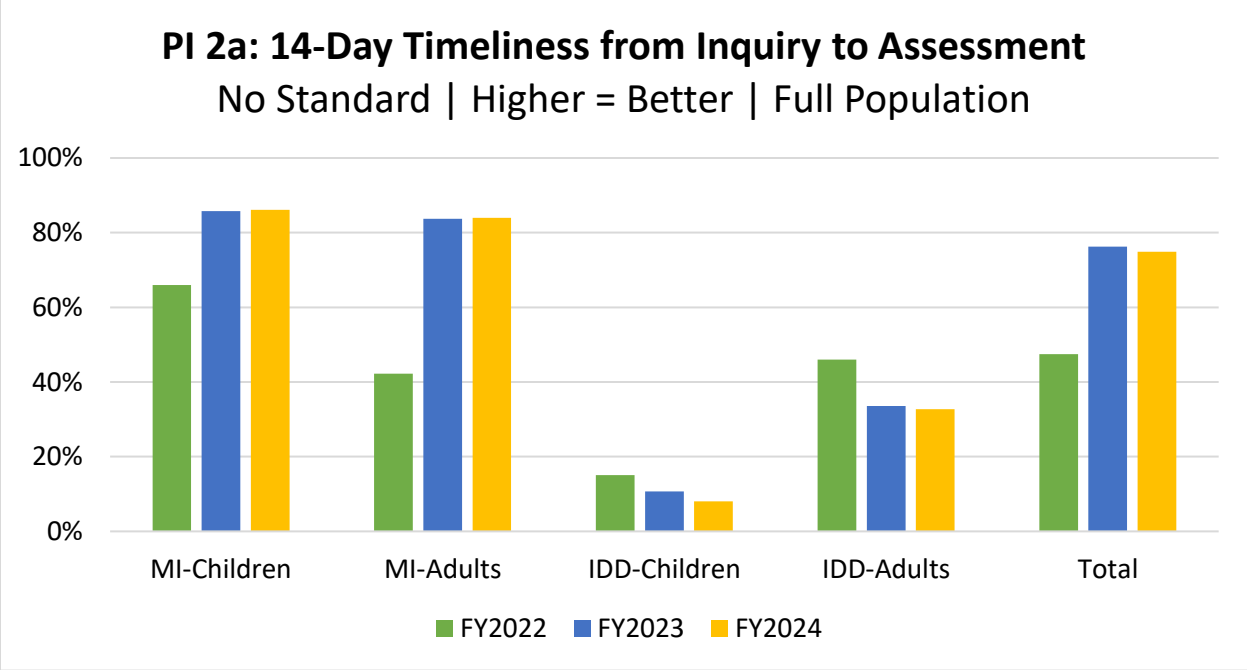
CMHA-CEI Performance Indicator Results (Medicaid Only)

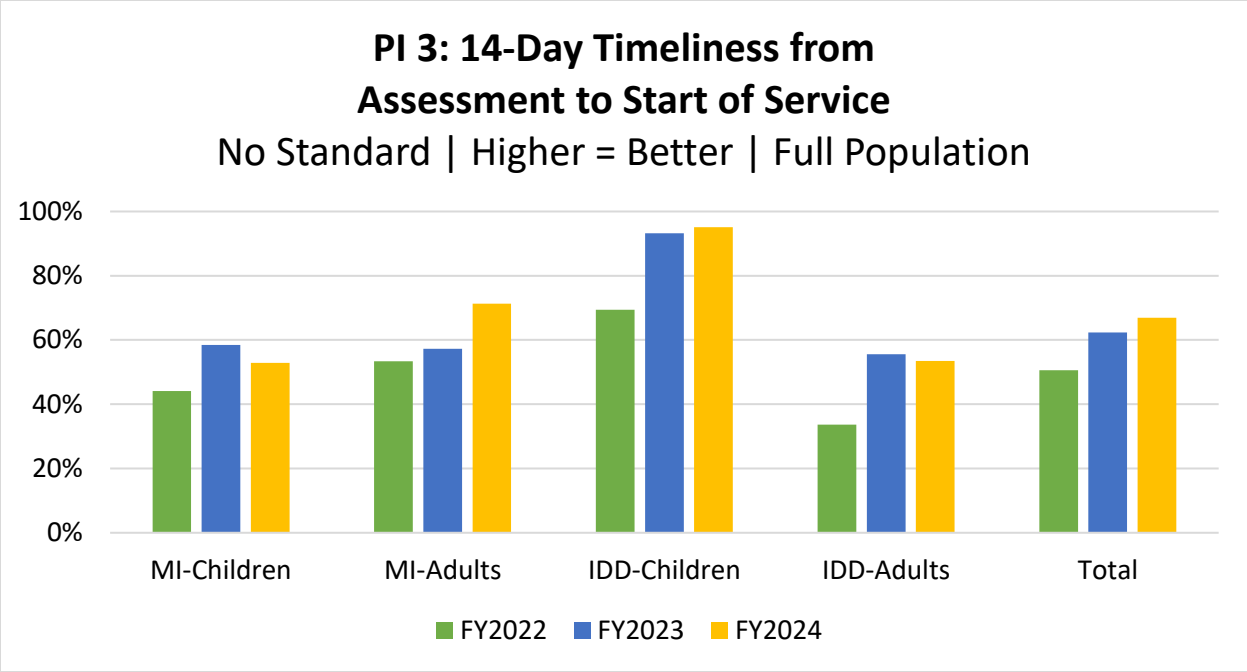
Indicator	Population	FY2022 Total	FY2023 Total	FY2024 Q1	FY2024 Q2	FY2024 Q3	FY2024 Q4	FY2024 Total
PI 1 ≥ 95%	Children	94.44%	95.82%	96.72%	97.04%	95.39%	98.76%	96.88%
	Adults	96.78%	98.53%	99.59%	99.41%	99.24%	99.08%	99.32%
	Total	**96.01%**	**97.69%**	**98.49%**	**98.52%**	**97.83%**	**98.98%**	**98.45%**
PI 2a	MI-Children	67.23%	84.73%	82.12%	85.71%	84.45%	88.37%	84.92%
	MI-Adults	46.75%	84.31%	82.89%	83.38%	81.77%	84.90%	83.28%
	IDD-Children	19.08%	12.00%	11.54%	10.17%	8.22%	15.38%	11.63%
	IDD-Adults	44.75%	38.50%	37.50%	60.00%	30.00%	20.00%	33.33%
	Total	**51.25%**	**77.28%**	**74.42%**	**78.15%**	**74.83%**	**75.48%**	**75.72%**
PI 3	MI-Children	42.32%	58.62%	53.09%	55.47%	50.83%	58.64%	52.36%
	MI-Adults	53.64%	57.56%	50.51%	75.62%	79.39%	77.88%	67.76%
	IDD-Children	70.42%	93.04%	96.94%	94.38%	93.68%	94.74%	94.00%
	IDD-Adults	29.61%	54.22%	55.56%	42.86%	63.64%	53.33%	50.00%
	Total	**50.29%**	**62.86%**	**58.35%**	**69.37%**	**70.07%**	**74.62%**	**65.54%**
PI 4a ≥ 95%	Children	100.00%	98.91%	95.45%	100.00%	100.00%	100.00%	99.03%
	Adults	76.01%	98.42%	99.01%	96.77%	93.60%	96.72%	96.37%
	Total	**98.62%**	**98.57%**	**98.37%**	**97.58%**	**94.67%**	**97.26%**	**96.88%**
PI 10 ≤ 15%	Children	8.88%	11.30%	11.90%	12.73%	2.08%	8.00%	8.67%
	Adults	10.21%	12.50%	11.93%	9.06%	11.68%	9.22%	10.40%
	Total	**9.93%**	**12.25%**	**11.93%**	**9.63%**	**10.53%**	**9.07%**	**10.17%**

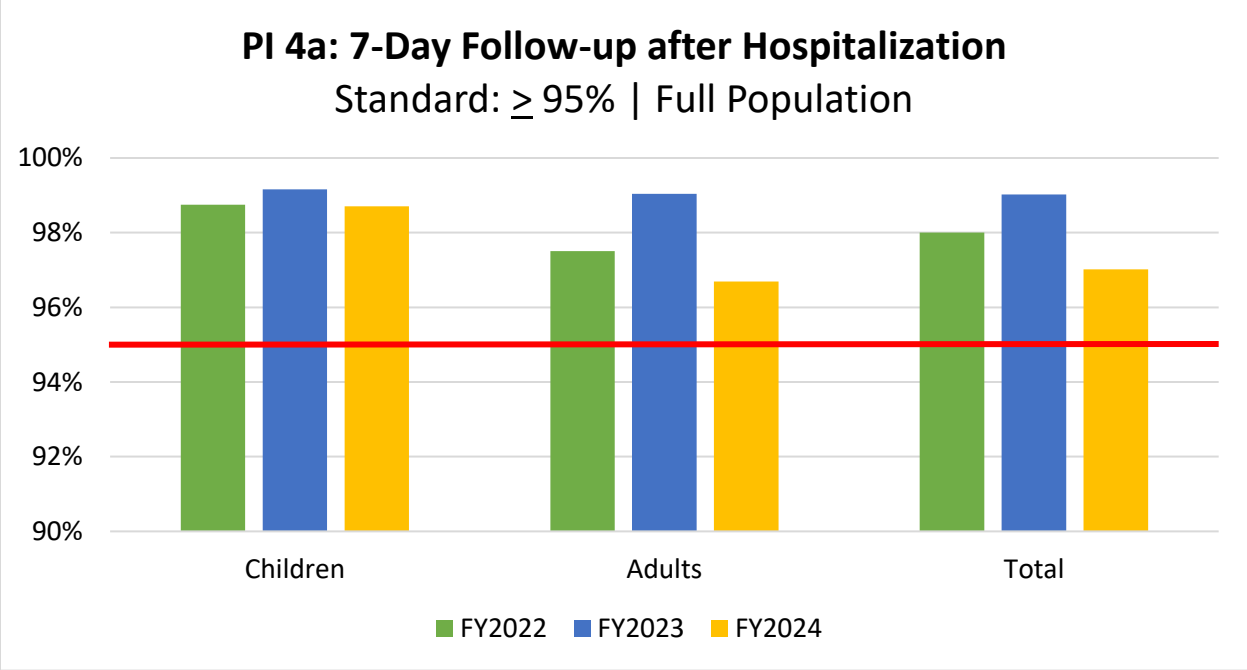
CMHA-CEI Performance Indicator Results (Full Population)

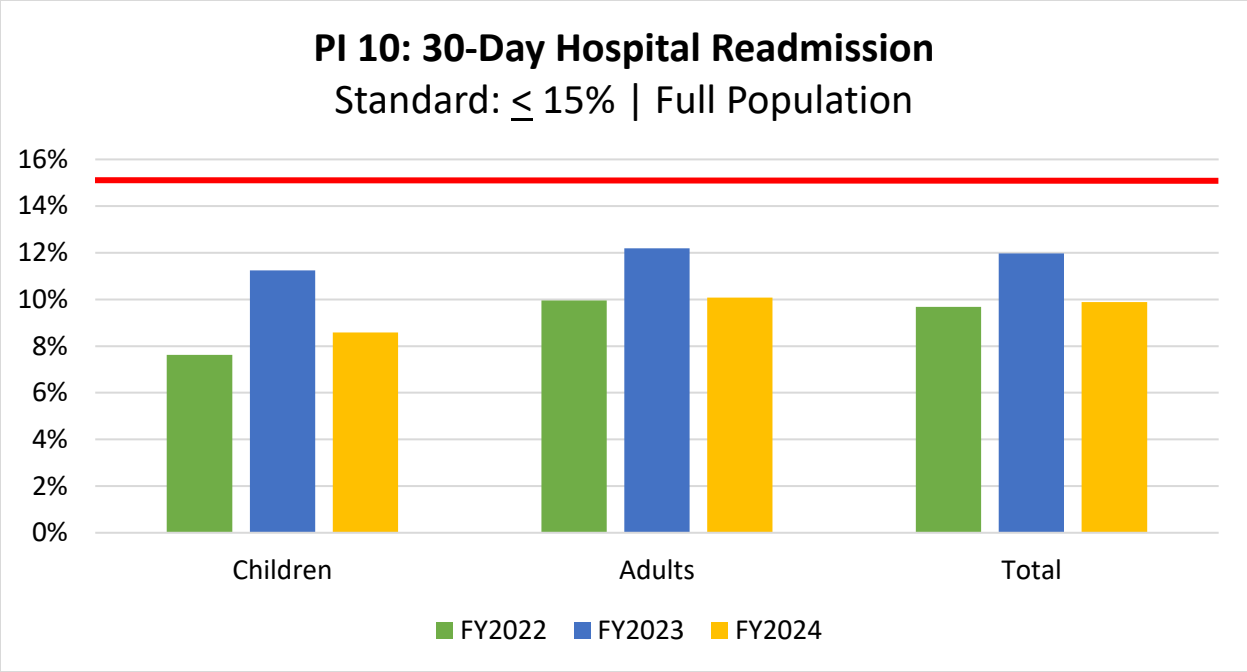
Indicator	Population	FY2022 Total	FY2023 Total	FY2024 Q1	FY2024 Q2	FY2024 Q3	FY2024 Q4	FY2024 Total
PI 1 ≥ 95%	Children	93.69%	95.72%	95.71%	95.60%	94.77%	98.34%	96.01%
	Adults	96.78%	98.51%	99.62%	99.47%	99.16%	98.86%	99.26%
	Total	**95.39%**	**97.63%**	**98.01%**	**97.96%**	**97.49%**	**98.69%**	**98.03%**
PI 2a	MI-Children	65.98%	85.77%	83.24%	86.93%	85.16%	90.04%	86.10%
	MI-Adults	42.25%	83.68%	83.73%	82.66%	83.20%	85.96%	83.95%
	IDD-Children	15.08%	10.71%	8.47%	7.29%	4.80%	11.48%	8.03%
	IDD-Adults	46.00%	33.58%	44.44%	53.85%	23.08%	21.74%	32.76%
	Total	**47.50%**	**76.29%**	**73.51%**	**76.38%**	**73.52%**	**76.15%**	**74.88%**
PI 3	MI-Children	44.07%	58.48%	52.07%	56.16%	48.19%	55.56%	52.83%
	MI-Adults	53.39%	57.29%	50.27%	76.18%	81.23%	76.83%	71.29%
	IDD-Children	69.42%	93.18%	97.00%	94.74%	93.88%	94.83%	95.11%
	IDD-Adults	33.61%	55.55%	55.56%	42.86%	63.64%	50.00%	53.49%
	Total	**50.54%**	**62.30%**	**56.81%**	**69.72%**	**68.80%**	**72.32%**	**66.89%**
PI 4a ≥ 95%	Children	98.75%	99.16%	99.37%	97.67%	100.00%	100.00%	98.71%
	Adults	97.51%	99.04%	99.42%	97.37%	93.53%	97.29%	96.69%
	Total	**98.00%**	**99.02%**	**99.05%**	**97.42%**	**94.53%**	**97.63%**	**97.01%**
PI 10 ≤ 15%	Children	7.63%	11.24%	11.63%	12.73%	2.00%	8.00%	8.59%
	Adults	9.96%	12.19%	11.69%	9.06%	11.46%	8.51%	10.07%
	Total	**9.68%**	**11.97%**	**11.68%**	**9.60%**	**10.37%**	**8.45%**	**9.88%**


PI 1: Crisis Screening Disposition
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2022
FY2023
FY2024


PI 2a: 14-Day Timeliness from Inquiry to Assessment
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2022
FY2023
FY2024


PI 3: 14-Day Timeliness from Assessment to Start of Service
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2022
FY2023
FY2024

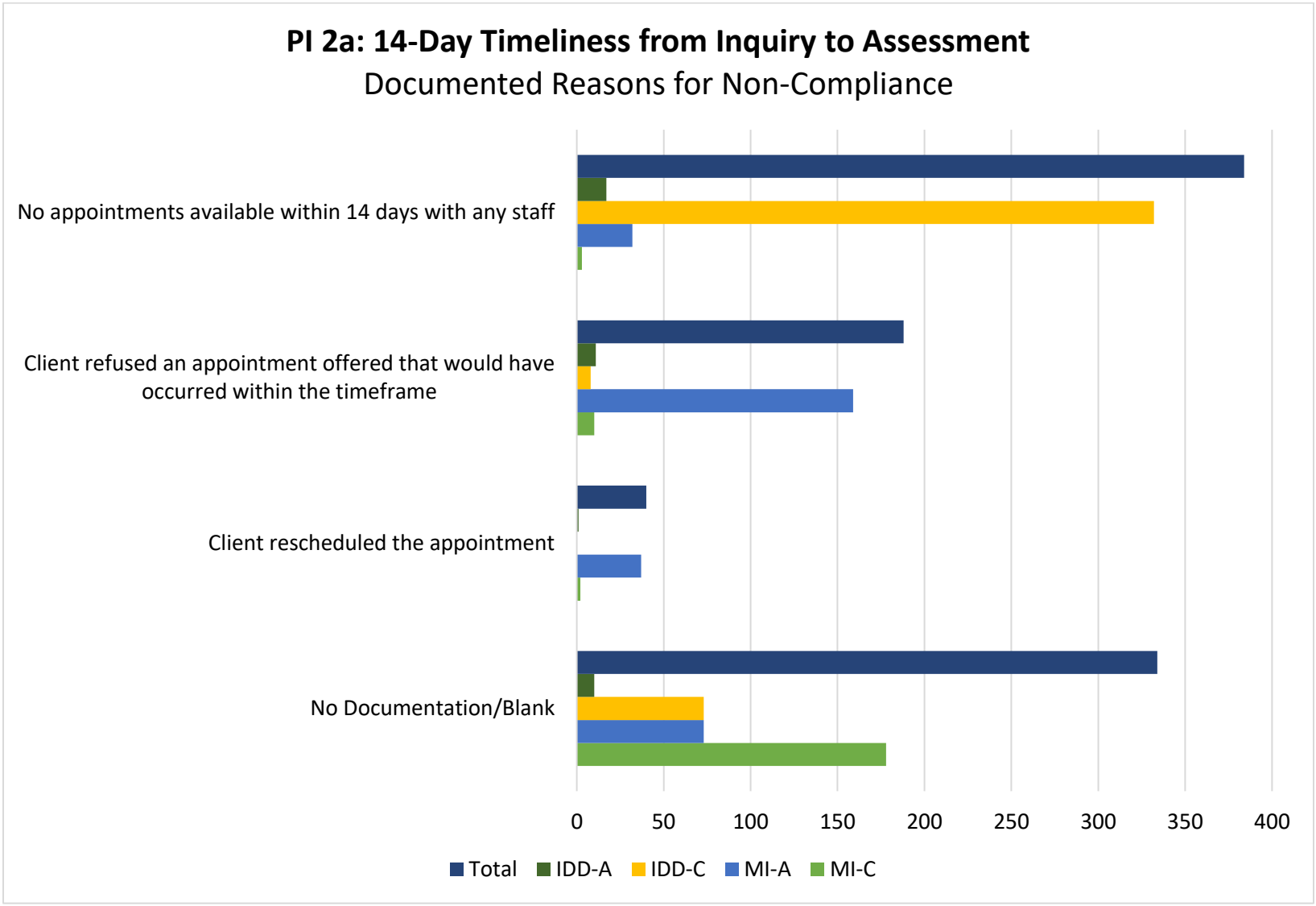

PI 4a: 7-Day Follow-up after Hospitalization
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2022
FY2023
FY2024



PI 5/6 *Full Population	Total # of New Persons receiving an initial non-emergent face-to-face professional assessment	Total # of Persons assessed but denied services	Total # of Persons requesting a second opinion	Total # of Persons receiving services after a second opinion
FY22 Total	3205	418	22	21
FY23 Total	3855	397	9	7
FY24 Q1	1002	101	0	0
FY24 Q2	1054	100	0	0
FY24 Q3	1085	96	0	0
FY24 Q4	1084	114	3	3
FY24 Total	4225	411	3	3

PI 5/6 *Full Population	% of Persons assessed but denied services	% of Persons requesting a second opinion	% of Persons receiving services after a second opinion
FY22 Total	13%	5%	95%
FY23 Total	10%	2%	78%
FY24 Total	10%	1%	100%

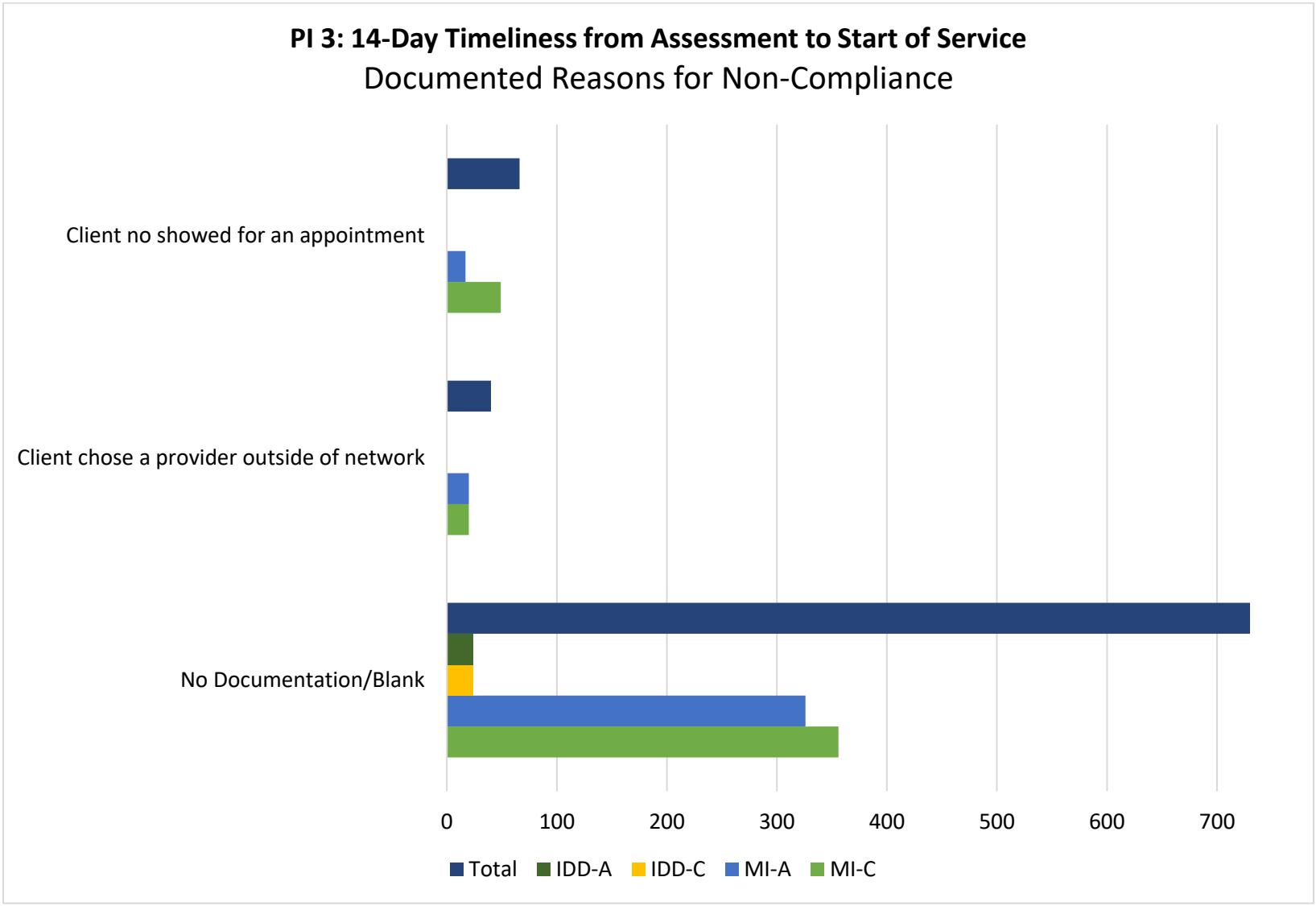
PI 2a: Documented Reasons for Non-Compliance



Full Population (Total)	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	85	71	95	83	334
Client chose not to pursue services	0	0	1	0	1
Client chose provider outside of network	1	0	0	0	1
Client no showed for an appointment	2	1	2	0	5
Client rescheduled the appointment	9	17	14	0	40
Client refused an appointment offered that would have occurred within the timeframe	45	49	51	43	188
No appointments available within 14 days with any staff	90	86	106	102	384
Staff Cancel/Reschedule	0	1	0	1	2
Other (Unable to complete assessment as a result of an emergent service needed; Closed client comes back within 60 days; Guardianship hearing; OBRA Enrollment; Substance Abuse Enrollment)	0	1	0	0	1
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	1	1	5	3	10
Client rescheduled the appointment	1	0	0	0	1
Client refused an appointment offered that would have occurred within the timeframe	1	5	1	4	11
No appointments available within 14 days with any staff	2	0	4	11	17
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	16	13	22	22	73
Client refused an appointment offered that would have occurred within the timeframe	0	1	2	5	8
No appointments available within 14 days with any staff	81	75	95	81	332

MI-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	13	12	17	31	73
Client chose not to pursue services	0	0	1	0	1
Client chose provider outside of network	1	0	0	0	1
Client no showed for an appointment	1	1	1	0	3
Client rescheduled the appointment	7	16	14	0	37
Client refused an appointment offered that would have occurred within the timeframe	41	41	44	33	159
No appointments available within 14 days with any staff	6	10	6	10	32
Staff Cancel/Reschedule	0	1	0	1	2
Other (Unable to complete assessment as a result of an emergent service needed; Closed client comes back within 60 days; Guardianship hearing; OBRA Enrollment; Substance Abuse Enrollment)	0	1	0	0	1
MI-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	55	45	51	27	178
Client no showed for an appointment	1	0	1	0	2
Client rescheduled the appointment	1	1	0	0	2
Client refused an appointment offered that would have occurred within the timeframe	3	2	4	1	10
No appointments available within 14 days with any staff	1	1	1	0	3

PI 3: Documented Reasons for Non-Compliance



Full Population (Total)	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	279	165	145	141	730
Client chose not to pursue services	8	0	0	0	8
Client chose a provider outside of network	3	0	0	0	3
Client no showed for an appointment	11	11	12	6	40
Client rescheduled an appointment	11	16	19	20	66
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	38	35	58	48	179
No appointment available within 14 days with any staff	7	1	10	5	23
Staff Cancel/Reschedule	2	3	2	5	12
Other (Closed client comes back within 60 days; Client not eligible for ongoing services; Intent of service was medication only or respite only; Substance Abuse Enrollment)	1	0	0	0	1
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	8	4	4	8	24
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	7	5	6	6	24

MI-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	112	67	57	90	326
Client chose not to pursue services	7	0	0	0	7
Client chose a provider outside of network	2	0	0	0	2
Client no showed for an appointment	11	3	2	4	20
Client rescheduled an appointment	7	4	2	4	17
Staff Cancel/Reschedule	2	2	2	1	7
Other (Closed client comes back within 60 days; Client not eligible for ongoing services; Intent of service was medication only or respite only; Substance Abuse Enrollment)	1	0	0	0	1
MI-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2024**
No Documentation/Blank	153	89	77	37	356
Client chose not to pursue services	1	0	0	0	1
Client chose a provider outside of network	1	0	0	0	1
Client no showed for an appointment	0	8	10	2	20
Client rescheduled an appointment	4	12	17	16	49
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	38	35	58	48	179
No appointment available within 14 days with any staff	7	1	10	5	23
Staff Cancel/Reschedule	0	1	0	4	5

Outcomes Management System: Efficiency Objective Data Collection for Integrative Treatment and Recovery Services

Efficiency Objective:	FY 2023-2024											
	Oct-Dec 2023			Jan-Mar 2024			April-June 2024			July-Sept 2024		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) The number of consumers who complete treatment successfully. **(ITRS Outpatient Clinton & Ingham)**							140	39	28%	141	51	36%
2) 95% of clients will have a Primary Care Physician by discharge. **(House of Commons)**	49	16	33%	57	10	28%	46	7	15%	53	18	33%
3) 90% of clients will have a Primary Care Physician by discharge. **(CATS Program)**	471	382	81.1%	403	264	65.51%	397	219	55.16%	224	224	100%
4) 80% of clients will successfully discharge. **(The Recovery Center)**	84	59/52	70%/ 67.49%	90	58/66	64%/ 68.04%	78	42/60	55%/ 63% (-8%)	94	48/48	58%/ 51% (-7%)

*Data is missing from October 2023 to March 2024 for Objective 1 from ITRS Outpatient due to staffing changes throughout that time period

Minimum = 80

Goal = 85

Optimal = 100

Consumer Satisfaction Survey

Summary

As part of CMHA-CEI's quality improvement efforts, satisfaction surveys are administered annually to active consumers. Results are used to gauge the level of satisfaction among consumers, determine ways to improve the quality of practice, and address identified areas of need. The purpose of the survey is to measure the quality of CEI services and summarize the level of satisfaction with the CMH service system.

Adults receiving services from AMHS or CSDD Adult completed the MHSIP adult satisfaction survey. The MSHIP template provided by MSHN utilized a 6 point Likert scale for 36 questions across 7 subscale domains.

MHSIP Likert Scale:
- Strongly Agree (1)
- Agree (2)
- Neutral (3)
- Disagree (4)
- Strongly Disagree (5)
- Not Applicable (9)

MHSIP Domains:
1. General Satisfaction
2. Access
3. Quality and Appropriateness
4. Participation in Treatment Planning
5. Outcome of Services
6. Functioning
7. Social Connectedness

Children, or their families if they were younger than 13, receiving services from Families Forward or CSSD Youth completed the YSSF youth satisfaction survey. The YSSF template provided by MSHN utilized a 5 point Likert scale for 26 questions across 7 subscale domains.

YSSF Likert Scale*:
- Strongly Agree (5)
- Agree (4)
- Neutral (3)
- Disagree (2)
- Strongly Disagree (1)

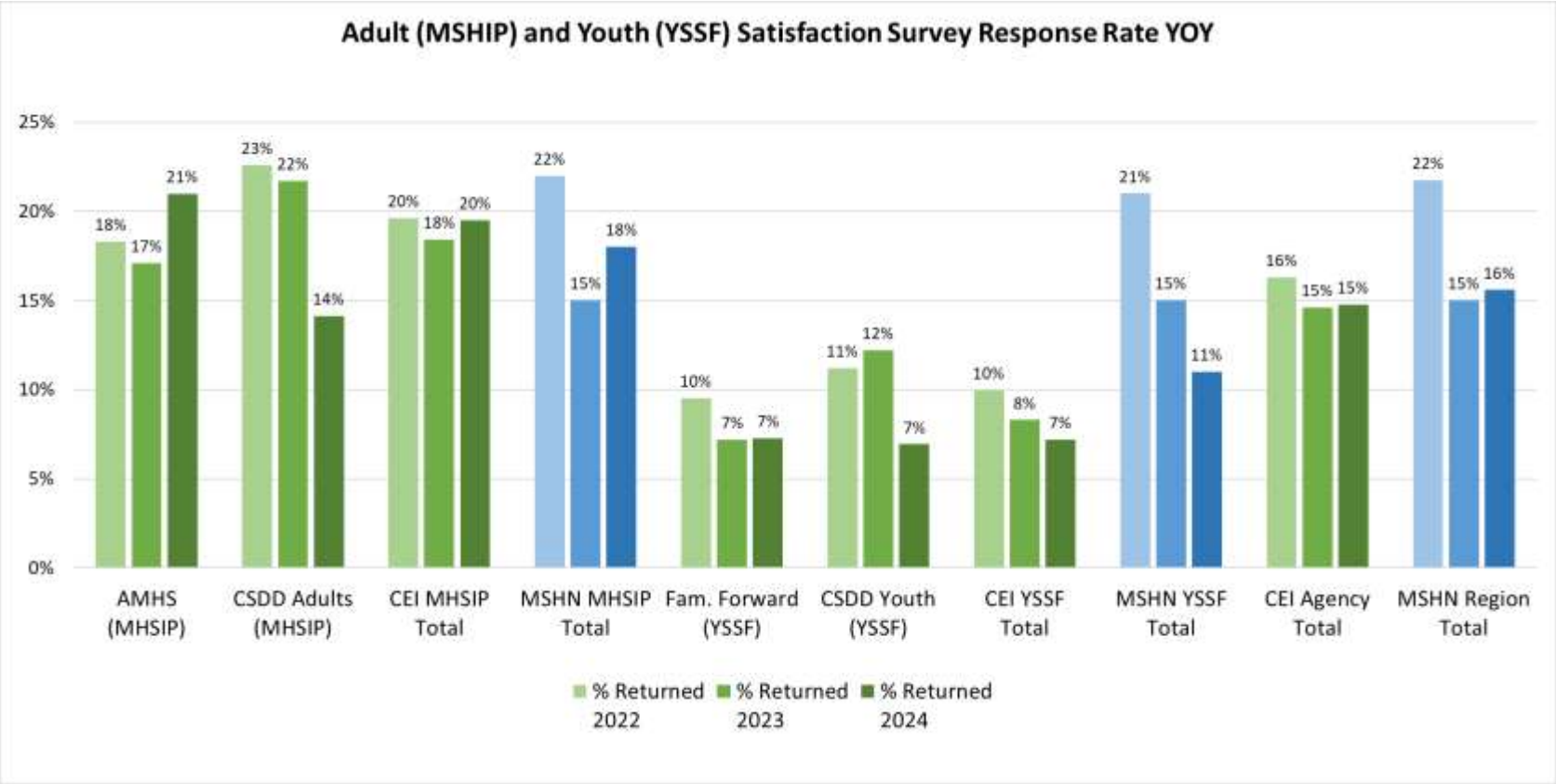
*YSSF numerical order is reversed compared to MSHIP adult survey

YSSF Domains:
1. Cultural Sensitivity
2. Access
3. Appropriateness
4. Participation in Treatment
5. Outcome of Services
6. Social Functioning
7. Social Connectedness

Results from AMHS, Families Forward, and CSDD programs are reported to MSHN annually by the QI Team for analysis. MSHN's report provides CEI with year-over-year regional comparisons and subscale ratings. Further analysis is completed internally to provide a detailed overview of survey performance for each individual CEI program.

In 2024, CMHA-CEI distributed 7,092 total consumer satisfaction surveys to mental health programs. There was an overall rate of return of 14.8%, which represents a slight increase from 2023 to 2024. A year-over-year comparison between individual CEI programs as well as the MSHN region is included on the next page.

Additionally, ITRS distributes satisfaction surveys to their consumers annually. In 2024, the MHSIP adult consumer satisfaction survey was used. 94 total consumers across 5 ITRS programs were surveyed on the quality of the care they received.


Adult (MSHIP) and Youth (YSSF) Satisfaction Survey Response Rate YOY
25%
20%
15%
10%
5%
0%
18%
17%
21%
23%
22%
14%
20%
18%
20%
22%
15%
18%
10%
7%
7%
11%
12%
7%
10%
8%
7%
21%
15%
11%
16%
15%
15%
22%
15%
16%
AMHS (MHSIP)
CSDD Adults (MHSIP)
CEI MHSIP Total
MSHN MHSIP Total
Fam. Forward (YSSF)
CSDD Youth (YSSF)
CEI YSSF Total
MSHN YSSF Total
CEI Agency Total
MSHN Region Total
% Returned 2022
% Returned 2023
% Returned 2024

Survey Response Rates YOY						
	Distributed 2022	% Returned 2022	Distributed 2023	% Returned 2023	Distributed 2024	% Returned 2024
AMHS (MHSIP)	2,153	18.3%	2,338	17.1%	3,420	21.0%
CSDD Adults (MHSIP)	961	22.6%	926	21.7%	942	14.1%
CEI MHSIP Total	3,114	19.6%	3,264	18.4%	4,362	19.5%
MSHN MHSIP Total	10,600	22.0%	18,793	15.0%	16,567	18.0%
Fam. Forward (YSSF)	1,180	9.5%	1,759	7.2%	2,095	7.3%
CSDD Youth (YSSF)	454	11.2%	491	12.2%	635	6.9%
CEI YSSF Total	1,634	10.0%	2,250	8.3%	2,730	7.2%
MSHN YSSF Total	3,914	21.0%	6,940	15.0%	8,709	11.0%
CEI Agency Total	4,748	16.3%	5,514	14.6%	7,092	14.8%
MSHN Region Total	14,514	21.7%	25,733	15.0%	25,276	15.6%

Procedure – Mental Health Programs

Surveys were mailed out and handed directly to consumers who received services from AMHS, Families Forward, or CSDD programs between 6/3/23 and 7/2/24. Response methods included mail, phone, face-to-face, and electronic submission. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The survey respondents were anonymous, although consumers were given the option to identify themselves at the end of the survey if they wished to be contacted at a later date for follow-up.

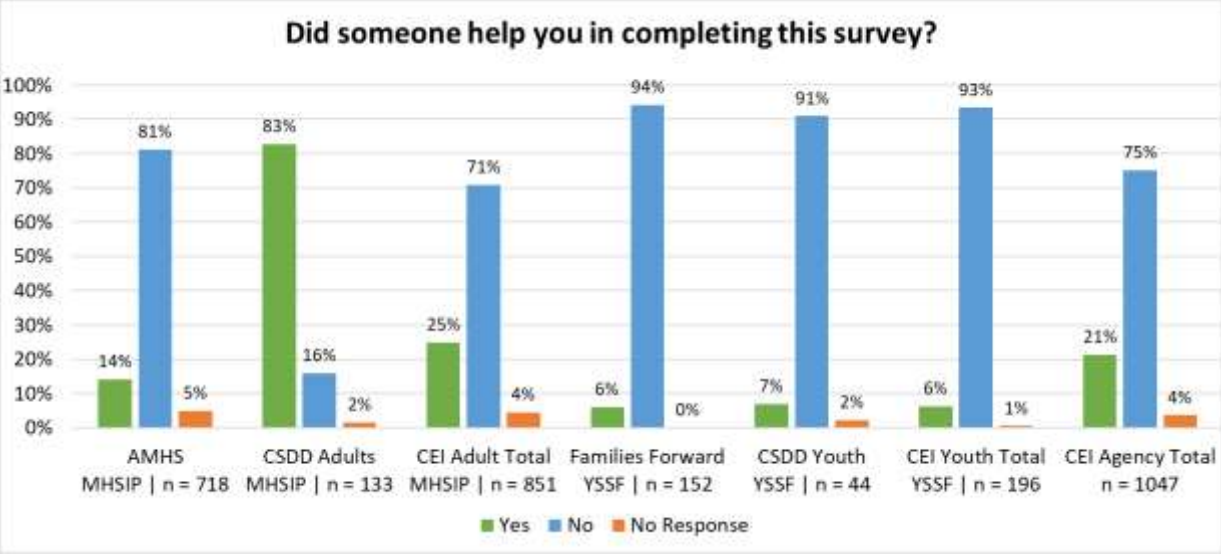
Findings – Mental Health Programs

Across all programs, the difference between the highest and lowest-performing questions remains relatively small. This indicates that consumers continue to be generally satisfied with CEI services. However, year-over-year, questions about the quality of staff and services frequently score above those regarding treatment outcomes.

All AMHS subscale scores and the majority of CSDD Adult subscale scores decreased from 2023 to 2024. However, most subscale scores in both Families Forward and CSDD Youth increased from 2023 to 2024. The MSHN regional average decreased from 2023 to 2024 in every subscale across both of the adult and youth surveys. CEI programs overall outperformed the 2024 MSHN regional average on the majority of subscales in CSDD Adult as well as all subscales in Families Forward and CSDD Youth.

Unfortunately, many consumers did not answer the response method question in 2024. Across all programs, however, the most common survey response method for those who did answer was by mail. The most common method was face-to-face in 2023.

CSDD Adult was the only program surveyed where a majority of consumers received assistance completing the survey. Many AMHS respondents also received assistance.



Analysis of Findings – Mental Health Programs

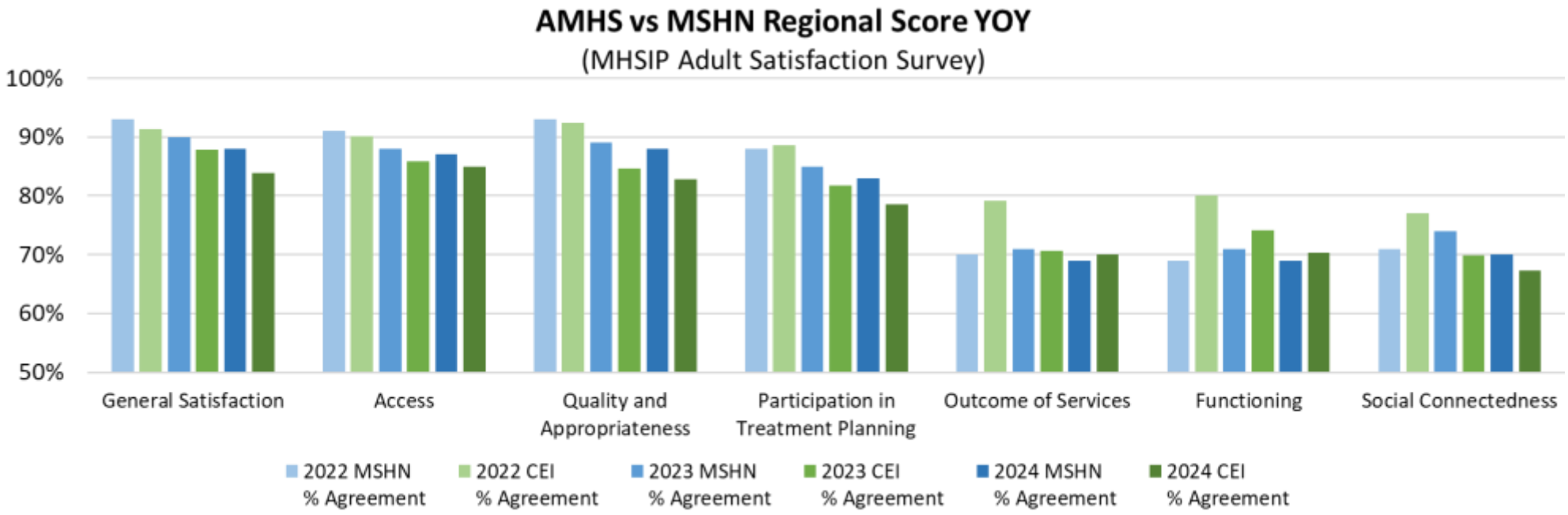
Adult Mental Health Services (AMHS)

Top 3 Questions (average scores)						
	2024 (Score)		**2023 (Score)**		**2022 (Score)**	
AMHS - MHSIP (Lower = Better) 2024: n = 718; Avg Score = 1.87 2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	7. Services were available at times that were good for me.	(1.58)	1. I like the services that I received.	(1.58)	1. I like the services that I received.	(1.43)
	1. I like the services that I received.	(1.59)	11. I felt comfortable asking questions about my treatment, services and medication.	(1.61)	7. Services were available at times that were good for me.	(1.47)
	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.60)	5. Staff were willing to see me as often as I felt it was necessary.	(1.62)	10. Staff believed that I could grow, change and recover.	(1.47)

Bottom 3 Questions (average scores)						
	2024 (Score)		**2023 (Score)**		**2022 (Score)**	
AMHS - MHSIP (Higher = Worse) 2024: n = 718; Avg Score = 1.87 2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	28. My symptoms are not bothering me as much.	(2.25)	28. My symptoms are not bothering me as much.	(2.25)	26. I do better in school and/or work.	(1.97)
	31. I am better able to handle things when they go wrong.	(2.17)	27. I am satisfied with my housing situation.	(2.18)	28. My symptoms are not bothering me as much.	(1.96)
	35. I feel I belong in my community.	(2.17)	35. I feel I belong in my community	(2.17)	35. I feel I belong in my community.	(1.96)

AMHS Performance Across the MHSIP Subscales

- Scored Best: Access (85% agreement)
- Scored Worst: Social Connectedness (67% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for both AMHS and the MSHN region.
- Comparing CEI data to MSHN region data for 2024 only:
    - AMHS scored above the regional average on Outcome of Services and Functioning.
    - AMHS scored below the regional average on General Satisfaction, Access, Quality/Appropriateness, Participation in Treatment Planning, and Social Connectedness.



AMHS vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
General Satisfaction	93%	-1.66	91%	1.52	90%	-2.24	88%	1.65	88%	-4.16	84%	1.70
Access	91%	-0.97	90%	1.58	88%	-2.21	86%	1.73	87%	-2.12	85%	1.71
Quality and Appropriateness	93%	-0.55	92%	1.56	89%	-4.40	85%	1.75	88%	-5.24	83%	1.76
Participation in Treatment Planning	88%	+0.59	89%	1.52	85%	-3.32	82%	1.68	83%	-4.41	79%	1.72
Outcome of Services	70%	+9.20	79%	1.82	71%	-0.41	71%	2.06	69%	+1.00	70%	2.07
Functioning	69%	+11.00	80%	1.81	71%	+3.07	74%	1.98	69%	+1.31	70%	2.02
Social Connectedness	71%	+6.03	77%	1.85	74%	-4.13	70%	2.06	70%	-2.67	67%	2.06

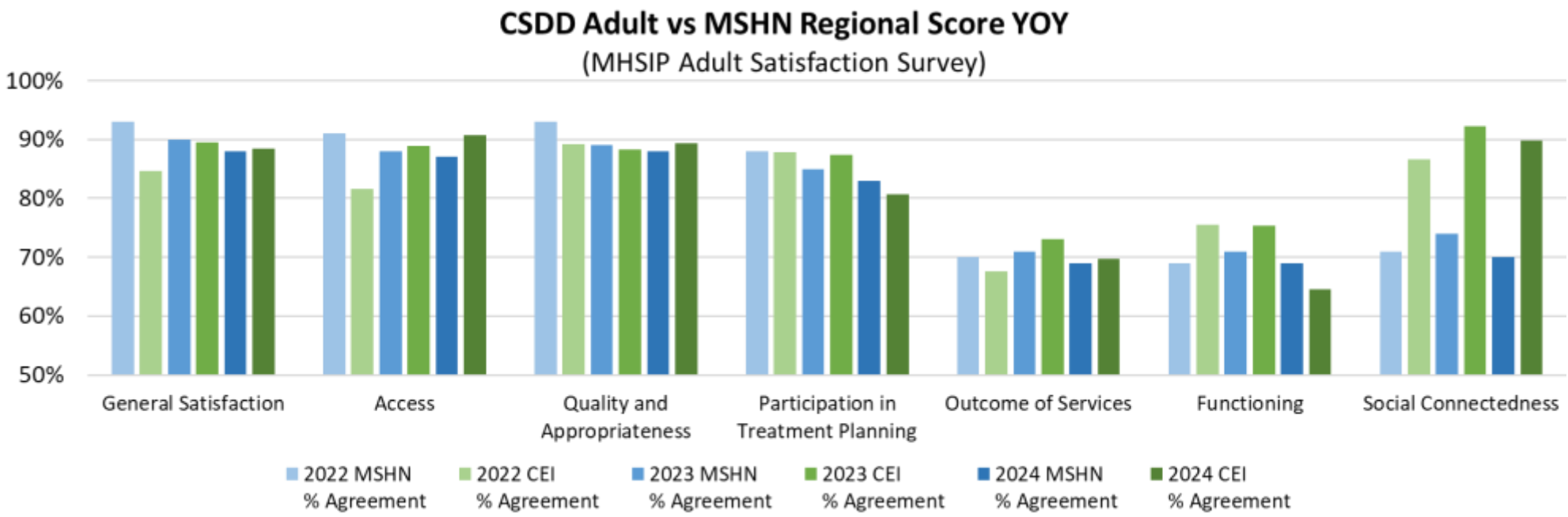
Community Services for the Developmentally Disabled (CSDD) Adult

Top 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Adults - MHSIP (Lower = Better) 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	5. Staff were willing to see me as often as I felt it was necessary.	(1.46)	36. In a crisis, I would have the support I need from family and friends.	(1.49)	11. I felt comfortable asking questions about my treatment, services and medication.	(1.60)
	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.46)	1. I like the services that I received.	(1.58)	5. Staff were willing to see me as often as I felt it was necessary.	(1.64)
	4. The location of services was convenient.	(1.48)	34. I have people with whom I can do enjoyable things.	(1.58)	7. Services were available at times that were good for me.	(1.65)

Bottom 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Adults - MHSIP (Higher = Worse) 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	31. I am better able to handle things when they go wrong.	(2.75)	31. I am better able to handle things when they go wrong.	(2.25)	26. I do better in school and/or work.	(2.29)
	23. I am better able to deal with crisis.	(2.74)	23. I am better able to deal with crisis.	(2.25)	23. I am better able to deal with crisis.	(2.23)
	30. I am better able to take care of my needs.	(2.55)	28. My symptoms are not bothering me as much.	(2.25)	31. I am better able to handle things when they go wrong.	(2.22)

CSDD Adult Performance Across the MHSIP Subscales

- Scored Best: Access (91% agreement)
- Scored Worst: Functioning (64% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- Most subscales decreased year-over-year from 2023 to 2024 for CSDD Adult, except for Access and Quality/Appropriateness which increased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - CSDD Adult scored above the regional average on General Satisfaction, Access, Quality/Appropriateness, Outcome of Services, and Social Connectedness.
    - CSDD Adult scored below the regional average on Participation in Treatment Planning and Functioning.



CSDD Adult vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
General Satisfaction	93%	-8.43	85%	1.83	90%	-0.55	89%	1.65	88%	+0.46	88%	1.62
Access	91%	-9.45	82%	1.82	88%	+0.83	89%	1.70	87%	+3.70	91%	1.64
Quality and Appropriateness	93%	-3.84	89%	1.85	89%	-0.70	88%	1.81	88%	+1.38	89%	1.67
Participation in Treatment Planning	88%	-0.20	88%	1.68	85%	+2.28	87%	1.69	83%	-2.27	81%	1.71
Outcome of Services	70%	-2.47	68%	2.13	71%	+2.08	73%	2.03	69%	+0.64	70%	2.17
Functioning	69%	+6.50	75%	2.00	71%	+4.28	75%	1.97	69%	-4.54	64%	2.21
Social Connectedness	71%	+15.62	87%	1.73	74%	+18.27	92%	1.60	70%	+19.84	90%	1.62

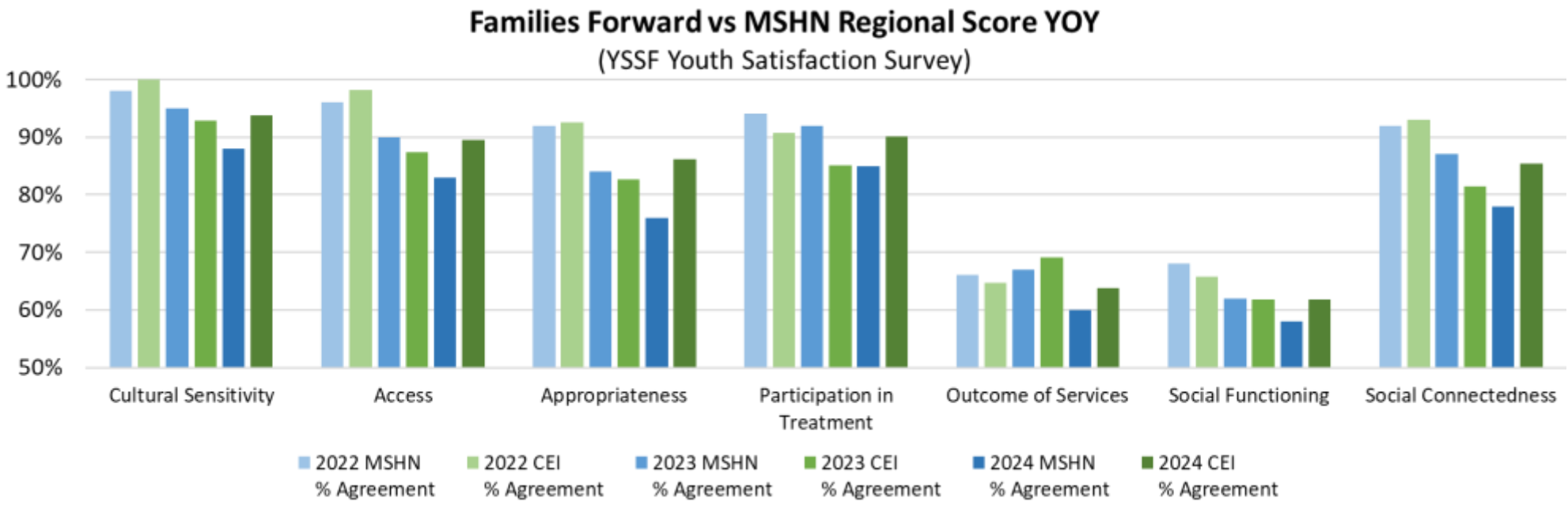
Families Forward

Top 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
Families Forward - YSSF (Higher = Better) 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	12. Staff treated me with respect.	(4.74)	12. Staff treated me with respect.	(4.67)	12. Staff treated me with respect.	(4.85)
	14. Staff spoke with me in a way that I understood.	(4.72)	14. Staff spoke with me in a way that I understood.	(4.66)	14. Staff spoke with me in a way that I understood.	(4.83)
	13. Staff respected my family's religious/spiritual beliefs.	(4.57)	13. Staff respected my family's religious/spiritual beliefs.	(4.61)	13. Staff respected my family's religious/spiritual beliefs.	(4.73)

Bottom 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
Families Forward - YSSF (Lower = Worse) 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	20. My child is better able to cope when things go wrong.	(3.41)	19. My child is doing better in school and/or work.	(3.59)	19. My child is doing better in school and/or work.	(3.56)
	21. I am satisfied with our family life right now.	(3.59)	21. I am satisfied with our family life right now.	(3.67)	20. My child is better able to cope when things go wrong.	(3.64)
	19. My child is doing better in school and/or work.	(3.61)	20. My child is better able to cope when things go wrong.	(3.79)	18. My child gets along better with friends and other people.	(3.72)

Families Forward Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity (94% agreement)
- Scored Worst: Social Functioning (62% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- Most subscales increased year-over-year from 2023 to 2024 for Families Forward, except for Outcome of Services which decreased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - Families Forward scored above the regional average on all subscales including Cultural Sensitivity, Access, Appropriateness, Participation in Treatment, Outcome of Services, Social Functioning, and Social Connectedness.



Families Forward vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
Cultural Sensitivity	98%	+2.00	100%	4.76	95%	-2.09	93%	4.63	88%	+5.71	94%	4.65
Access	96%	+2.18	98%	4.69	90%	-2.60	87%	4.51	83%	+6.47	89%	4.48
Appropriateness	92%	+0.59	93%	4.49	84%	-1.32	83%	4.33	76%	+10.09	86%	4.32
Participation in Treatment	94%	-3.35	91%	4.50	92%	-6.96	85%	4.33	85%	+5.13	90%	4.40
Outcome of Services	66%	-1.24	65%	3.75	67%	+2.11	69%	3.80	60%	+3.82	64%	3.73
Social Functioning	68%	-2.29	66%	3.73	62%	-0.21	62%	3.82	58%	+3.84	62%	3.75
Social Connectedness	92%	+0.94	93%	4.35	87%	-5.55	81%	4.26	78%	+7.33	85%	4.25

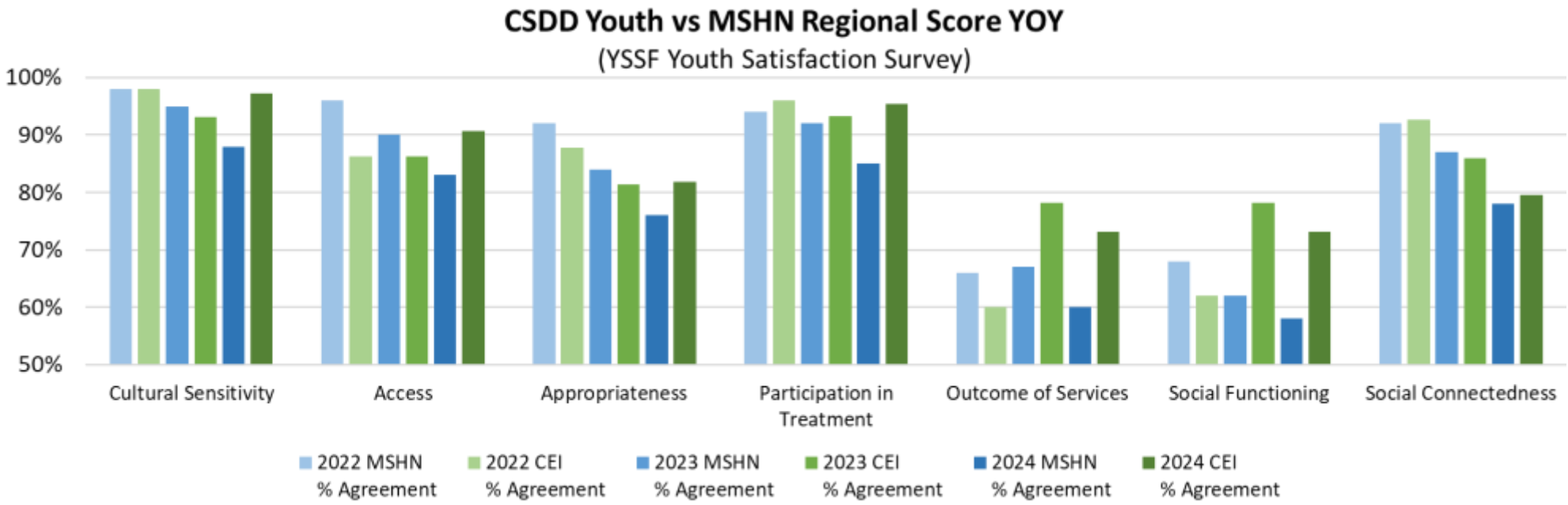
Community Services for the Developmentally Disabled (CSDD) Youth

Top 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Youth - YSSF (Higher = Better) 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	14. Staff spoke with me in a way that I understood.	(4.72)	12. Staff treated me with respect.	(4.57)	14. Staff spoke with me in a way that I understood.	(4.69)
	13. Staff respected my family's religious/spiritual beliefs.	(4.68)	14. Staff spoke with me in a way that I understood.	(4.55)	12. Staff treated me with respect.	(4.65)
	15. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language).	(4.62)	13. Staff respected my family's religious/spiritual beliefs.	(4.53)	6. I participated in my child's treatment/services.	(4.60)

Bottom 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Youth - YSSF (Lower = Worse) 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	20. My child is better able to cope when things go wrong.	(3.55)	20. My child is better able to cope when things go wrong.	(3.75)	20. My child is better able to cope when things go wrong.	(3.59)
	22. My child is better able to do things he or she wants to do.	(3.63)	22. My child is better able to do things he or she wants to do.	(3.91)	16. My child is better at managing daily life.	(3.72)
	16. My child is better at managing daily life.	(3.85)	21. I am satisfied with our family life right now.	(3.93)	19. My child is doing better in school and/or work.	(3.75)

CSDD Youth Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity (97% agreement)
- Scored Worst: Social Functioning and Social Connectedness (73% agreement - tied)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- The majority of subscales increased year-over-year from 2023 to 2024 for CSDD Youth, except for Outcome of Services, Social Functioning, and Social Connectedness which decreased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - CSDD Youth scored above the regional average on all subscales including Cultural Sensitivity, Access, Appropriateness, Participation in Treatment, Outcome of Services, Social Functioning, and Social Connectedness.



CSDD Youth vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
Cultural Sensitivity	98%	0.00	98%	4.62	95%	-1.90	93%	4.52	88%	+9.22	97%	4.66
Access	96%	-9.73	86%	4.39	90%	-3.79	86%	4.36	83%	+7.70	91%	4.55
Appropriateness	92%	-4.24	88%	4.21	84%	-2.64	81%	4.22	76%	+5.82	82%	4.26
Participation in Treatment	94%	+2.00	96%	4.47	92%	+1.22	93%	4.46	85%	+10.45	95%	4.49
Outcome of Services	66%	-6.00	60%	3.76	67%	+11.18	78%	3.96	60%	+13.17	73%	3.85
Social Functioning	68%	-6.00	62%	3.73	62%	+16.18	78%	3.96	58%	+15.17	73%	3.85
Social Connectedness	92%	+0.59	93%	4.14	87%	-1.04	86%	4.30	78%	+1.55	80%	4.19

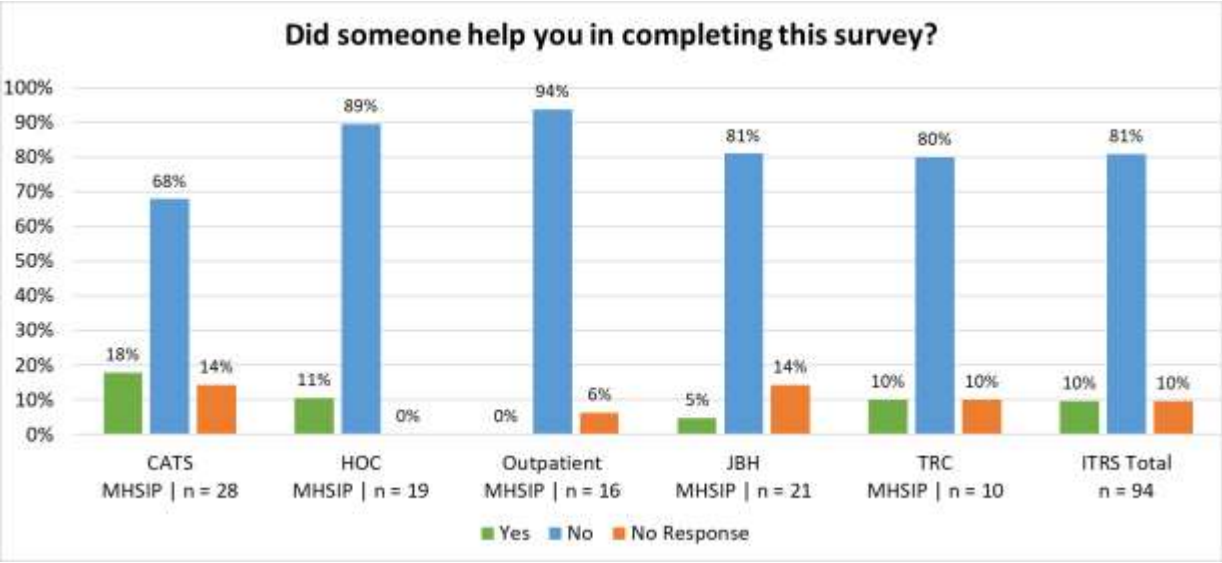
Findings – ITRS Programs

In 2024, the MHSIP adult satisfaction survey described above was distributed by Integrated Treatment & Recovery Services (ITRS) to 94 consumers across 5 programs:

- Correctional Assessment & Treatment Services (CATS) – Ingham County jail
- The House of Commons (HOC) – residential treatment
- ITRS Outpatient (OP) – outpatient treatment
- Justice Behavioral Health (JBH) – mental health
- The Recovery Center (TRC) – detox services

CATS and JBH scored below the MSHN regional average on most subscales while HOC, OP, and TRC outperformed the region on most subscales. The largest discrepancies between the region and ITRS programs occurred in the subscales of Access, Functioning, and Social Connectedness.

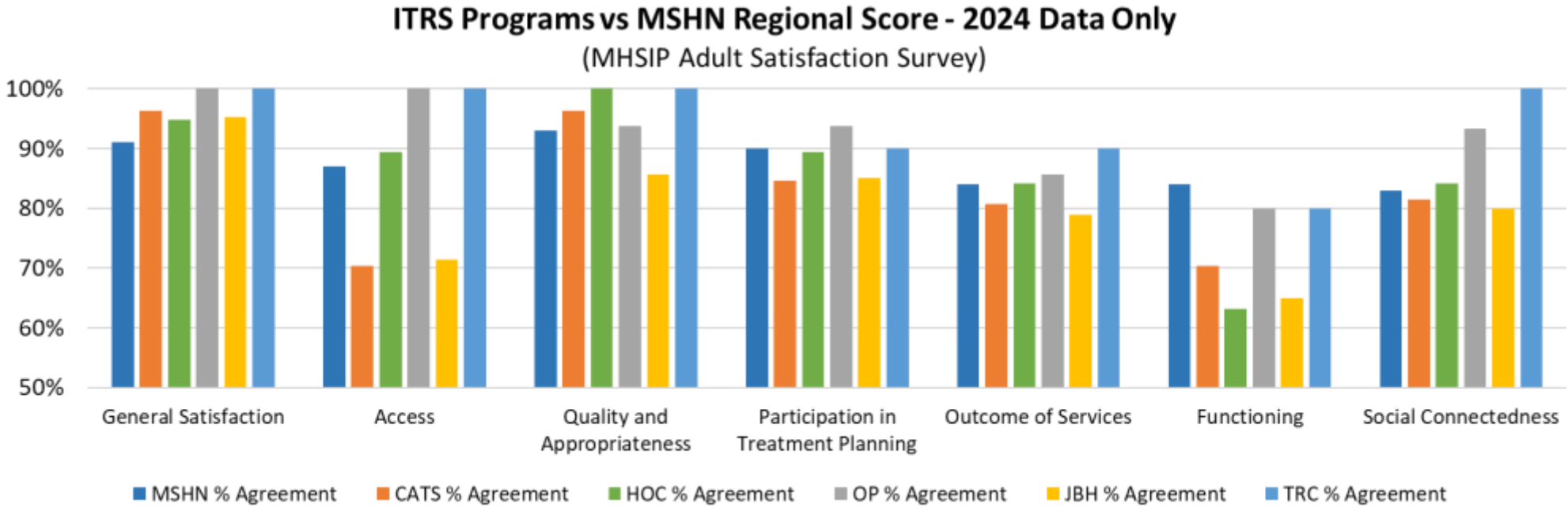
CATS was the ITRS only program surveyed where a significant portion of consumers received assistance completing the survey. Many HOC and TRC respondents also received assistance.



In previous years, a specialized substance use disorder (SUD) satisfaction survey was distributed to treatment programs to assess quality of consumer care. The switch to the general MHSIP adult satisfaction survey occurred region-wide. Year-over-year analysis is not yet possible as a different survey was used in 2023. Data from 2024 will be used as a baseline for comparison in the future.

Analysis of Findings – ITRS Programs

- Questions are scored on a scale of 1 to 5 with lower numerical scores indicating greater performance
- The average satisfaction score across all MHSIP subscales and ITRS programs was 1.72
- Overall, TRC had best average score with 1.40 while CATS had the worst average score with 1.87
- Scored Best (across all programs): General Satisfaction – 97% agreement, average score of 1.42
- Scored Worst (across all programs): Functioning – 70% agreement, average score of 1.93



ITRS Programs vs Region (MHSIP) Average Scores: Lower = Better	MSHN % Agreement	CATS vs Region	CATS % Agreement	CATS Avg Score	HOC vs Region	HOC % Agreement	HOC Avg Score	OP vs Region	OP % Agreement	OP Avg Score	JBH vs Region	JBH % Agreement	JBH Avg Score	TRC vs Region	TRC % Agreement	TRC Avg Score
General Satisfaction	91%	+5.30	96%	1.51	+3.74	95%	1.46	+9.00	100%	1.33	+4.24	95%	1.48	+9.00	100%	1.10
Access	87%	-16.63	70%	2.08	+2.47	89%	1.58	+13.00	100%	1.46	-15.57	71%	1.94	+13.00	100%	1.22
Quality and Appropriateness	93%	+3.30	96%	1.76	+7.00	100%	1.52	+0.75	94%	1.42	-7.29	86%	1.71	+7.00	100%	1.14
Participation in Treatment Planning	90%	-5.38	85%	1.63	-0.53	89%	1.58	+3.75	94%	1.28	-5.00	85%	1.60	0.00	90%	1.20
Outcome of Services	84%	-3.23	81%	1.95	+0.21	84%	1.81	+1.71	86%	1.78	-5.05	79%	2.05	+6.00	90%	1.65
Functioning	84%	-13.63	70%	2.01	-20.84	63%	1.84	-4.00	80%	1.70	-19.00	65%	2.05	-4.00	80%	1.98
Social Connectedness	83%	-1.52	81%	1.90	+1.21	84%	1.72	+10.33	93%	1.67	-3.00	80%	1.84	+17.00	100%	1.47

Quality Improvement and Performance Measurement Report for CARF Accredited CMHA-CEI Programs

CMHA-CEI is nationally accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF).

CARF International has announced that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) has been accredited through June 30, 2026. This is the seventh consecutive Three-Year Accreditation that the international accrediting body has given to CMHA-CEI. The agency retained accreditation for eighteen clinical programs and all administrative units.

In 2023, CMHA-CEI was granted a three-year accreditation for all administrative units (General Administration, Properties & Facilities, Human Resources, Finance/Contracts, Quality, Customer Service, and Recipient Rights), as well as 19 clinical programs in Adult Mental Health Services (AMHS), Families Forward (FF), Community Services for the Developmentally Disabled (CSDD), and Integrated Treatment and Recovery Services (ITRS). CMHA-CEI's current CARF Accreditation runs through June 2026. An application for re-accreditation will be completed by December 2025 for a survey in the summer of 2026. Current CARF-accredited CMHA-CEI programs are:

CMHA-CEI Department	CMHA-CEI Program	**CARF Core Program**
AMHS	ACT - Cedar	ACT
AMHS	Team I Case Management	Case Management - MH
AMHS	Team II Case Management	Case Management - MH
AMHS	Team 3 Case Management	Case Management – MH
AMHS	Outreach CM	Case Management - MH
AMHS	Older Adult Services	Case Management - MH
AMHS	ECCC	Case Management - MH
AMHS	CCCC	Case Management - MH
AMHS	MROP	Case Management - MH
AMHS	Waverly Wellness	Case Management - MH
ITRS	ITRS Outpatient	Outpatient Treatment Alcohol and other drugs – Adults
ITRS	CATS	Outpatient Treatment Alcohol and other drugs – Criminal Justice
ITRS	House of Commons	Residential Treatment Alcohol and other drugs – Criminal Justice
ITRS	The Recovery Center	Detoxification/Withdrawal Support Treatment Alcohol and other drugs – Adults

Families Forward	Parent-Young Child Program	Intensive Family Bases Services – Early Intervention
Families Forward	Parent-Infant Program	Intensive Family Bases Services – Early Intervention
Families Forward	Family Guidance Services	Intensive Family Bases Services – Home Based
CSDD	Life Consultation	Case Management – psychosocial rehab
CSDD	Family Support Case Management	Case Management – psychosocial rehab

The QI Team is charged with facilitating and preparing each unit for the survey. Part of survey preparation includes submitting annual efficiency measures and outcomes data from CARF-accredited programs in the form of a Quality Improvement and Performance Measurement Plan. The plan is composed of data from performance indicators, satisfaction surveys, incident reports, and other internal QI initiatives. Additional information on performance can be found in the annual Quality Improvement Plan (QIP) and QIP Evaluations found online here: http://ceicmh.org/about-us/quality-and-compliance

Findings, Recommendations, and Accreditation Timeline

CARF Survey and Accreditation Timeline		
Date	**Action**	**Comment**
June 30, 2023	CMHA-CEI Received full accreditation through 2026 as the result of Virtual Survey	
September 5, 2023	CARF QIP reviewed at Quality Improvement and Compliance Committee	Reviewed recommendations and action items for QIP. Assigned responsibilities to programs and Directors with target deadlines
October 31, 2023	Submitted QIP to CARF	
June 30, 2024	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline
January 7, 2025	Review of CARF QIP at QICC Meeting	Review QIP from last CARF survey, look at potential additional programs to be added in 2026.
June 30, 2025	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline

December 31, 2025	Application for CARF Reaccreditation	Survey to be scheduled Summer of 2026
June 2026	CARF Survey – On Site	

CARF Findings and Recommendations at a Glance	
Responsible Program	**CARF Recommendation**
QI/QCSRR	• Assist all programs and administrative units in implementing changes • Chart reviews highlighting specific recommendations
Finance	• Annual Review of Contracts
Human Resources	• Annual Review of Procedures • Workforce and Succession Planning • Code of Ethics (Addressing Peer Support Services and boundaries) • Diversity, Equity, and Inclusion Plan
Information Systems	• Records in EHR be completed and legible – addressing missing information in Assessment and other fields
Properties & Facilities	• Annual review of procedures, tests, drills, and safety inspections
Medical Director	• Updates to Medication Procedures and Physician Peer Review
Clinical Programs	• Uniform use of supervision notes and Suicide Screening • Updates to Guidelines or Program Descriptions to emphasize admission standards and decision making • CATS: Updates to Person Centered Planning that addresses CARF Standards

Policy and Procedure Review

CMHA-CEI hosts 427 active files in PolicyStat, a cloud-based Document Management System. This includes 127 Policies, 238 Procedures, 45 Operating Guidelines, and 17 Forms/User Guides. The system is available for all staff to view and for applicable staff to edit and manage documents. CMHA-CEI has fully transitioned all agency Policies and Procedures into PolicyStat. This transition remains ongoing for program Operating Guidelines and other miscellaneous files such as Forms, User Guides, and Plans.

All agency Policies and Procedures are required to be reviewed at least annually. The review process for Policies and Procedures is built into the PolicyStat system, with specific areas and approval workflows for each document type. The system automatically prompts applicable staff for annual updates and reviews to maintain 100% compliance with CARF and other applicable standards.

The following report from PolicyStat tracks the average lifetime workflow turnaround time for Policies and Procedures since the system went live in FY22:

Policy/Procedure Area	Average Days for Approval	Average # of Review Steps	Average Days Per Step
Administrative Policies	27.3	2.5	11
Administrative Procedures	28.9	2.7	10.8
Clinical Policies	21.8	2.7	8.1
Clinical Procedures	24.8	2.6	9.4
Finance Policies	33.3	2	16.6
Finance Procedures	30.1	2	15
Human Resources Policies	16.7	2	8.3
Human Resources Procedures	5.8	2	2.9

The Quality Improvement Team continues to integrate agency Operating Guidelines into PolicyStat. To date, 45 Operating Guidelines have been converted:

Guideline Area	#	Sub-Areas (if applicable)
Admin Guidelines	31	Access, Admin (General), Corporate Compliance, Customer Service, Property/Facilities, Recipient Rights
Clinical Guidelines	8	N/A – Only Clinical
Finance Guidelines	1	N/A – Only Finance
MI-Adult Guidelines	3	AMHS, Crisis Services
Utilization Management	2	N/A – Only UM

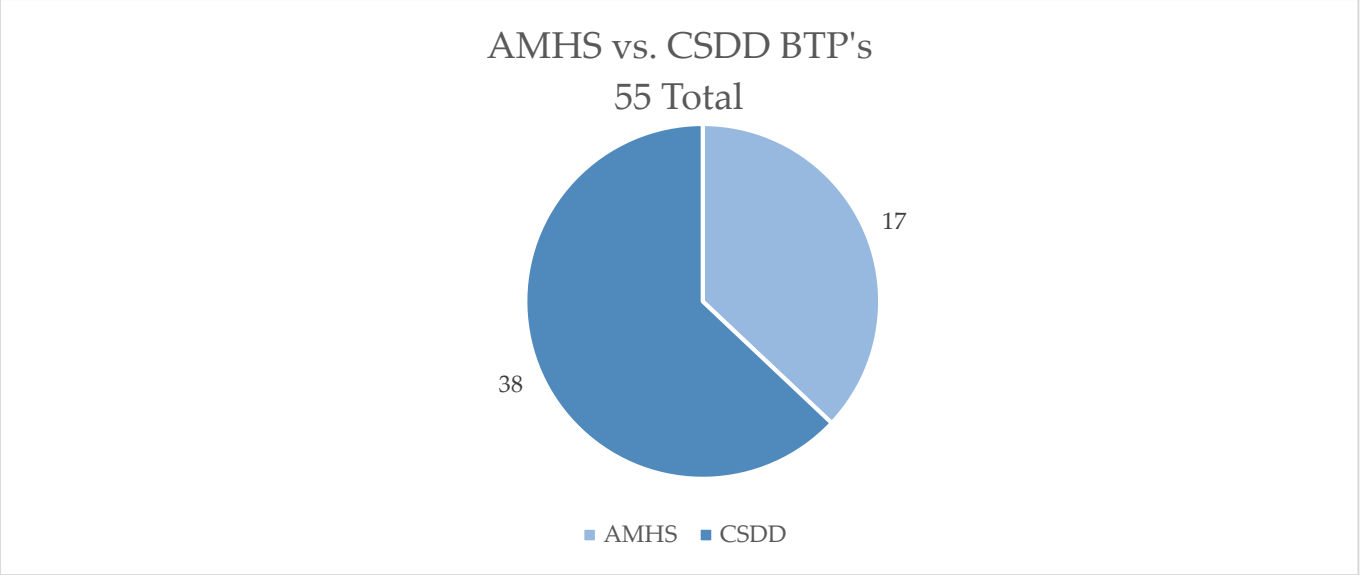
QI has the goal of having all remaining Operating Guidelines converted into PolicyStat and managed by the applicable program in the system by the end of FY25:

Area	Operating Guidelines	Status	Goal

Clinical	8 Files	All Complete Conversion Finalized	Complete
Utilization Management	23 Files	2 Complete 21 Archived Conversion Finalized	Complete
ITRS	118 Files	In Progress All Drafts	Finalize Q1 2025
Admin	42 Files	31 Complete 5 Archived 6 TBD	Q1 2025
Finance	13 Files	1 Complete 12 TBD	Q1 2025
CSDD	~95 Files	All TBD	Q1/Q2 2025
MI-Adult	92 Files	3 Complete 7 Drafts 82 TBD	Q2 2025
MI-Child	72 Files	All TBD	Q3 2025

Behavior Treatment Committee (BTC)

CMHA-CEI's Behavior Treatment Committee conducts expedited, quarterly, annual, and new plan reviews. All Behavior Treatment Plans are monitored through CHMA-CEI's Behavior Treatment Committee which serve several consumers from various agencies throughout the tri-county area. The BTC consists of the Medical Director, AMHS Representatives, CSDD Representatives, Recipient Rights (ex-officio), and QI staff.



Clinician Agency	# of BTPs
CMHA-CEI	34
Gage Consulting	7
ROI	4
Great Lakes Center for Au	4
Flatrock	4
Total Spectrum	1
Centria Healthcare	1

Incident Reporting

Incident categories include consumer deaths, medication errors, emergency care, behavioral episodes, arrests, physical illness, and injuries. Incident report data is reviewed by CIRC for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

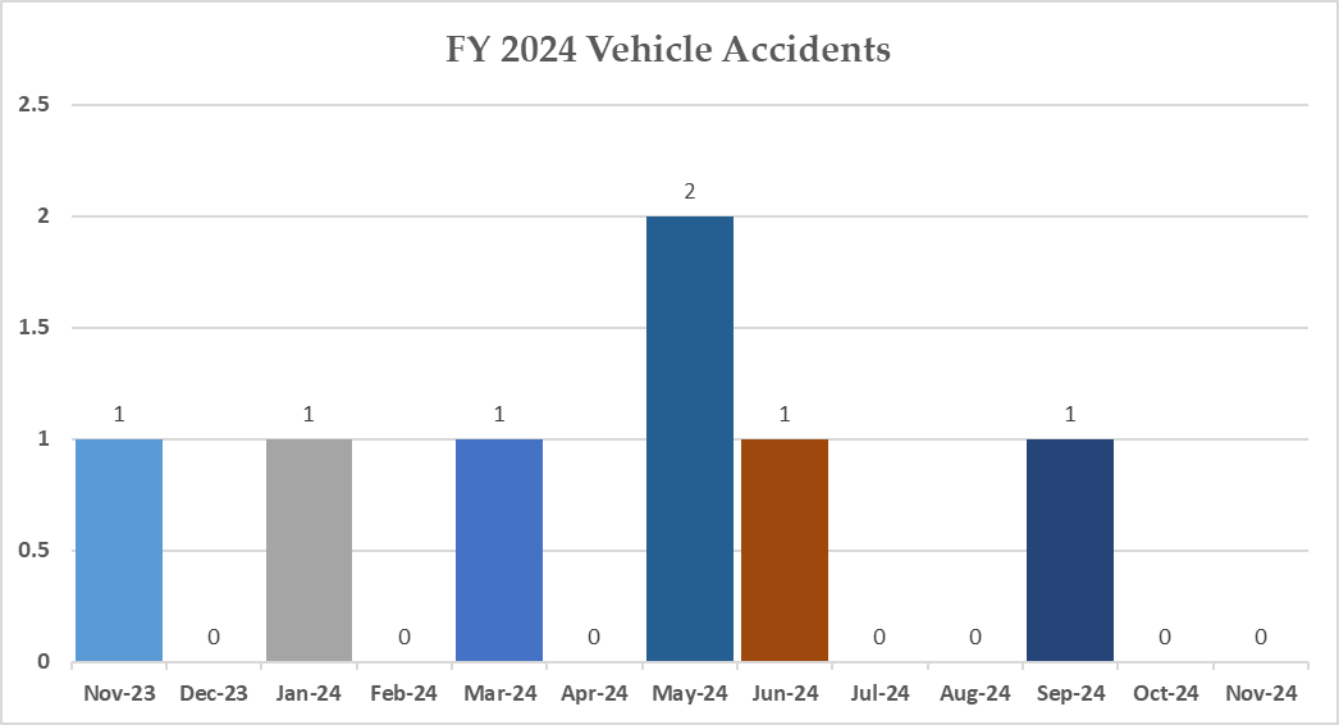
Sentinel Event Reports

Per CMHA-CEI's Sentinel Event Procedure, 1.1.14, a Sentinel Event is defined as "an unexpected occurrence to a recipient of services involving death or serious physical (loss of limb or function) or psychological injury, or the risk thereof. (Risk thereof includes any process variation that would most likely would result in a sentinel event if it reoccurred). All sentinel events are reviewed at CIRC monthly. If the event is determined to be sentinel, and in-depth review of the consumer's chart is conducted to help determine cause and steps to reduce reoccurrence in the future. Sentinel events are reported to MSHN and MDHHS when required.

Sentinel Event Type – FY 2024	Total
Death	**16**
Suicide	7
Overdose	6
Choking	2
Homicide	1

Staff Injuries/Vehicle Accidents

Ensuring safe driving and proper vehicle maintenance is essential when CMHA-CEI employees are operating CHMA-CEI owned vehicles. Drivers of CMHA-CEI vehicles must meet all driver license requirements as established by Michigan law, Procedure 2.2.5 Driving Records, and comply with CMHA-CEI's vehicle insurance carrier. All vehicle accidents are reported to the Safety Director and Safety Committee who then reviews all accident reports and makes determinations and recommendations based on the review.



Grievances, Appeals, and Fair Hearings

When a consumer/guardian has a complaint, they can file a grievance through the QCSRR office. Staff then work with representatives of the CMHA-CEI Program in question, respond to the grievance, send an acknowledgement letter within three days of the receipt of the grievance and then a disposition letter with the determination of the resolution of the grievance within 90 days. Consumers can file a local appeal or an Administrative Fair Hearing (if they are a Medicaid Beneficiary) and have been denied a requested service(s) or have had their current service(s) delayed, reduced, suspended or terminated.

	Total in FY22	Total in FY23
# of Grievances	16	13
# of Appeals	7	8
# of Fair Hearings	0	2

Provider Monitoring

Overview

CMHA-CEI has three quality advisors who conduct site visits for contract sites for the following contract types:

- Applied Behavior Analysis/Autism provider
- Hospitals/Partial Hospital
- Fiscal Intermediary
- Community Living Support (CLS)/Respite/Nursing
- Residential type A & B
- Pre-Vocational Training/Skill Building
- CMH-CEI-Residential and Non Residential

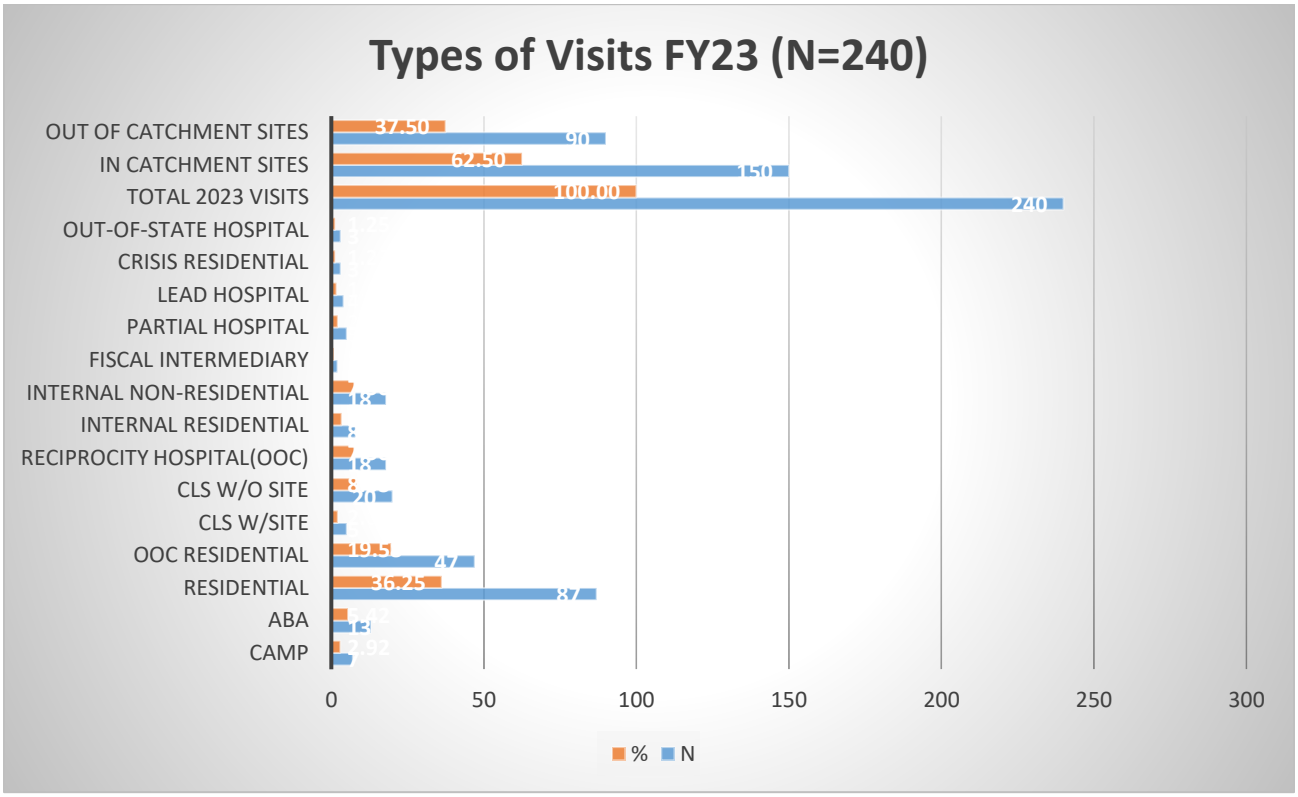
Quality advisors conduct three types of site visits annually, a recipient rights review, a quality and compliance review, and a home and community based review, if necessary. Items reviewed during the site visits include:

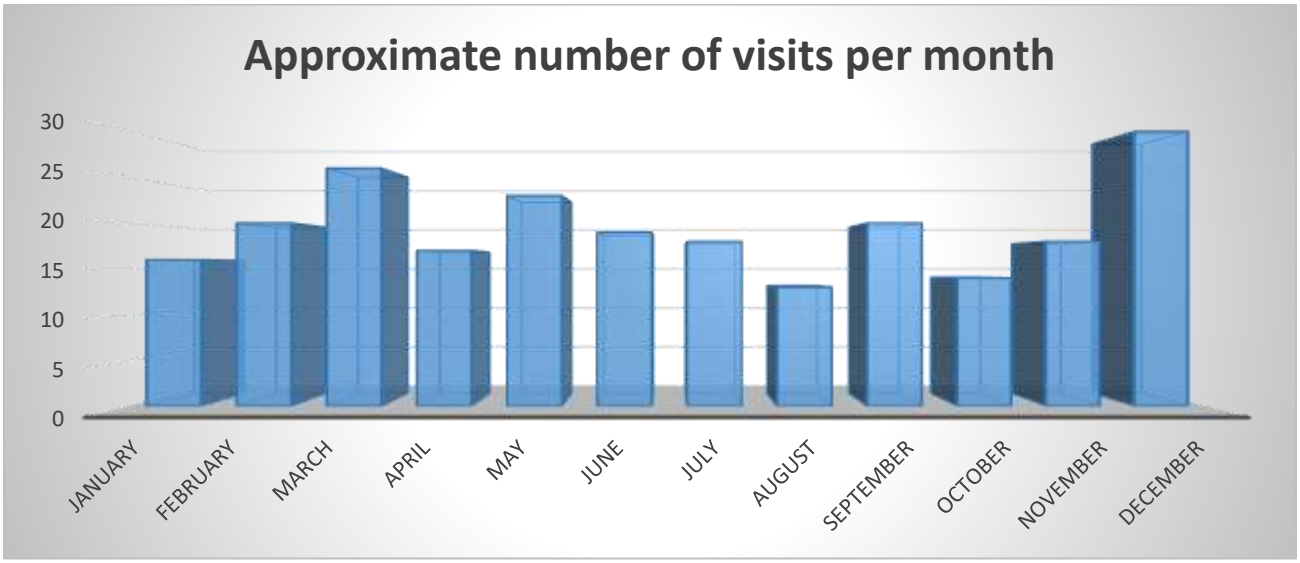
- Recipient Rights training dates for all staff (initial and annual)
- CMHA-CEI required staff training
- Background checks
- Person Centered Plan training and implementation
- Community inclusion documentation
- Documentation related to restrictions (if applicable)
- Medicaid Event Verification – documentation of billed services
- Tour of the site/facility for health or safety concerns

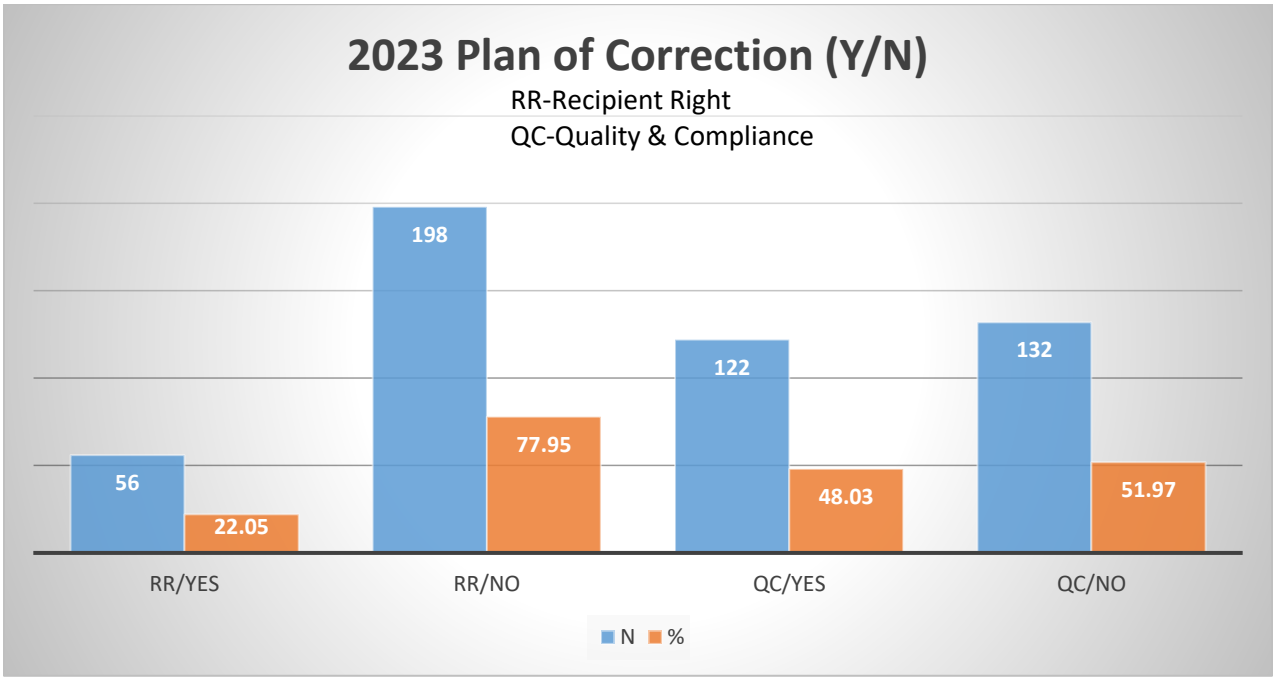
Full, in-person, site reviews resumed in FY23 for all in-catchment sites. An option for virtual reviews was available for out-of-catchment sites, and where a positive COVID-19 case was identified at the home. Quality Advisors continued to assist providers in navigating COVID-19 protocol, reporting requirements, and other burdens providers experienced.

Site Visit Overview

- 240 Site reviews were conducted in FY23
- Overall completion rate (from initial visit date to full compliance) was an average of 52 days, which was approximately similar to FY22 (50 days) and improvement from for FY21 (57 days).
    - Approximately 48% of sites reviews required a Plan of Correction (POC) for Quality and Compliance (QC), and only 22% required a Recipient Rights (RR) portion of the review in FY23.
    - More site visits were conducted in march (N=26) and December (N=30). Refer to the graph below for more site information data.


Types of Visits FY23 (N=240)
OUT OF CATCHMENT SITES
IN CATCHMENT SITES
TOTAL 2023 VISITS
OUT-OF-STATE HOSPITAL
CRISIS RESIDENTIAL
LEAD HOSPITAL
PARTIAL HOSPITAL
FISCAL INTERMEDIARY
INTERNAL NON-RESIDENTIAL
INTERNAL RESIDENTIAL
RECIPROCITY HOSPITAL(OOC)
CLS W/O SITE
CLS W/SITE
OOC RESIDENTIAL
RESIDENTIAL
ABA
CAMP
37.50
90
62.50
150
100.00
240
19.51
47
36.25
87
0
50
100
150
200
250
300
% N


Approximate number of visits per month
30
25
20
15
10
5
0
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER



Improvement Opportunities

Our vision is to facilitate ongoing collaboration by providing support, advocacy and education to contracted service providers. Quality advisors along with Contract & Finance Dept. and Clinical programs continue to assist providers in the following areas in the coming year:

- Improved online training system (i.e., CMHA-CEI online system, Improving MI Practices system, and other platforms)
- Collaborate with other CMHs to improve review process for out of catchment sites (i.e., reciprocity process)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Continue to revise site visit process and documentation to improve efficiency
- Collect, review and assess site visit data on a regular basis to make informed choices and target areas for improvement.

Improved communication with clinical programs and providers on training needs for direct care staff, specific to supplemental plans such as BTPs, nutrition plans, etc.

FY24 Chart Review Results

Chart Review Process

Chart reviews are completed on a quarterly basis by the Quality Improvement and Utilization Management team. Specific programs/units to be chart reviewed are selected through the Quality Improvement and Compliance Committee and by Program request. A random sample of consumer charts are selected for the Clinical Program that is being reviewed, including charts for consumers that have been discharged from services.

Reviews will be completed at least quarterly and will address:

a) Quality of service delivery as evidenced by the record of the consumer;
b) Appropriateness of services;
c) Patterns of services utilization; and
d) Model fidelity, when an evidence-based practice is identified.

QCSRR compiles the aggregate data and forwards the results to the Clinical Programs. QI schedules a meeting with the clinical program to review results, determine areas of improvement, and develop a plan to address the issues identified, if needed. The clinical record review results are discussed quarterly at the Quality Improvement and Compliance Committee.

Chart Review Schedule

Timeframe is when the actual chart reviews were completed, Reviews include documentation from the previous 12 months prior to the review quarter.

Timeframe	Programs for Chart Review
FY24 1st Quarter	ITRS
FY24 2nd Quarter	AMHS & CSDD - 1915i
FY24 3rd Quarter	FF
FY24 4th Quarter	CSDD

Chart Review Results

Aggregate Chart Review Standard Ratings	
Completely Met	100% Compliance
Substantially Met	85-99% Compliance
Partially Met	70-84% Compliance
Not Met	69% and Below

FY24 Quarter 1 – ITRS										
Standard	House of Commons		The Recovery Center		Corrections and Treatment Services		ITRS Outpatient		Total ITRS	
	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%
Is Client Info (Admin) section on sexual orientation completed? Or is info in another spot?	26	56%	27	37%	25	92%	26	88%	104	68%
Intake/Assessment										
At point of initial contact, provider collected the following: • Date of initial contact, Signature of Staff Person Collecting Information, Follow-up Communication(s) • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination	26	96%	27	94%	25	94%	26	96%	104	95%
In addition to required screening information captured in REMI, there is evidence of screening for: • HIV/AIDS, STD/Is, TB, Hepatitis • Trauma	26	73%	27	81%	25	84%	26	88%	104	82%
Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment • Advanced Directives • Member Handbook • SUD Recipient Rights	26	96%	27	87%	25	96%	26	92%	104	93%
Consumer strengths are documented. Examples of strengths might be a health support network, stable housing, a willingness to participate in counseling, etc.	26	90%	27	89%	25	98%	26	96%	104	93%

FASD - The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral: When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother, the client will be referred to the primary care physician for further assessment. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation.	14	100%	15	93%	16	100%	18	94%	63	97%
Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care • MDOC referred individuals provided assessment regardless of screening documentation .	26	88%	27	91%	25	94%	26	85%	104	89%
Screening completed for Gambling Disorder in REMI. If screen was positive, the 10-question assessment was completed.	22	14%	19	11%	20	53%	20	93%	81	42%
Individual Treatment/Recovery Planning and Documentation										
Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 3rd session • Residential – within 72-hours of admission • Detoxification – within 72-hours of admission	26	94%	24	75%	25	100%	26	88%	101	90%
Is there evidence of strength-based treatment and recovery planning	26	94%	25	68%	25	96%	24	85%	100	86%
Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness	26	90%	23	65%	25	92%	24	85%	98	84%

• Co-Occurring D/O • History/Risk/Present Trauma • Gambling										
Plan includes the following: 1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan. 2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients. 3. Measurable objectives – The ability to determine if and when an objective will be completed. 4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan. 5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature. 7. Recovery planning activities are taking place during the treatment episode	26	81%	25	52%	25	82%	24	71%	100	72%
Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. • Outpatient – minimal 90-day • Residential/Withdrawal Management – 7-day	22	59%	14	50%	17	88%	17	82%	70	70%
The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive	5	70%	8	75%	4	100%	14	93%	31	85%

services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.										
The treatment and recovery plan progress review to check for: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	25	86%	18	50%	16	91%	16	75%	75	76%
Case management services shall be guided by each client's individualized treatment plan. Treatment plan review(s) will incorporate case management goals and outcomes with targeted completion dates that are consistent with the treatment plan and are reflected and/or modified in treatment plan review(s).	18	89%	13	81%	20	88%	12	88%	63	87%
Record Documentation & Progress Notes										
An evidence-based practice was used and documented in the record for trauma.	25	24%	23	54%	23	100%	25	92%	96	67%
Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals.	26	88%	23	78%	22	91%	17	85%	88	86%
An evidence-based practice was used and documented in the record.	23	48%	23	50%	20	80%	22	86%	88	65%
Services are provided as specified in the plan(s).	26	77%	21	62%	22	80%	19	58%	88	70%
Coordination of Care										
There is evidence of primary care physician coordination of care efforts.	20	80%	24	79%	22	59%	22	52%	88	68%
There is evidence of coordination of care with external entities including, but not limited to, legal system, child	21	90%	17	85%	17	85%	16	81%	71	86%

welfare system, and behavioral healthcare system. • MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent										
There is evidence of effective coordination of care for any consumer currently or previously enrolled with external SUD provider and coordinating care efforts align with best practice guidelines.	16	88%	12	92%	11	91%	15	83%	54	88%
There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	24	85%	24	90%	15	90%	20	75%	83	85%
Discharge/Continuity of Care										
Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc.	23	72%	25	66%	15	87%	13	81%	76	74%
MDOC referred individuals have evidence of the following (with appropriate release): • Provider will ensure a recovery plan is completed and sent to the supervising agent within five (5) business days of discharge- plan must include individual's knowledge of plan and any aftercare services • Provider will ensure documentation of informing the client's supervising agent prior to any discharge due to violation of program rules/regulations except in extreme circumstances. Provider will collaborate with the supervising agent for any non-emergency discharge of the referred individual and allow the MDOC time to develop a transportation plan and/or a supervision plan prior to removal.	1	0%	N/A	N/A	2	50%	2	0%	5	20%
Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	25	86%	26	83%	17	100%	17	79%	85	86%
Residential										

Residential detoxification At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. Residential The recipient record for residential service categories shall also include medical history and physical examination	8	81%	22	84%	2	0%	3	50%	35	76%
Residential Treatment PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission	18	100%	19	100%	2	50%	3	17%	42	92%
Chart reflects services provided in accordance with the ASAM LOC Determination. • 3.1 = 5 hours Core Services & 5 hours Life Skills/week • 3.3= 13 hours Core Services & 13 hours Life Skills/week • 3.5 & 3.7 = 20 hours Core Services & 20 hours Life Skills/week	18	92%	16	84%	4	75%	7	86%	45	87%
MDOC Referred Individuals ONLY (with proper release): • Individual referred does not appear or is deemed to not meet residential medical necessity the provider will notify the supervising agent within one (1) business day • Referred individual may not be given unsupervised day passes, furloughs, etc without consultation with the supervising agent. • Leaves for any non-emergent medical procedures should be reviewed/coordinated with the supervising agent • If a MDOC referred individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the supervising agent by the day on which the event occurred. • The PIHP/designated provider may require individuals participating in residential treatment to submit to drug	1	100%	N/A	N/A	N/A		N/A	N/A	1	100%

testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent.										
MDOC-Additional reporting notifications for individuals receiving residential care include: • Death of an individual under supervision. • Relocation of an individual's placement for more than 24 hours. • The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves. • The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.	1	100%	N/A	N/A	N/A		N/A	N/A	1	0%
Medication Assisted Treatment										
Documentation that a medical evaluation, including a medical history and physical examination, has been performed before the patient receives the initial methadone or Suboxone dose. (However, in an emergency situation the initial dose of methadone may be given before the physical examination).	2	50%	1	100%	N/A		N/A	N/A	3	67%
Documented random toxicology testing. SUBOXONE ONLY: toxicology screens must be done at intake and then randomly, at least weekly, until 3 consecutive screens are negative. Methadone ONLY: consumer screened weekly. Monthly only occurs after 6-months of consecutive negative screens. Any positive screen results in new 6-month cycle of weekly screens.	2	50%	2	50%	N/A		N/A	N/A	4	50%

Copies of the prescription label, pharmacy receipt, or pharmacy print out, must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.	3	67%	N/A	N/A	N/A		N/A	N/A	3	0%
Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, a prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	3	0%	N/A	N/A	N/A		N/A	N/A	3	0%
Documentation that there is coordination of care with prescribing physician when there are prescriptions for controlled substances.	2	50%	N/A	N/A	N/A		N/A	N/A	2	0%
All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	2	50%	N/A	N/A	N/A		1	100%	3	67%
Women's Designated										
There is an assessment of needs completed on consumer & each dependent child.	N/A	N/A	2	0%	N/A		N/A	N/A	2	0%
There is evidence of gender-specific service provision(s): 1. Accessibility 2. Assessment 3. Psychological Development 4. Abuse/Violence/Trauma 5. Family Orientation 6. Mental Health Issues 7. Physical Health Issues 8. Legal Issues 9. Sexuality/Intimacy/Exploitation 10. Survival Skills 11. Continuing Care/Recovery Support	2	100%	6	67%	3	67%	4	100%	15	80%
Recovery Housing										
Resident chart includes the following information: • Standard demographic information	8	100%	13	100%	11	100%	12	100%	44	100%

• Releases of Information (MSHN, Medical, Treatment Provider, Emergency Contact) • Signed Acknowledgement of Rules						

FY24 Quarter 2 – AMHS and CSDD - 1915i						
Standard	Total = All		AMHS		CSDD	
	Total Charts	%	Total Charts	%	Total Charts	%
A.5.3 If an enrollee receives Environmental Modifications or Equipment, the PIHP/CMHSP has implemented prior authorizations in accordance with their process.	4	100%	0	N/A	4	100%
E.2.A Evaluations were completed where applicants met the eligibility criteria for 1915(i) State plan HCBS benefit. (SPA 3.1-i.2)	91	87%	51	93%	40	80%
E.2.B The record reviewed reflected evidence that the instruments and tools were appropriately applied to determine eligibility of 1915(i) services	91	90%	51	95%		84%
E.2.C Re-evaluation for eligibility was within 365 days of the last eligibility determination.	90	60%	50	62%	40	65%
P.1.A.1 IPOS had adequate strategies to address their assessed health and safety needs, including coordination with primary care provider. (SPA 3.1-i.2)	91	80%	51	78%	40	81%
P.1.A.2 Individual Plans of Service (IPOS) addresses the assessed needs of a beneficiary.	91	96%	51	97%	40	95%

P.1.A.3 The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and independent facilitation. 3. use of PCP process in developing IPOS	91	78%	51	72%	40	86%
P.1.B.1 IPOS was updated within 365 days of their last plan of service. (SPA 3.1-i.2)	89	76%	49	72%	40	80%
P.1.B.2 Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS.	91	56%	51	52%	40	61%
If physical health is indicated on needs list in assessment and/or if there is a goal related to physical health in the treatment plan, the healthcare integration/physical health goal box is checked	87	58%	48	63%	39	53%
P.1.B.3 Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing	91	57%	51	54%	40	61%
B.1.The BTPRC process includes all the following elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR; 2. Evaluation of committees' effectiveness occurs as specified in the TR; 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of intrusive/restrictive techniques by each individual receiving the intervention; 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques; 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis;	2	100%	0	N/A	2	100%

6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or hospitalization and death are reported to the Department via the event reporting system; 7. Documentation that there is a mechanism for expedited review of proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.						
B.2. Behavior treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans which include restrictive/intrusive interventions include a functional behavior assessment and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if there is a recommendation for the the use of aversive techniques, physical management, or seclusion or restraint in the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.	2	100%	0	N/A	2	100%
G.2 Individual served received health care appraisal. (Date/document confirming_____)	91	73%	51	88%	40	53%

FY24 Quarter 3 – Families Forward										
Standard	Families Forward		IOP		Home Based		Urgent Care		Early Intervention	
	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	126	79%	51	62%	67	83%	10	100%	23	80%
Are consumer's needs & wants are documented?	123	91%	51	79%	64	91%	10	100%	23	98%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	124	98%	51	82%	65	100%	10	100%	23	100%
Substance use (current and history) included in assessment?	120	85%	50	76%	62	90%	10	100%	20	85%
Current physical health conditions are identified?	124	95%	51	79%	65	98%	10	100%	23	96%
Current health care providers are identified?	122	82%	50	71%	64	80%	10	85%	23	74%
Previous behavioral health treatment and response to treatment identified?	116	90%	48	69%	60	95%	10	100%	19	92%

Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	123	81%	50	59%	65	85%	10	100%	23	91%
Did crisis screening and other life domain needs screening occur?	123	96%	50	78%	65	98%	10	95%	23	98%
Was consumer offered the opportunity to develop a Crisis Plan?	123	97%	50	81%	65	99%	10	100%	23	100%
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	123	80%	50	66%	65	89%	10	80%	23	91%
If they are in the SEDW, has the CAFAS/PECFAS been completed quarterly	101	78%	43	29%	51	81%	7	100%	15	73%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	122	90%	50	84%	64	92%	10	95%	23	100%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	123	91%	50	94%	65	92%	10	100%	23	89%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	123	62%	50	69%	65	67%	10	60%	23	72%

The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	123	92%	50	69%	65	97%	10	85%	23	96%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	123	81%	50	63%	65	85%	10	80%	23	93%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	123	76%	50	53%	65	72%	10	100%	23	78%
A timeline for review. (Are reviews occuring at least every 6 months?)	123	50%	50	47%	65	51%	10	30%	23	54%
If applicable, the IPOS addresses health and safety issues.	116	76%	48	88%	60	76%	10	85%	21	74%
If applicable, identified history of trauma is effectively addressed as part of PCP.	116	75%	45	85%	63	68%	10	80%	22	70%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	123	57%	50	38%	65	62%	10	80%	23	78%
Are services being delivered consistent with plan in terms of scope, amount and duration? Q3: Review services that occurred during January-March 2024	119	57%	48	38%	64	63%	9	56%	23	65%
Monitoring and data collection on goals is occurring according to time frames established in plan?	119	61%	48	44%	64	63%	9	61%	23	70%
Are periodic reviews occurring according to time frames established in plan?	118	41%	48	22%	64	45%	8	44%	23	46%
NEW: Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services?	124	88%	51	71%	65	95%	10	85%	23	96%

For medication services, informed consent was obtained for all psychotropic medications?	49	89%	15	58%	26	96%	8	75%	6	100%
Is there evidence of outreach activities following missed appointments?	105	75%	47	63%	55	83%	5	70%	18	81%
Is there evidence of coordination with Primary Care Physician in the record?	123	73%	50	59%	65	79%	10	100%	23	98%
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	124	72%	51	71%	65	71%	10	95%	23	76%

FY24 Quarter 4 - CSDD				
Standard	Life Consultation		FSP Case Management	
	Total Charts	%	Total Charts	%
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	81	78%	49	86%
Are consumer's needs & wants are documented?	82	99%	52	99%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	82	99%	52	98%
Substance use (current and history) included in assessment?	79	97%	39	71%
Current physical health conditions are identified?	81	99%	50	100%

Current health care providers are identified?	82	91%	52	91%
Previous behavioral health treatment and response to treatment identified?	81	96%	46	95%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	82	70%	52	86%
Did crisis screening and other life domain needs screening occur?	82	98%	52	100%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	80	100%	51	100%
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	82	89%	52	67%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	77	98%	41	80%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	82	98%	51	91%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	82	31%	51	59%

The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. **Make note if there are any ranges used for services and give a 1** (MDHHS cited for med clinic, psychology, CLS)	82	53%	51	79%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	82	90%	51	83%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	82	85%	51	82%
A timeline for review. (Are reviews occuring at least every 6 months?)	80	98%	48	96%
If applicable, the IPOS addresses health and safety issues.	77	93%	44	84%
If applicable, identified history of trauma is effectively addressed as part of PCP.	31	48%	30	80%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	82	62%	51	63%
Are services being delivered consistent with plan in terms of scope, amount and duration? Q4: Review services that occurred during April - June 2024	82	68%	51	59%
Monitoring and data collection on goals is occurring according to time frames established in plan?	82	77%	50	94%
Are periodic reviews occurring according to time frames established in plan?	75	72%	44	86%

NEW: Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services? Ex: If a consumer was authorized to receive Respite services starting February 1st, but no services actually occurred until March 1st, is there an ABDN to explain the delay, or is there a contact note/service note showing that the family chose to delay the start of the service?	73	95%	51	93%
For medication services, informed consent was obtained for all psychotropic medications?	37	54%	12	79%
Is there evidence of outreach activities following missed appointments?	37	81%	25	86%
Is there evidence of coordination with Primary Care Physician in the record?	82	57%	51	73%
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	82	66%	52	57%

MDHHS Audit

Every two years, MDHHS audits the following waiver programs: SEDW, CWP, HSW, and (i)SPA/1915i. Quality Improvement staff work with the clinical departments to meet the standards MDHHS has set for these programs.

In 2024, CMHA-CEI underwent a full site review by MDHHS for SEDW, CWP, HSW, and iSPA/1915i. The site review was conducted for the full MSHN region and included all 12 CMHSPs in the region. The review was completed virtually. For CMHA-CEI, 8 SEDW, 7 CWP, 9 HSW charts, and 14 (i)SPA/1915i charts were reviewed by MDHHS. Areas reviewed were case files, provider qualifications, and administrative processes related to health and welfare. Below are the findings and remedial action plans accepted by MDHHS.

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
A. ADMINISTRATIVE PROCEDURES				
A.3.3 Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)	22	1	REPEAT CITATION **CEI** **WSA #1890334** – H2021 billed, should be H2022 when SEDW.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that, claims are coded in accordance with MDHHS policies and procedures. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**: ☒ **Individual Remediation:** • By 10/31/2024 Claims coded incorrectly for WSA#1890334 will be corrected, and the plan amended, to reflect the correct services that are medically necessary. ☒ **Systemic Remediation:** • By 10/31/2024 WA staff training will occur around the correct coding of supports/services deemed medically necessary for a recipient. **MDHHS Response**: ☐ **Response accepted**

				☒ **Response not accepted. –** **__No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ **Other:** **For MSHN** (**for each performance measure cited, throughout this document)**, please provide additional information on your Delegated Managed Care/DMC Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the

				MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **MDHHS 2nd Response: Response Accepted**
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.3 SEDW				
P.3.4 IPOS for enrolled consumers is developed in accordance with policies	8	15	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure

and procedures established by MDHHS. Evidence: 1. IPOS contains meaningful and measurable goals and objectives. 2. Prior authorization of services corresponds to services identified in the IPOS. (PM-D-4)			**Bay Arenac Behavioral Health**	that the IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. **BABHA RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration).

			WSA #1857331 - Respite hours were identified but duration was not determined in the IPOS. **WSA #2163474** - No second SED Waiver service, CLS: Not in IPOS, Respite discussed on 2/21/2024 – no discussion since. Not in IPOS. **CEI** **WSA #1838025** – No safety/crisis plan developed at initial Wraparound meeting. Mission statement must be decided with	☒ Other: (See response below) WSA# 1857331 and WSA# 2163474: Unable to have individual remediation as both consumers have been closed out of SEDW services. **☒ Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted on developing measurable goals/ securing prior authorizations. ☒ Other: (See response below) WSA# 1857331: By 12/15/24, staff training will be completed to remind staff that consumers on SEDW services need a second SEDW service per month. Education will also be completed to remind staff that the duration of services need to be included in the IPOS. WSA# 2163474: By 12/15/24, staff training will be completed to remind staff that consumers on SEDW services need a second SEDW service per month. **CEI RESPONSE** **☒Individual Remediation:** ☐ By (Date) _____ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☐ Other: (See response below) • **WSA #1838025** – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process, including the development of a crisis/safety plan during the first meeting and completing the Mission Statement. This team training will be completed by 11/1/24. • **WSA #1890334** – CEI Clinical team will review the goals and objectives of the current plan and complete an IPOS addendum by 11/1/2024 to ensure goals/objectives are measurable and the Wraparound plan includes all required components, including the Mission Statement. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. Wraparound team will attend a staff training on SEDW

			Child and Family Team and documented. **WSA #1890334** – IPOS goals not measurable (repeat citation); Wraparound plan needs Mission statement that is with Child and Family Team and documented. **WSA #1925206** - IPOS goals not measurable (repeat citation). **WSA #1938080** – Wrap plan did not include a mission statement decided with family, no outcomes were established in plan, and needs were not addressed with wraparound for youth and family. **WSA #2160367** – Strengths and needs of the youth and family were not identified. Mission statement was not decided by family and documented.	fidelity and the required pieces of the wraparound process. This team training will be completed by 11/1/24. • **WSA #1925206** –This consumer was discharged from services in February 2024. Staff training regarding components of measurable objectives will occur in unit meetings and at an all-staff meeting; trainings will be completed by 12/1/24 • **WSA #1938080**: – CEI Clinical team will review the goals and objectives of the current plan and complete an IPOS addendum by 11/1/2024 to ensure goals/objectives are measurable. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. Wraparound team will attend a staff training on SEDW fidelity and the required pieces of the wraparound process. This team training will be completed by 11/1/24. • **WSA #2160367** – By 11/1/24 an IPOS addendum will be completed to ensure that family strengths are reflected in the IPOS. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. **☒ Systemic Remediation:** • CEI will review training materials related to person centered planning, components of measurable objectives, and SEDW requirements in unit meetings and an all-staff meeting. These trainings will be completed by December 1, 2024. • Supervisors of ancillary services will review service referrals and if goals/objectives are not measurable, they will give feedback immediately to clinicians. • Quarterly chart reviews will be completed of SEDW records and will include a review of IPOS goals/objectives to ensure they are measurable, to review enhanced waiver services offered and/or provided to waiver participants, and identify participants are receiving at least one waiver service per month outside of Wraparound. **CENTRAL MICHIGAN CMH RESPONSE** **☒ Individual Remediation:**

				Case Holder will review services, authorization usage, and make changes to the plan of service by completing an addendum by 12/1/2024. ☒ **Systemic Remediation:** Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS. **LIFEWAYS RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☒ Other: (See response below) 1251346: Consumer Disenrolled in Waiver 1926014: Consumer Closed from Services ☒ **Systemic Remediation:** ☒ By (Date) _____11/15/2024_____, staff training will be conducted on developing measurable goals/ securing prior authorizations. ☐ Other: (See response below)
			Central Michigan CMH **WSA #1652452** – IPOS uses ranges for services. **WSA #2204299** - IPOS uses ranges for services. No	**MONTCALM RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☒X Other: (See response below)

			safety/crisis plan developed at initial Wraparound meeting. **<u>LifeWays</u>** **WSA #1251346** – Wraparound did not recertify the youth on time, 1.5 months late. **WSA #1926021** – Services were not provided as requested per family, home based requested and outpatient provided. No second SED Waiver service provided. **<u>Montcalm</u>** **WSA #1539550** – IPOS/Wrap plan goals/outcomes include ranges for services.	Case is closed and cannot be corrected. ☒ **Systemic Remediation:** ☐ By (Date) ____________, staff training will be conducted on developing measurable goals/ securing prior authorizations. ☒X Other: (See response below) *See MSHN response noted above* **SAGINAW COUNTY CMHA RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) __________ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) __________ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☒ Other: (See response below) WSA# 1609528 is no longer assigned to the Wraparound program. He has been assigned to SCCMHA Supports Coordination. Case Holder for this team has made attempts to contact this person/served to schedule initial appointment to complete new IPOS. This will be completed by 10/31/24. ☒ **Systemic Remediation:** ☒ By (Date) 10/31/24, staff training will be conducted on developing measurable goals/ securing prior authorizations. ☐ Other: (See response below) **THE RIGHT DOOR RESPONSE** ☒ **Individual Remediation:** ☒ By 10/1/24 For WSA 2149761 - a PCP was completed on 8/1/2024 that aligned with the feedback given by the state that meets this remediation requirement. For WSA 2155980 the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes by 10/1/2024. ☒ By 10/1/2024 the plan will be amended to resolve the need

			<u>Saginaw County CMHA</u> **WSA #1609528** - IPOS and Wraparound plan does not meet the requirements that are required for both plans.	to align recommended services with prior authorizations (in the same amount/ scope/ duration) for WSA 214976 and WSA 2155980 ☐ Other: (See response below) ☒ **Systemic Remediation:** ☒ By (Date) _8/2/204_____, staff training will be conducted on developing measurable goals/ securing prior authorizations. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. –** __**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **MSHN:** Insufficient systemic remediation for the use of ranges (rather than reflecting specific amount/scope/duration/frequency/ASDF of services, as required, within the Plans of Service). MSHN appears to be conveying intent to not remediate those plans that reflect ranges. Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **<u>CEI:</u>**

			<u>The Right Door</u> **WSA #2149761** - IPOS goals/outcomes are not measurable. No second SED Waiver service per month. **WSA #2155980** - IPOS goals/outcomes are not measurable. No second SED Waiver service per month. (Closed SEDW)	**WSA #1838025: No individual remediation found (only a remediation that appears systemic). Please add.** **WSA #1938080 Individual remediation does not match that of the citation.** **TA: WSA#s 1890334,1938080, 2160367: Individual remediations accepted with expectation of documented involvement of the youth/families in the discussion/amending process.** **<u>Central Michigan CMH :</u>** **WSA #1652452 & 2204299:** Lack both Individual and Systemic remediation for the requirement to reflect specific Amount/Scope/Duration/Frequency (ASDF) of services within the Plan. Please revise/provide. **<u>Montcalm</u>** **WSA #1539550 Systemic remediation does not address specific Amount/Scope/Duration/Frequency (ASDF) of services required within Plans of Service. Please provide.** **<u>TRD</u>** **WSA #2155980** **Individual and systemic remediation does not address the need for a 2nd SED Waiver service, per month, within the Plan of Service. Please revise.** **PIHP/CMHSP 2nd Response:** **MSHN** MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R.

				330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS

				Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024 and is no longer enrolled in wraparound services.
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.6. SEDW				
P.6.1 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM D-7)	4	19	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring services and supports are provided as specified in the IPOS including type, amount, scope, duration, and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN**

			CEI **WSA #1627715** – Wraparound not provided per fidelity of the model. Home-Based therapy not provided per IPOS. TA: No second SED Waiver service. **WSA #1823599** – Wraparound not provided per fidelity of the model. **~~WSA #1838025~~** – Wraparound not provided per fidelity of the model. Home-Based therapy not provided per IPOS. Adjust IPOS if services are not provided as written (Substance use treatment). **WSA #1890334** – Wraparound not provided per fidelity of the model. No second SED Waiver service. Home-Based therapy not provided per IPOS.	MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** **☒ Individual Remediation:** **WSA #1627715** – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1627715, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. **WSA #1823599** – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. **WSA #1838025 -** Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1838025, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided, and identify that the consumer is receiving at least one additional wavier service outside of WA. **WSA #1890334** - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1890334, and will include a review of enhanced waiver services offered and/or provided, and identify participants are receiving at least one waiver service per month outside of Wraparound. **WSA #1925206** - Individual remediation is unable to occur as this consumer was discharged from services in February 2024. Systemic Remediation to address. **WSA #1938080** - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews

			~~WSA #1925206~~ - Wraparound not provided per fidelity of the model. CLS, PSP, Psychotherapy, and Home-Based therapy not provided per IPOS. (Closed SEDW) **~~WSA #1938080~~** – Wraparound not provided per fidelity of the model. CLS not provided per IPOS. **WSA #2160367** – Wraparound not provided per fidelity of the model. Psychotherapy and respite were not provided per IPOS. No second SEDW service provided. **WSA #2193441** - Wraparound not provided per fidelity of the model. CLS, therapy, and PSP not provided per IPOS. No second SEDW service provided.	will be completed of SEDW records, including #1938080, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. **WSA #2160367** - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1838025, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided, and identify that the consumer is receiving at least one additional service outside of Wraparound. **WSA #2193441 -** Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #2193441, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided and identify that the consumer is receiving at least one additional service outside Wraparound. ☒ **Systemic Remediation:** CEI will review training materials related to person centered planning, service delivery, and SEDW requirements in unit meetings and an all-staff meeting. These trainings will be completed by December 1, 2024. Ongoing training and reminders about the importance of delivering services as authorized are provided at program staff meetings and department staff meetings, along with the reminder of documenting when services are not delivered as authorized including treatment plan addendums to change the plan of service as needed. Quarterly chart reviews will be completed of SEDW records and will include a review of services delivered as authorized, enhanced waiver

				services offered and/or provided to waiver participants, and identify participants are receiving at least one waiver service **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **No individual remediation found.** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI** **WSA#s 1627715, 1823599, ~~1838025~~, 1890334, ~~1938080~~, 2160367, 2193441:** Remediation is systemic only. Individual remediation lacks documenting for disparity between recommended and provided services, and steps to resolve that disparity. ***Also, what will be done regarding the need to provide Wraparound services per fidelity to the model, as well as a second service, for those records cited for lacking this?*** Will these plans be amended to align Wraparound to the model, or to document if/when the family is declining those levels of recommended supports, as well as the level of supports they are willing to receive? Please revise. ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below)

				PIHP/CMHSP 2nd Response: **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual.

				MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024 and is no longer enrolled in wraparound services. WSA #1627715:By 12/31/24, the clinical team will review and if necessary, amend the IPOS to align Wraparound to the model and to reflect current home-based needs. The clinical team will ensure that services are provided as authorized and documented when scheduled services are cancelled. The clinical team will document the rationale for any reduction in services, steps taken to address barriers, and reflect a discussion about the intensity of services provided through SEDW. If there are disparities between recommended services and what is provided, clinical staff will document services offered, when the family is declining the recommended supports, and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that

				consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #1823599: This consumer/family is no longer enrolled in Wraparound Services and transitioned out in September 2024. WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1890334: By 12/31/24, the clinical team will review and if necessary, amend the IPOS to align Wraparound to the model and to reflect current home-based needs. The clinical team will ensure that services are provided as authorized and documented when scheduled services are cancelled. The clinical team will document the rationale for any reduction in services, steps taken to address barriers, and reflect a discussion about the intensity of services provided through SEDW. If there are disparities between recommended services and what is provided, clinical staff will document services offered, when the family is declining the recommended supports, and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024.

				WSA #2160367: By 12/31/24, the clinical team will review and if necessary, amend the IPOS to accurately reflect services. If there are disparities between recommended services and what is provided, clinical staff will document rationale in the record, including when the family is declining the recommended supports and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #2193441: This consumer's SEDW is ending October 2024 due to request from the family.
P.6.4 The IPOS was updated at least annually	16	7	REPEAT CITATION **CEI** **WSA #1627715** – IPOS reviews not completed. **WSA #1823599** - IPOS reviews not completed.	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that IPOS is updated at least annually. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**: ☒ **Individual Remediation:** ☐ By (Date) _____, for WSA #_____, the required documentation will be entered into the record. ☒ Other: (See response below) **WSA #1627715** – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date.

			WSA #1838025 – IPOS reviews not completed. **WSA #1890334** – IPOS reviews not completed. **WSA #1925206** - IPOS reviews not completed. (Closed SEDW) **WSA# 1938080** – IPOS reviews not completed. **WSA #2160367** – IPOS reviews not completed.	**WSA #1823599** - By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. **WSA #1838025** – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. **WSA #1890334** – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. **WSA #1925206** -.Consumer has discharged from services, individual remediation unable to occur. **WSA# 1938080** – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. **WSA #2160367** – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. ☒ **Systemic Remediation:** By 10/1/24, the process for completing IPOS reviews will be revised. Effective 10/1/24, IPOS reviews will be completed within the EHR's Treatment Plan Review/Addendum template, which ensures that each goal and objective are appropriately addressed, and satisfaction with supports/services are clearly documented. Training to all staff regarding this process update is ongoing to assist with the transition **MDHHS Response**: ☒ **Response accepted with evidence of the above documentation, as well as on-going training of staff, expected at the 90-day review.**
Q. STAFF QUALIFICATIONS				
Q.3 SEDW				
Q.3.1 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP prior to providing	65	3	A total of **68 Professional Staff** were reviewed under MSHN SEDW	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound

services. (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for child mental health professionals). (PM C-1)			REPEAT CITATION **CEI** *Insufficient evidence of CMHP certification prior to hire, or supervision by a CMHP upon hire, until credentialing requirements met.* **WSA# 1838025:** Cody Shields **WSA# 1938080:** Heidi Phillips ~~**WSA# 1627715:** Rudy Ruffer~~	facilitators are credentialed prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**: ☒ **Individual Remediation:** **WSA# 1838025:** For cited staff, evidence of CMHP certification prior to hire or supervision by a CMHP will be provided to MDHHS at a 90-day follow-up review. **WSA# 1938080** For cited staff, evidence of CMHP certification prior to hire or supervision by a CMHP will provided to MDHHS at a 90-day follow-up review. **WSA# 1627715:** Per communication 9/5/24, this finding has been withdrawn. **Systemic Remediation:** CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **__No individual remediation found**

				☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI:** Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective

				action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25. Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP

				status with primary source verification through staff attestation, resume, or transcripts, For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts by 1/16/25. **MDHHS 2nd Response: Response Accepted** with proofs submitted at the 90 Day Follow Up.
Q.3.3. Non-licensed/non-certified providers meet provider qualifications. Evidence: personnel records contain documentation that staff is: 1. At least 18 years of age, 2. Is in good standing with the law 3. Is free from communicable disease. Documentation staff has completed all core training requirements – e.g., recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP. (PM C-3) 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).	10	4	A total of **14 Aide Level Staff** were review under MSHN SEDW. REPEAT CITATION **CEI** *Lack of evidence of being 18 years or older.* **WSA# 1838025:** Sophie Phillips	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** **WSA#1838025,** evidence of staff being 18 or older has been obtained and will be provided to MDHHS during the 90-day follow-up review. ☒ **Systemic Remediation:** On 9/6/24, QI staff met with the clinical program and on 9/10/24 QI staff met with the HR department to review requirements related to staff credentialing.

4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.				**MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** __**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH

				plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1. CWP				
P.1.1: The IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. (PM-D-3)	10	2	REPEAT CITATION **<u>Community Mental Health Authority Clinton-Eaton-Ingham Counties (CEI)</u>:** **WSA 21162** - Pre-plan and IPOS done on the same day with no rationale found.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ WSA # _____ will be offered Self-Determination / Independent Facilitation with documentation in the record by the 90-day f/u site review. ☒ By (Date) 8/29/24 pre-planning will occur to better inform IPOS process, with the PCP meeting to occur by 10.18.24, with evidence in the record by the 90-day f/u

				site review for WSA #21162 ☐ Other: (See response below) **☒ Systemic Remediation:** ☐ By (Date) _____, staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. ☐ By (Date) _____, EMR will be adjusted to include this information as required fields in the pre-planning document. ☐ Effective (Date) _____, CM Supervision will monitor a random selection of records quarterly to monitor for this requirement. ☒ Other: (See response below) A formal training with case management team will be completed to capture pre-planning process (including purpose, timeline, etc.), with ability to highlight audit findings. Tools will be reviewed, and the importance of documentation will be captured. This will be completed by 10/31/24. Initial review of pre-planning and treatment planning timelines will be included. A follow-up review will occur 3-6 months post-training. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** __ **No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For MSHN (for each performance measure cited, throughout this document)**, please provide additional information on your Delegated Managed Care/DMC

				Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver

				programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **MDHHS 2nd Response:** **Response Accepted**
P.1.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	6	6	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS addresses all service needs reflected in the assessments. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the

			CEI: **WSA 34468** - Mom indicated several times she wanted his toileting routine to be followed at home, no goals/objectives were found in IPOS in regard to that. **WSA 21360** - Lack of sufficient clarity about TCM, and Music Therapy. **WSA 21162** - Lack of sufficient clarity about amount scope duration of CLS services being split between two separate providers. **WSA 21157** - Lack of sufficient clarity about amount scope duration of TCM.	corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) __10/31/24, amendments will be completed to address identified needs in assessments, not yet resolved in IPOS for WSA #34468, 21360, 21162 and 21157 ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. ☐ Beginning (Date) _____, monitoring by supervisory staff will be done through quarterly clinical chart reviews, for required elements of plans addressing identified needs. ☒ Other: (See response below) A formal training with case management team will be completed which will focus on the golden thread of needs identified in the assessment and the carry-over to the treatment plan. Will review how to defer an identified treatment need, as well as coordinating with community providers to have the identified need met. Training will be completed by 10/31/24 **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **__No individual remediation found**

				☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will

				continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **MDHHS 2nd Response: Response Accepted.**
P.1.3. The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers. (PM-D-2)	10	2	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care

			CEI: **WSA 21162 -** Insufficient evidence of annual health care appraisal. Document found (Questionnaire) lacked signature of author, date or clarity as to the purpose of the form.	physicians. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 10/31/24, an annual health care appraisal will be completed/reflected in the record. Case manager will complete a PCP addendum to reflect identified safety needs. This will be completed by 10/31/24. ☒ **Systemic Remediation:** ☐ By (Date) _____, additional training will be provided to the staff at large regarding the required elements of addressing health / safety, coordination of care, psychiatric evaluations, and medication consents. ☒ Other: (See response below) A formal training with case management team will be completed to review requirement of adequately addressing assessed health and safety needs within the IPOS as well as ensuring coordination of care with primary physician occurs and is documented in the chart. Training will highlight audit findings and will be completed by 10/31/24. QI will ensure the health and safety needs and coordination of care items are reviewed during CEI quarterly chart reviews and will ensure that a review of CWP consumers are completed in the next calendar year

				MDHHS Response: ☒ **Response accepted with documented evidence of the above expected at the 90-day review.**
P.1.4. The IPOS is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. plan contains measurable goals/objectives and time frames. 2. Category of Care/Intensity of Care determination was completed by staff certified or trained by MDHHS in Category of Care/Intensity of Care determination. (PM D-4)	4	8	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many

			CEI: **WSA 34468** - Range language used for TCM and Music. Lack of sufficient clarity about TCM. **WSA 21162** - Lack of sufficient clarity about TCM and CLS **WSA 21157** - Lack of sufficient clarity about TCM is being provided. **WSA 20369** - Lack of sufficient clarity about child receiving CWP services in IPOS. **WSA 21360** - Lack of sufficient clarity regarding amount and scope of TCM and music therapy.	pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. **CEI Response**: ☒ **Individual Remediation:** ☐ By (Date) _____ the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ CM staff will receive COC training/ certification. ☒ WSA #34468 plan will be amended, by 10/31/24 to include number TCM and music therapy. WSA #21162 plan will be amended by 10/31/2024 to include number of TCM and CLS. WSA #21157 plan will be amended by 10/31/24 to include number of TCM. WSA #20369 plan will be amended by 10/31/24 to include number of CWP services. WSA #21360 plan will be amended by 10/31/24 to include number of TCM and music therapy. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted on developing measurable goals ☒ Other: (See response below) Staff will receive training on Goal and Objective writing by 10/31/24. QI staff will ensure goals/objectives are measurable by CEI quarterly chart reviews and will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training.

				MDHHS Response: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **MSHN:** Insufficient systemic remediation for lack of lack of clarity, within the plans for services being recommended (i.e., for specific amount/scope/duration/frequency/ASDF of services within the Plan). MSHN appears to be conveying intent not remediate those plans that reflect ranges. Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **CEI:** For this repeat citation, insufficient individual and systemic remediation. Regarding individual remediation: Only listing amount of services (without also including clarifying scope/frequency/duration) does not sufficiently remediate. Please revise. Regarding systemic remediation, the citations (for lack of clarity around services)

				do not appear to be addressed at all, in planed trainings. Please revise. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs

				in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical

				assistance, or in some instances, 4) contract non-compliance action. **CEI** Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy. Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's

				Waiver case. All current staff with CWP cases have completed this training. **MDHHS 2nd Response: Response Not Accepted.** **MSHN:** Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **PIHP 3rd Response:**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.4. CWP				
P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM-D-7)	3	9	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that services and supports are provided as specified in the IPOS, including amount, scope, duration, and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

			CEI: **WSA 34468** - TCM not provided as specified in the IPOS. **WSA 21360** – TCM Inconsistent amount, (needs to be clearer in IPOS) **WSA 21162** - TCM Inconsistent amount, (needs to be clearer in IPOS) **WSA 21157** - TCM Inconsistent amount, (needs to be clearer in IPOS) **WSA 20693** TCM not provided as specified in the IPOS. **WSA 48404** - TCM not provided as specified in the IPOS.	**MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI Response**: ☒ **Individual Remediation:** ☒ By (Date) 10/31/24, WSA #34468, 21360, 21162, 21157, 20693 plan will be amended for resolving/addressing service provision as recommended. Case manager will complete an IPOS addendum to adequately reflect medically necessary services that are being provided while explaining efforts to reduce barriers for ensuring all services are provided within amount, scope, and duration ☐ By (Date) _____, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☒ Other: (See response below) A formal training with case management team will be completed to review and emphasize the importance of ensuring services and supports are provided as specified in IPOS as well as amending the plan if the person's needs change or if the services are not able to be provided. Training will highlight audit findings also and will be completed by October 31, 2024. CEI quarterly chart review will include review of services provided and determination if utilization is within amount, scope and duration and frequency authorized.

				MDHHS Response: ☐ **Response accepted** ☒ **Response not accepted. –** __ **No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI:** No individual remediation found for WSA# 48404. Please provide. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-

				up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy. Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training.

				MDHHS 2nd Response: Response Accepted *TA for CEI WSA# 48404: As this case is now closed, per WSA, no individual remediation is expected.*
G. **WAIVER PARTICIPANT HEALTH AND WELFARE**				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	12	0		
G.2 Individual served received health care appraisal. (Date/document confirming_____)	11	1	**CEI**:	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI Response**: ☒ **Individual Remediation:** ☒ By (Date) 10/31/24, WSA # 21162 will receive a

			WSA 21162 - Insufficient evidence of annual health care appraisal. Document found (Questionnaire) lacked signature of author, date or clarity as to the purpose of the form.	health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ By (Date) _____, training will be provided to CM staff regarding this requirement. ☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below) By 10/31/24, staff training will be provided on the necessity of coordination of care, including the requirement of maintaining a copy of the annual health care appraisal. QI will conduct random audits to ensure compliance with this rule. **MDHHS Response**: ☒ **Response accepted with documented evidence expected at the 90-day review.**
Q. STAFF QUALIFICATIONS				
Q.1 CWP				

Q.1.1. Clinical service providers and case managers are credentialed by the CMHSP prior to providing services. (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP). (PM C-1)	18	7	A total of **25 Professional Staff** were review under MSHN CWP. REPEAT CITATION **CEI** *Insufficient evidence of QIDP prior to hire, or supervision by a QIDP upon hire, until credentialing requirements met.* **WSA# 21162, 21157:** Alicia Clark **WSA# 20693, 48404:** Bethany Zimmerman **WSA# 21630:** Jensen Kurmel *Lack of evidence of initial background check being completed prior to hire.* **WSA# 34468:** Mary Wilson	**MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI Response**: ☒ **Individual Remediation:** ☐ By (Date) _____, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☒ Other: (See response below) Evidence of QIDP for WSA #21162, 21157, 20693, 48404, 21630 will be completed by 10/31/24. Evidence of CBC completed prior to hire will be provided at 90-day follow up for WSA #34468. ☒ **Systemic Remediation:** ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, prior to service delivery, of newly hired/assigned staff to CWP enrollees, by (Date) _____. ☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration

				will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** __**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI:** Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific

				programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and

				Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy.

				Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training. **MDHHS 2nd Response: Response Accepted**
Q.1.3. Non-licensed/non-certified providers meet provider qualifications. Personnel records contain documentation that staff is: 1. At least 18 years of age, 2. In good standing with the law 3. Able to practice prevention techniques to reduce transmission of any communicable diseases. Documentation staff has completed all core training requirements – e.g.,	18	3	A total of **21 Aide Level Staff** were reviewed under MSHN CWP REPEAT CITATION **CEI** *Lack of evidence of Blood Borne Pathogen/BBP training, First Aid Training, and Emergency Procedures training.* **WSA# 34468:** Kayla Wirtjes *Lack of evidence of BBP and Emergency Procedures Training*. **WSA# 20369:**	**MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI Response**: ☒ **Individual Remediation:** ☐ By (Date) _____, cited staff for WSA #_____ will provide evidence of being 18 or older. ☐ By (Date) _____, cited staff for WSA #_____ will secure a criminal background check ☒ Other: (See response below) Staff identified in the audit are no longer employed and are not available to complete training. ☒ **Systemic Remediation:** ☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff

recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP or hired through Choice Voucher arrangements.) (PM C-3)			Thomas Schwander	credentialing. ☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. ☒ Other: (See response below) Staff Training on this process will occur by 10/31/24. Staff will receive training on how to the importance of monitoring provider qualification. Staff will also receive a tracking sheet to utilize with families when notified by the Financial Management Service. QI will conduct random CEI audits on a quarterly basis to ensure staff meet provider qualifications. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the

				regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance

				and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **MDHHS 2nd Response: Response Accepted.**

Habilitation Support Waiver (HSW)

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	30	8	REPEAT CITATION **CMH Authority of Clinton-Eaton-Ingham Counties/CEI**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately identifies the individual's goals and preferences. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews.

			WSA# 4589: Need for RN services not resolved in the Plan; Perceived need for restrictive gate not resolved in Plan and need for psychiatric services not established in the Plan. **WSA# 5430, 4448, 4519:** Lack of person-centered goals (service/eligibility goals developed, instead).	**CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES/CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/1/24 for WSA # 4589, 5430, 4448, the plan will be amended to reflect his/her goal/preferences. ☒ By (Date) 8/29/24 for WSA #4519 annual IPOS will be completed to reflect his/her goal/preferences. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be provided on the need to adequately address the preferences and desires of the individual served. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so ensure compliance. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ____ Other CEI: Systemic remediation insufficient. Two years ago, the systemic remediation was staff training and

				quarterly monitoring. 2024 only reflects staff training (not an enhancement of prior systemic remediations, for this repeat citation). Please provide additional information as to how CEI will remediate this matter systemically. **For MSHN** (**<u>for each performance measure cited, throughout this document</u>**), please provide additional information on your Delegated Managed Care/DMC Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS

				citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI By 12/1/24, individualized training during supervision will occur on the need to adequately address the preferences and desires of the individuals served. This training will be documented on a staff training log. **MDHHS 2nd Response:** **Response Accepted**
P.2.4. The individual plan of service is modified in response to changes in the individual's needs. (HSW PM D-6)	26	3	REPEAT CITATION NA = 9 **CEI:** **WSA# 5170:** Plan not amended to add SLP/eating guidelines. **WSA# 5091**: Plan not amended for inclusion of OT services (evaluation).	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered plan is modified in response to changes in the individual's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI REPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/1/24 for WSA # 5170, 5091, the record will reflect at least quarterly opportunities in which he/she provides feedback on supports/services and progress.

				☒ Other: (See response below) WSA 5170, 5091 IPOS and services will be reviewed by the clinical team and an amendment will be completed if necessary to reflect [OT/SLP] current services and guidelines. completed by 11/31/24" **☒ Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) Staff training will be provided on the need to amend treatment plans when individual's needs change. Completed by 11/31/24 **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ____**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN**

				MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by

				MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action **MDHHS 2nd Response: Response Not Accepted:** **PIHP/CMHSP 3rd Response:**
P.2.5. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. MCL 330.1701(g)	35	3	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. The plan must be submitted within 30 days of receipt of

			CEI: **WSA# 4589**	this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/1/24 for WSA # 4589, the plan will be amended to reflect/address his/her community inclusion needs. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be provided on the need of the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **____No individual remediation found** ☐ No systemic remediation found

				☐ No timelines indicated ☒ Other: (See response below) **CEI:** Systemic remediation insufficient. Two years ago, the systemic remediation was staff training and quarterly monitoring. 2024 only reflects staff training (not an enhancement of prior systemic remediations, for this repeat citation). Please provide additional information as to how CEI will remediate this matter systemically. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full

				implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action **CEI**

				By 12/1/24, individualized training during supervision will occur on the need of the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. This training will be documented on a staff training log. **MDHHS 2nd Response:** **Response Accepted**
P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	25	13	REPEAT CITATION **CEI** **WSA# 5274:** Lack of medication consents (case now closed). **WSA# 5107**: Lack of psychiatric evaluation.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS addresses health and safety, including coordination with primary care providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/15/24 for WSA # 5274, the annual IPOS will be completed and will include only active services. ☒ By (Date) 11/1/24 for WSA # 5107, the following will be completed/reflected in the record: - Psychiatric Eval

				☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations, and medication consents. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary.

				To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance

				and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action **MDHHS 2nd Response: Response Accepted**
P.2.7: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	25	13	REPEAT CITATION **CEI** **WSA# 5274, 5170, 5107** Periodic Reviews completed without guardian input.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/1/24 the following will be completed/reflected in the record: for WSA # 5170, 5107:

				- Other (See below): Periodic Review will be completed to include guardian input. ☒ By (Date) 11/15/24 the following will be completed/reflected in the record: for WSA #5274: - Other (See below): Guardian will be offered a Periodic Review prior to the 11/15/24 IPOS. If declined, input will be sought and documented within the upcoming IPOS. **☒ Systemic Remediation:** ☒ By (Date) 12/1/24, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☐ Effective (Date) _____, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **__No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **BABH: WSA# 4171**: Insufficient individual remediation. It is within a periodic review (vs a progress note) that input from guardian is needed, as well as a satisfaction check with individual/guardian regarding supports/services. What will BABH do to address this citation? Schedule a Review with the

				individual/guardian, by a specific date, to request/secure the needed involvement? Please revise. **CEI:** Insufficient systemic remediation. Two years ago, for this repeat citations, CEI had staff training as one of three steps they would take to address systemically. In 2024, only training is recommended to address systemically (not an enhancement of what was recommended in 2022). Please include additional steps that CEI/MSHN will take to address systemically. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in

				each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action

				CEI By 12/1/24, individualized training during supervision will be provided regarding the required elements of the person-centered planning process occur on . This training will be documented on a staff training log. **MDHHS 2nd Response: Not Accepted** **PIHP/CMHSP 3rd Response:**
P.2.8: Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service, or item description, start date and the amount or length of time the service is needed).	5	8	REPEAT CITATION **NA= 25** **CEI** **WSA# 5430:** OT is indicated in Plan, multiple years, but not prescription(s) found.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that services requiring physician signed prescription follow Medicaid Provider Manual requirements. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**

				☒ **Individual Remediation:** ☒ By (Date) 11/1/24 for WSA #5430, a physician-signed prescription (with the required elements) will be obtained for OT/PT/PDN support and reflected in the record. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be conducted, on the need to ensure physician-signed prescriptions for these services, going forward. ☐ CMHSP will develop/provide a guidance tool to provide to primary care physician, to assist in securing the needed elements of the prescription, by (Date) _____. ☐ Other: (See response below) **MDHHS Response**: ☒ **Response accepted.**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.5. HSW				
P.5.1. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)	5	33	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the

			CEI **WSA#s 5274, 5170, 5107, 5091: Lack of specific ASDF of TCM services** (range language used instead). **WSA# 4589:** Lack of Specific ASDF of services reflected in Plan (ranges used), measurable goal/objectives and prior authorization (within Plan) for psychological services. **WSA# 4448, 4519, 5430**: Lack of measurable objectives	IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, plan will be amended for resolving/addressing service needs

				identified in assessments. ☒ By (Date) 11/1/24 for WSA # 5274, 5170, 5107, 5091 plan will be amended to include amount scope duration of recommended TCM services. ☒ By (Date) 8/29/24 for WSA # 4589 annual IPOS will be completed and will include specific amount scope duration of psychological services. ☒ By (Date) 11/15/24 for WSA # 4448, 4519, 5430, annual IPOS will be completed or addendum completed, which will include measurable objectives. ☐ Other: (See response below) **☒ Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. ☐ Effective (Date) _____, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) By 12/1/24, staff training will also be conducted on using specific amounts of services rather than ranges and ensuring the IPOS includes measurable objectives. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **___No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below)

				MSHN: Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **CEI: WSA3 4589: Insufficient individual remediation** for lack of measurable objectives (not addressed in individual remediation). **Insufficient systemic remediation** (staff training), for this repeat citation. Staff training was recommended two years ago. What additional steps will CEI take to ensure this citation is not repeated, going forward. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712,

				Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each

				CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** WSA #4589 had an addendum completed in August, which includes amount and scope of psychological services.

				Systemic Remediation: By 12/1/24, individualized training during supervision will occur on the need to address/resolve needs identified in the assessments, within the IPOS. This training will be documented on a staff training log. **MDHHS 2nd Response: Response Not Accepted** **MSHN:** Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **CEI** **Insufficient individual remediation** WSA #4589 Remediation only addressed specific amount, scope, duration and frequency. Remediation needs to also address measurable goals. **PIHP/CMHSP 3rd Response:**

P.5.2. Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. (HSW PM D-7)	18	20	REPEAT CITATION **CEI** **WSA# 5274**: Medication review not provided as specified. **WSA# 5170**: CLS not provided as specified. **WSA# 4589**: TCM (including review) and psychiatric services not provided as specified in Plan. **WSA# 5091**: TCM and CLS services not provided as specified in Plan.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, plan will be amended for resolving/addressing service provision as recommended. ☒ By (Date) 11/1/24 for WSA # 5274, 5170, 4589, 5091, case manager will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted.

				☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **___No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) . **CEI:** **Insufficient systemic remediation**. Two years ago, the systemic remediation was staff training (same as above). What additional steps will CEI be taking to address this repeat citation. Please add to/revise. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly

				scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual.

				MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Systemic Remediation: on 10/17/24 a training was held, and a second staff training will be conducted by 12/1/24, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. Coordinators will follow up on training topics with clinicians during November supervision and document those conversations. **MDHHS 2nd Response: Not Accepted** **CEI: Systemic Remediation lacks ongoing monitoring, such as random quarterly chart reviews.** **PIHP/CMHSP 3rd Response:**

P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. (HSW PM D-5)	37	1	**CEI:** **WSA# 4589**	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date), the IPOS will be updated. ☒ Other: (See response below) This consumer's IPOS was reviewed and amended on 8/7/24. The annual IPOS will be completed prior to or on the due date of 2/25/25 ☒ **Systemic Remediation:** ☒ By (Date) 12/1/24, staff training will be conducted, on the need to ensure that the IPOS is updated at least annually. ☐ Effective (Date) _____, quarterly monitoring of annual updating of the IPOS will occur by SC Supervisory staff. ☐ Other: (See response below)

				MDHHS Response: ☒ **Response accepted**
B. <u>BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES</u> Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical, and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan	5	7	REPEAT CITATION NA = 26 **<u>CEI</u>** **WSA# 4589:** Freedom of movement/FOM limitations within home, without prior approval/oversight of BTPRC. **WSA# 5091**: FOM limitations (4-sided adult crib) without sufficient justification in the record, or BTPRC oversight/involvement (all elements of).	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☒ By (Date) 11/1/24 BTP, functional behavior assessment will be completed for WSA # 4589. ☐ By (Date) _____, special consent will be obtained for WSA #_____. ☒ By (Date) 9/9/24, WSA #5091 will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any

5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e., at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.				approved measures. ☐ By (Date) _____, the IPOS will be amended to reflect recommendations within the BPT for restrictive measures. ☐ Other: (See response below) **☒ Systemic Remediation:** ☒ By (Date) 11/1/24, staff training will be conducted, on the required steps for BTRC involvement. ☐ Effective (Date) _____, quarterly monitoring of BTRC involved records will occur by SC/Clinical Supervisory staff, for following BTRC technical requirements. ☐ Other: (See response below) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ____ **No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CEI,** for these citations which are considered in need of urgent corrective action, individual remediations are in sufficient. • For WSA# 4589, completing a BTP is only the first step in correcting this matter. Please include the other steps that must also be completed, within the

			.	next 90 days, to sufficiently address, with timelines. • For WSA# 5091, please provide information on the required steps that must also be completed, prior to the BTPRC review, with timelines (so that MDHHS is able to confirm corrective action is consistent with the technical requirements).. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review

				citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI**

				For WSA #4589, the treatment team will determine if there are restrictions in the home and evaluate the need for a BTP. If a BTP is needed, a behavior psychologist will create and implement the plan upon approval by the BTC, by 12/1/2024. For WSA #5091, by 9/9/2024, staff will gather the necessary documents to help inform the BTC if a BTP is warranted. Staff will coordinate with guardian, other supports, primary care physician, and a psychologist to determine if this matter requires BTC oversight or if it is a health and safety concern. The BTC will continue to monitor gathered documentation until this determination is made. By 12/1/2024, staff will update the consumers chart documentation based on the determination. **MDHHS 2nd Response: Not accepted** **CEI restrictions are in place at the current time. Rationale not followed from previous response from MDHHS in Blue above.** **PIHP/CMHSP 3rd Response:**
Q. STAFF QUALIFICATIONS				
Q.2. HSW				

Q.2.1. The PIHP ensures that Waiver service providers meet credentialing standards prior to providing HSW services. (HSW PM C-1) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	35	1	A total of **36 Professional Staff** were reviewed under MSHN HSW. REPEAT CITATION **CEI** *Insufficient evidence of QIDP prior to hire, or supervision by a QIDP upon hire, until credentialing requirements met.* **WSA# 4448:** Savannah Scheur	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers meet credentialing standards, prior to providing HSW services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**: ☒ **Individual Remediation:** ☒ By (Date) 10/1/24, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, prior to service delivery, of newly hired/assigned staff to HSW enrollees, by (Date) _____. ☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly,

				from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI:** Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next

				90 days, for currently employed staff during their re-credentialing? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to

				regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25.

				Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts, . For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts by 1/16/25. **MDHHS 2nd Response: Response Accepted**
Q.2.2. The PIHP ensures that Waiver service providers continue to meet credentialing standards on an ongoing basis. (HSW PM C-2) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	35	1	REPEAT CITATION **CEI** *Insufficient evidence of QIDP, or supervision by a QIDP ongoing.* **WSA# 4448:** Savannah Scheur	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers continue to meet credentialing standards on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI REPSONSE** ☒ **Individual Remediation:** ☒ By (Date) 10/1/24, evidence of QIDP, or supervision by a QIDP, will be obtained for provision

				to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☐ Other: (See response below) **☒ Systemic Remediation:** ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, ongoing, of staff to HSW enrollees by (Date) _____. ☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found

				☐ No timelines indicated ☒ Other: (See response below) **CEI:** Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time

				MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in

				some instances, 4) contract non-compliance action. **CEI** CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25. Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts, . For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts by 1/16/25. **MDHHS 2nd Response: Response Accepted**
Q.2.3. The PIHP ensures that non-licensed Waiver service providers meet the provider qualifications identified in the Medicaid Provider Manual. (HSW PM C-3)	258	67	A total of **325 Aide Level Staff** were reviewed under MSHN HSW REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt

Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.			**CEI** *Insufficient evidence of Emergency Procedures Training*. **WSA# 5091:** Billie Leonard **WSA# 4448:** Lori Babcock McKenzie Simmons **WSA# 5170**: Michaelle Brown **WSA# 5107:** Rubonnir Kahumyo, Ron Vaughn *Lack of evidence of Blood Borne Pathogen/BBP training.* **WSA# 5170:** Erica Kinyan *Lack of date of hire information to determine compliance with initial CBC check.* **WSA# 5170:** Michaelle Brown *Lack of evidence of completing First Aid training.* **WSA# 5170:** ~~Sage Royston~~ *Lack of evidence of Recipient Rights/RR Training.* **WSA# 5091:** Taylor Galloway	of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** **☒ Individual Remediation:** ☒ On 9/5/24, WSA #5170 (Erica Kinyan) completed emergency procedures. On 9/5/24, WSA #5170 (Michaelle Brown) completed emergency procedures. On 10/30/23, WSA #5091 (Taylor Galloway) completed recipient rights. By 12/1/24, the remaining staff for WSA# 5091: Billie Leonard, WSA# 4448: Lori Babcock and McKenzie Simmons, WSA# 5170: Michaelle Brown, WSA# 5107: Rubonnir Kahumyo, and Ron Vaughn will have proof of completion of emergency training. ☒ By (Date) 10/31/2024 WSA #5170: Michaelle Brown will secure a criminal background check. LARA has issued a letter for her that will automatically notify the provider if anything new shows up. ☐ Other: (See response below) **☒ Systemic Remediation:** ☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. ☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. ☒ Other: (See response below)

				CEI's Quality Advisors will review requirements related to staff credentialing documents during each provider's annual site visit to ensure compliance standards are being met. Quality Advisors will also stress that for first aid training, the training must specifically state that is first aid training, not just life support. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring. HR Dept will randomly select a staff sample to review quarterly for required trainings, Effective upon MDHHS approval of the systemic remediation **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI:** No individual remediation found for *Lack of evidence of Blood Borne Pathogen/BBP training.* **WSA#5170: Erica Kinyan**

				Lack of evidence of completing First Aid training. **WSA# 5170: Sage Royston** *Lack of date of hire information.* **WSA# 5170:** Michaelle Brown *TA: Regarding CEI systemic remediation, evidence of the first quarterly review (documented outcomes of provider compliance with required trainings) will be required at the 90-day review, to successfully meet the systemic remediation.* **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the

				citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI On 9.5.24,WSA #5170 (Erica Kinyan) completed Blood Borne Pathogens. File name: WSA #5170 Environmental Safety and BBP Trainings Erica Kinyan. As of 6.22.24, WSA #5170 (Sage Royston) no longer works for that provider so cannot complete first aid training. By 12.1.24, CEI will obtain date of hire information for WSA #5107 (Michaelle Brown). **MDHHS 2nd Response: Response Accepted** with proof of individual and systemic remediation provided at the 90 day follow up review.
Q.2.4 All HSW providers meet staff training requirements. (HSW PM C-4) • *Not limited to group home staff. All HSW providers for the samples should meet staff training requirements (includes own home and family home).* evidence: Training records: • *Has received training in the beneficiary's IPOS.*	294	31	REPEAT CITATION **CEI** **WSA# 5091:** Amy Ramirez, Autumn McGovern, Keri Bennett, Nicole Earhart, Shay Cook, Shelly Melrose, Taylor Galloway, Tosha Parks **WSA# 4448:** Tammy Sherman	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all HSW providers meet the staff training requirements specific to beneficiary specific IPOS, prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews.

				CEI RESPONSE ☒ **Individual Remediation:** ☒ By (Date) 12/1/24, cited staff will receive required IPOS training specific to the beneficiary they are supporting. ☐ Other: (See response below) ☒ **Systemic Remediation:** ☐ By (Date) _____ CMHSP/PIHP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). ☐ Effective (Date)_____ Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. ☒ Other: (See response below) CEI's Quality Advisors will review requirements related to IPOS documentation during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –**

				___**No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **CEI::** Insufficient systemic remediation. No timelines/target dates found that fall within a 90 day remediation period. What evidence will be provided of systemic remediation, in 90 days, to demonstrate efforts to address this. Please revise. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS

				citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI Systemic Remediation: CEI's Quality Advisors will review requirements related to IPOS documentation to ensure all staff have been trained on the IPOS as evidenced by signing the IPOS In-Service sheet by 12.1.24 and annually during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation**.** **MDHHS 2nd Response: Response accepted** with proof of both individual and systemic remediation provided at the 90 Day Follow Up.

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
F. FREEDOM OF CHOICE				
F.2. iSPA				
F.1. C.1 Individual was informed of their right to choose among PROVIDERS.	**65**	**11**	**CMH Authority of Clinton-Eaton-Ingham Counties/CEI** **WSA#: 1353439**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual has the ability to choose their providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES/CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ WSA # _____will receive information regarding right to choose iSPA providers, with documentation in the record by the 90-day f/u site review. ☒ Other: (See response below) WSA # 1353439 was informed of the right to choose iSPA providers on 7-25-24. ☒ **Systemic Remediation:** ☐ By (Date) _____, training will be provided on the advising of iSPA recipients of this information, and documentation of the conveyance of this information in the record.

				☐ By (Date) _____, EMR will be adjusted to include this information in required fields within the pre-planning document. ☒ Other: (See response below) This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** ___**No individual remediation found.** ☐ No systemic remediation found ☐ No timelines indicated ☒ **Other:** **CEI:** For systemic remediation, more information is needed. What will the newly assigned CEI case manager specifically do to ensure that iSPA recipients will receive notification of their right to choose among providers of service, and that the conveyance of that information will be sufficiently documented in the record. What will be provided in 90 days to give evidence of this? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring

				and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will

				act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Systemic: This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. On 7/25/2024, CEI Case Manager met with individual to complete their annual assessment and IPOS pre-plan, which identifies the individual's ability to choose amongst providers. This documentation can be provided if/when requested.
F.1.C.2: Individual was informed of their right to choose among SERVICES.	49	27		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual has the ability to choose their services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN**

			CEI **WSA# 1353439**	MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ WSA # _____will receive information regarding right to choose among iSPA services, with documentation in the record by the 90-day f/u site review. ☒ Other: (See response below) WSA # 1353439 was informed of the right to choose iSPA providers on 7-25-24. ☒ **Systemic Remediation:** ☐ By (Date) _____, training will be provided on the advising of waiver recipients of this information, and documentation of the conveyance of this information in the record. ☐ By (Date) _____, EMR will be adjusted to include this information in required fields within the pre-planning document. ☒ Other: (See response below) This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** ___ **No individual remediation found.**

				☐ No systemic remediation found ☐ No timelines indicated ☒ **Other:** **CEI: Insufficient individual remediation**. It is choice of services that must be conveyed, not providers as reflected in individual remediation. Please revise. Re **Systemic Remediation**, more information is needed. What will the newly assigned CEI case manager specifically do to ensure that iSPA recipients will receive notification of their right to choose among services, and that the conveyance of information will be sufficiently documented in the record. What will be provided in 90 days to give evidence of this? **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At

				which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI**

				Individual: WSA#1353439 was informed of the right to choose iSPA providers, choice of services, and was informed about how to request new providers/services on 7/25/2024. Systemic: This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. On 7/25/2024, CEI Case Manager met with individual to complete their annual assessment and IPOS pre-plan, which identifies the individual's ability to choose amongst providers. This documentation can be provided if/when requested. **MDHHS 2nd Response: Response Accepted.** TA: CEI see highlighted response above. Last 2 sentences reverts back to providers not services.
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1.A.1: Individual plan of service addressed health and safety, including coordination with primary care providers.	54	22		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately addresses health and safety, including coordination with primary care physicians. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the

			CEI	corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ for WSA # _____, • Health care coordination with primary care physician will occur, and/or. • A psychiatric evaluation will be obtained, and/or • A signed medication consent will be obtained, and/or • Other:_____ ☒ Other: (See response below) WSA#1353194 will have in his chart proof of COC with PCP by Nov 30th 2024 and a signed medication consent will be obtained by Nov. 20/24. WSA# 1353192 will have in her chart proof of COC with PCP by Oct. 8th 2024 and a signed medication consent will be obtained by Nov. 20/24. WSA#1353181 and 1353439 will have in their chart proof of COC with PCP by Nov 30th and a signed medication consent by guardian will be obtained by Nov. 5th/24. ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be provided on the need to adequately address the health and safety of the individual served. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so ensure compliance with this performance measure.. ☒ Other: (See response below)

			WSA# 1353194: Lack of COC with PCP. **WSA# 1353192:** Lack of COC with PCP and lack of signed medication consents. **WSA#s 1353181, 1353439:** Lack of COC with PCP, psychiatric eval and med consent signed by guardian.	By Dec. 31/24, staff training will be provided on the need to adequately address the health and safety on the individuals served. Effective Oct 1st. 2024, quarterly monitoring of random sample of IPOS plans for HSW will occur by coordinator or supervisor staff, so ensure compliance with this performance measure. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** ___**No individual remediation found.** ☐ No systemic remediation found. ☐ No timelines indicated. _X_ Other: **CEI:** Lack of individual remediation for WSA#s **1353181, 1353439, specific to their need for psychiatric evaluations. Please revise.** **fCMHCM:** Lack of Individual remediation for WSA# 1353592: "COC found in chart under Record of Disclosure documents dated: 03/10/2023". A documented dated March 2023 is too old to have met the requirement at the time of the annual review or at the 90-day review. Please revise, for this annual requirement. **PIHP/CMHSP 2nd Response:** **MSHN**

				MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans

				MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Individual: WSA#1353181 and WSA#1353439 will have proof of Coordination of Care with their Primary Care Physician in their chart, and, if needed, a 1) psychiatric evaluation and 2) a signed medication consent by 11/30/2024. **MDHHS 2nd Response:** **Response Accepted** with proof of Individual and Systemic remediations provided at the 90 Day Follow Up
P.1.A.2. The individual plan of service addresses the assessed needs of a beneficiary.	67	9		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual plan of service adequately address needs of a beneficiary. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

			CEI **WSA# 1353183**: Need for job coaching services not addressed the Plan.	**MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ for WSA # _____, the plan will be amended to reflect6 the assessed needs of the individual served ☒ Other: (See response below) WSA# 1353183: By 12/1/24, the employment related needs will be reassessed with the individual and the plan will be updated if the needs are still present. ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be provided on the need to adequately address needs (identified in assessments or during on-going services), within the plan of service. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance with the performance measure.. ☒ Other: (See response below) By 11/1/24, staff training will be provided on the need to adequately address needs (identified in assessments or during on-going services), within the plan of service. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** **___No individual remediation found.**

				☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly

				review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **MDHHS 2nd Response: Response Accepted**
P.1.A.3: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and	53	23		Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this

3. use of PCP process in developing IPOS. (HSW PM D-4)			**CEI** **WSA# 1353189:** Periodic Review completed without Guardian input. **WSA#1353169:** Lack of adequate due process for removal of respite from Plan of Service. **WSA# 1353179:** Lack of sufficient evidence of guardian involvement (or attempts to get guardian involvement) in pre-planning process. **WSA# 1353183:** Lack of adequate due process for removal of psychiatric services, and lack of sufficient transition planning prior to moving recipient from a stable living arrangement, to another setting, without sufficient rationale for the move. **WSA# 1353439**: Lack of pre-planning, including the offering of Independent Facilitation/IF & Self Directed/SD services. IPOS effective date before IPOS meeting held.	report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____ the following will be completed/reflected in the record: for WSA #_____: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below) WSA# 1353189: Guardian input will be sought and documented thoroughly in the pre-planning process by 12/8/24. WSA#1353169: An IPOS addendum was completed on 5/17/24 to authorize Respite. WSA# 1353179: Individual closed to services on 11/16/23. WSA # 1353183: By 12/1/24, the clinical team will review the IPOS and authorized services with the consumer/guardian to ensure services meet the consumers identified need. If necessary, an IPOS addendum will be completed. WSA# 1353439: A pre-planning meeting, to include the offer of Independent Facilitation and Self-Directed Services was completed on 7/25/24. The IPOS was held on 8/9/24 ☒ **Systemic Remediation:** ☐ By (Date) _____, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process.

				☐ Effective (Date) _____, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☒ Other: (See response below) By 12/1/24, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process to include due process. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** __**No individual remediation found.** ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) **CEI: Insufficient systemic remediation**. No mention found in planned training of the need for guardian involvement/attempted involvement in planning and plan review activities. Please revise. **PIHP/CMHJSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place

				outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been

				addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Systemic: By 12/1/2024, additional staff training will be provided to staff at large regarding the required elements of the person-centered planning process, including education regarding involvement/attempts at involvement of the guardian or other supports, the pre-planning process, availability of self -determination, using the PCP to develop the IPOS, etc. **PIHP/CMHSP's 3rd Response:**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.1.B.1: The IPOS for individuals enrolled in the iSPA is updated within 365 days of their last IPOS.	59	3	NA = 14	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS for individuals enrolled in the iSPA is updated within 365 days of their last IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN**

			CEI **WSA# 1353169** **WSA#1353439**	MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, the IPOS will be updated. ☒ Other: (See response below) WSA# 1353169: The annual IPOS will be completed by 9/27/24, which is within 365 days of the previous IPOS. WSA#1353439: The IPOS was updated on 8/9/24. ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted, on the need to ensure that the IPOS is updated at least annually. ☐ Effective (Date) _____, quarterly monitoring of annual updating of the IPOS will occur by SC Supervisory staff. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to ensure that the IPOS is updated at least annually. **MDHHS Response**: ☒ **Response accepted.**
P.1.B.2. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing, are identified in the IPOS.	11	65	**CEI** **WSA# 1353071**: Lack of specific ASDF of TCM services and measurable goal objectives.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in

			WSA# 1353169: Lack of specific ASDF of TCM services within Plan, and lack of recipient based measurable goal objectives. **WSA# 1353179:** Lack of specific ASDF of services within the Plan. **WSA# 1353182**: Lack of specific ASDF of TCM services within Plan, and measurable objectives. **WSA# 1353183**: Lack of specific ASDF of TCM and Psychiatric services (ranges used instead). **WSA# 1353439**: Lack of specific ASDF of services, and lack of behavioral treatment goal/objective, recommended in Behavior Treatment Plan/BTP. **WSA# 1353189:** Ranges used for TCM. Not all goal/objectives are measurable. **WSA# 1353190**: Not all goal/objectives are measurable. **WSA# 1353191**: TCM and Medication Reviews use range language for services. **WSA# 1353194**: Lack of specific ASDF for all services. Not all goal/objectives are measurable. **WSA# 1353192**: Not all goal/objectives are measurable.	the IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, plan will be amended for resolving/addressing service needs identified in

			WSA # 1353195: Not all goal/obj are measurable.	assessments. ☐ By (Date) _____, plan will be amended to include specific amount scope duration frequency of recommended supports, and/or to include measurable goal/objectives ☒ Other: (See response below) WSA# 1353071, WSA# 1353169, WSA# 1353182, WSA# 1353183, WSA# 1353189, WSA# 1353195, and WSA# 1353191: By 12/1/24, plan will be amended to include specific amount scope duration frequency of recommended supports, and to include measurable goal/objectives WSA# 1353179: Individual closed to services on 11/16/23. WSA# 1353439: By 12/1/24, plan will be amended to include goals will be included related to the Behavior Treatment Plan. (1353190) by Sep. 30th annual treatment will be completed with measurable goal objectives. (1353192) by Sep. 30th annual treatment will be completed with measurable goal objectives. (1353194) by Nov. 1st annual treatment will be completed with measurable goal objectives. **☒ Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. ☐ Effective (Date) _____, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. By Nov. 30th, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount

				scope duration frequency of recommended services and measurable goal/objectives. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted. –** ___**No individual remediation found.** ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) **MSHN:** Insufficient systemic remediation for lack of specific amount/scope/duration/frequency/ASDF of services within the Plan (conveying intent not to remediate these citations). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. **CEI: WSA# 1353439, WSA# 1353194:** Insufficient individual remediation. No remediation found for lack of specific ASDF. Please revise. **PIHP/CMHSP 2nd Response:** **MSHN** MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved

				during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90

				days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Individual: By 12/1/2024, WSA#1353194's IPOS will be amended to include specific amount, scope, duration, and frequency of recommended supports, and include measurable goals and objectives. Individual: By 12/1/2024, WSA#1353439's IPOS will be amended to include specific amount, scope, duration, and frequency of recommended supports. The addendum will

				include measurable objectives and goals related to the Behavior Treatment Plan.
P.1.B.3: Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing.	25	51	**CEI** **WSA# 1353190**: TCM not provided as specified. **WSA# 1353191**: Medication Reviews not provided as specified in Plan. **WSA# 1353194**: Medication Reviews not provided as specified in Plan. **WSA# 1353192**: TCM, CLS, Therapy not provided as specified. **WSA# 1353195**: TCM, Medication Reviews, Nutrition services not provided as recommended in Plan. **WSA# 1353071**: TCM, Support Employment Services not provided as specified. **WSA# 1353169**: Lack of recipient/guardian satisfaction check at time of Plan Review, and CLS not provided as specified in Plan. **WSA# 1353179**: Psychiatric and CLS services (no CLS logs made available) not provided as specified in Plan. Also failure of CEI to	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, plan will be amended for resolving/addressing service provision as recommended. ☐ By (Date) _____, SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☒ Other: (See response below) (WSA#1353190) By Sep. 30th annual treatment plan will be completed resolving the disparity between TCM recommended and provided services. WSA# 1353191: By 12/1/24, plan will be amended for

			maintain **sufficient capacity** (for level IV residential facility) to allow this individual to reside in a lesser restrictive setting (before individual was moved to a nursing home). **WSA# 1353181**: TCM, Peer Services, Psychiatric, CLS services not provided as specified. **WSA# 1353182**: Lack of guardian involvement/attempts to get guardian involvement in Plan Review. **WSA# 1353183**: TCM (monthly and full Plan Review) not provided as specified/required. **WSA# 1353439**: TCM, Psychiatric and psychological services not occurring as specified.	resolving/addressing service needs. (WSA#1353194) By Oct. 30th annual treatment plan will be completed resolving the disparity between Medication Reviewed recommended and provided services. (WSA#1353192) By Sep. 30th annual treatment plan will be completed resolving the disparity between TCM and CLS recommended and provided services. (WSA#1353195) By Nov. 30 annual treatment plan will be completed resolving the disparity between Medication Reviewed and Nutrition recommended and provided services. WSA# 1353071: By 12/1/24, plan will be amended for resolving/addressing service needs, including Supported Employment. WSA #1353169: The IPOS review will be completed by 12/1/24 resolving the disparity between CLS recommended and provided services with guardian satisfaction documented. WSA# 1353179: Individual closed to services on 11/16/23. (WSA#1353181) By Nov. 30 annual treatment plan will be completed resolving the disparity between Medication Reviewed recommended and provided services. WSA# 1353182: The IPOS review will be completed by 12/1/24 with evidence of guardian input. WSA# 1353183: By 12/1/24 annual treatment plan will be reviewed as specified and then monthly as required. WSA# 1353439: By 12/1/24, a review of current provider capacity will occur and new referrals made if services cannot be provided to the frequency needed of the person. ☒ **Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount

				scope duration frequency of recommended services and measurable goal/objectives. By Nov. 30th, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. **MDHHS Response**: ☐ **Response accepted.** ☒ **Response not accepted.** **– No individual remediation found.** ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) **CEI** **WSA# 1353439 Individual remediation does not resolve the discrepancy of service included in the EMR for this individual. Please revise.** **PIHP/CMHSP 2nd Response:** **MSHN** MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place

				outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been

				addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. **CEI** Individual: By 12/1/2024, WSA#1353439's IPOS will be reviewed and amended resolving the disparity between TCM, psychological services, and psychiatric services.
C. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out.	0	6	NA = 70 **CEI:** **WSA# 1353179:** Potentially restrictive equipment (seatbelts on wheelchair for a previously ambulatory individual, following falls,	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:**

3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.			without sufficient documentation in the record to rule out this equipment being used to restrict her ability to ambulate. If to restrict ambulation, no evidence of BRPRC involvement. (Closed iSPA) **WSA#1353439**: For freedom of movement/FOM limitations, lack of special consent, the less restrictive interventions attempted, and timely BTPRC approval and oversight, as required.	☐ By (Date) _____, BTP, functional behavior assessment will be completed for WSA #_____. ☐ By (Date) _____, special consent will be obtained for WSA #_____. ☐ By (Date) _____, WSA #_____ will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. ☐ By (Date) _____, the IPOS will be amended to reflect recommendations within the BPT for restrictive measures. ☒ Other: (See response below) WSA# 1353179: Individual closed to services on 11/16/23. WSA#1353439: A referral was made to a new behavioralist to review the current needs and supports. By 12/1/24, an updated plan will be presented to the BTRC for approval/disapproval of any restrictive measures recommended. **☒ Systemic Remediation:** ☐ By (Date) _____, staff training will be conducted, on the required steps for BTRC involvement. ☐ Effective (Date) _____, quarterly monitoring of BTRC involved records will occur by SC/Clinical Supervisory staff, for following BTRC technical requirements. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the required steps for BTRC involvement. **MDHHS Response**: ☐ **Response accepted with proof of Individual and Systemic remediation submitted at the 90 Day follow up review.** ☒ **Response not accepted.** __ **No individual remediation found**

				☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) **CEI:** For WSA# 4589, completing a BTP is only the first step in correcting this matter. Please include the other steps that must also be completed (including special consent, inclusion into the Plan of Service, etc), within the next 90 days, to sufficiently address, with timelines. **PIHP/CMHSP 2nd Response:** **MSHN** **CEI** *MDHHS indicated the incorrect WSA above (4589). This was confirmed by CPD on 10/25/24. Individual: WSA#1353439: By 12/1/2024, a referral to a behavior psychologist will be made to review the current needs and supports. An updated Behavior Treatment Plan will be developed, in accordance with documenting the restrictions/intrusive techniques, an FBA, and special consent. The Behavior Treatment Plan will be included in the individuals IPOS. The Behavior Treatment Plan will be monitored through quarterly reviews by the Behavior Treatment Committee..

				MDHHS 2nd Response: Response Not Accepted. **CEI:** Not only does the BTP need to be developed by the 90 day follow up, but all of the steps required under the BTPRC technical requirements. Please provide dates in which the FBA and special consent will be completed, the IPOS will be amended to include these interventions as well as BTPRC review/approval. **PIHP/CMHSP 3rd Response:**
G. WAIVER PARTICIPANT HEALTH AND WELFARE Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	72	5	**CEI** **WSA# 1353439**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual is provided information/education on how to report abuse/neglect/exploitation and other critical incidents. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**

				☒ **Individual Remediation:** ☐ By (Date) _____, WSA # _____ will be provided information/education on how to report abuse/neglect/exploitation and other critical incidents, as evidenced in the record by _____. ☒ Other: (See response below) WSA#1353439: By 11/1/24, will be provided information and education on how to report abuse/neglect/exploitation and other critical incidents as evidenced in the record through the service note. ☒ **Systemic Remediation:** ☐ By (Date) _____, training will be provided to CM staff regarding this requirement. ☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below) By 12/1/24, training will be provided to CM staff regarding this requirement.
G.2 Individual served received health care appraisal. (Date/document confirming_____)	71	5		Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be

			CEI **WSA#s 1353190, 1353194, 1353192,**	corrected within 90 days after the in action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, WSA # _____ will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. ☒ Other: (See response below) WSA#1353190 will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. (WSA#1353192) will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. (WSA#1353194) will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. ☒ **Systemic Remediation:** ☐ By (Date) _____, training will be provided to CM staff regarding this requirement. ☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below)

				By Dec. 2024, training will be providing to CM staff regarding this requirement. Effective Dec.2024, the EMR will be adjusted to include a field that captures this PM in the pre-planning process Effective Oct. 2024, Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. **MDHHS Response**: ☒ **Response accepted with proof of individual and systemic remediation provided at the 90 Day Review.**
Q. STAFF QUALIFICATIONS				
Q.2. iSPA				
Q.4.3. The PIHP ensures that non-licensed iSPA service providers meet the provider qualifications identified in the Medicaid Provider Manual. Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty	210	62	There was a total of **272 Aide Level Staff** reviewed under MSHN iSPA **CEI** *Lack of evidence of First Aid Training* **WSA# 1353194:** Amy Smith **WSA#s 1353179, 1353197:** Carol Fischer **WSA# 1353192:** Denise Reeves **WSA# 1353181:**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE**

he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.			Larry Chillers *Lack of evidence of initial background check being completed prior to hire.* **WSA# 1353182:** Ashlee Ruthig Myra Ruthig Rodney Baxter **WSA# 1353189:** Helen Bushrey Lisa Bailey *Lack of Emergency Procedures Training* **WSA# 1353190:** Aster Mekonnen Daniel Collar **WSA# 1353189:** Helen Bushrey* Jennifer Young **WSA# 1353182:** Myra Ruthig* *Lack of Blood Borne Pathogen/BBP Training* **WSA# 1353190:** Gloria Doebler **WSA# 1353181:** James Wilson Larry Chillers,* Tiffany Sims *Lack of evidence of name change to resolve credentialing evidence.* **WSA# 1353195:** Hope Jenks	☒ **Individual Remediation:** ☐ By (Date) _____, cited staff for WSA #_____ will provide evidence of being 18 or older. ☐ By (Date) _____, cited staff for WSA #_____ will secure a criminal background check ☒ Other: (See response below) By 11/4/2024, cited staff for WSA #**1353194,** will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #**1353179** and **1353197,** will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #**1353192,** will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #**1353181,** will provide evidence of First Aid Training. By 11/4/2024 cited staff for WSA #**1353182:** The non-compliance with requirements was discussed with the new owners on 06/06/24 and they are aware of the requirements for any new staff moving forward. By 11/4/2024 cited staff for WSA #**1353189** will obtain and submit a criminal background check. By 11/4/2024, cited staff for WSA #**1353190,** will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #**1353189,** will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #**1353182,** will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #**1353190,** will provide evidence of Blood Borne Pathogen/BBP Training. By 11/4/2024, cited staff for WSA #**1353181,** will provide evidence of Blood Borne Pathogen/BBP Training. By 11/4/2024, cited staff for WSA #**1353195,** will provide evidence of legal name change to resolve credentialing evidence. ☒ **Systemic Remediation:** ☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing.

				☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings, with fust full review provided to MDHHS at the 90-day review.. ☒ Other: (See response below) Quality Advisors will review requirements related to staff credentialing documents during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract Emergency Training completion: This training requirement was not met due to Mid-State Health Network having the incorrect information on their training grid that is provided to every CMHSPs within the region prior to the new fiscal year. CEI now knows that the training requirement standard for environmental training is every three years as indicated on the FY25 MSHN training grid. Quality Advisors will review staff trainings at every annual site review and corrective action plans will be requested from the provider if non-compliance is identified. HR Dept will randomly select a staff sample to review quarterly for required trainings, Effective upon MDHHS approval of the systemic remediation **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **___No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated

				☒ Other: (See response below) **CEI;** TA: Systemic remediation accepted with evidence of the first quarterly review, of provider credentialing records, due at the 90-Day review. **PIHP/CMHSP 2nd Response:**
Q.4.4 All iSPA providers meet staff training requirements. *Not limited to group home staff. All iSPA providers for the samples should meet staff training requirements (includes own home and family home).* evidence: Training records: • *Has received training in the beneficiary's IPOS.*	195	77	**CEI:** **WSA# 1353182:** Ashlee Ruthig, Kristy Ruthig, Rodney Baxter **WSA# 1353195:** Asia Walls. Ayana Simmons, Dakotha Drushel, Hope Jenks, India Marizette, Jazzlyn Campbell, Raziya Terry, Teighlor Campbell Kathleen Price **WSA#s 1353179, 1353197:** Carol Fischer **WSA# 1353183:** Chris Rhymes, Lola Suttles **WSA# 1353191:**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all iSPA providers meet the staff training requirements specific to beneficiary specific IPOS, prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **MSHN** MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. **CEI RESPONSE** ☒ **Individual Remediation:** ☐ By (Date) _____, cited staff will receive required IPOS training specific to the beneficiary they are supporting. ☒ Other: (See response below) By 11/4/2024, cited staff for WSA **#1353182** will receive required training in the IPOS for the consumer they are supporting.

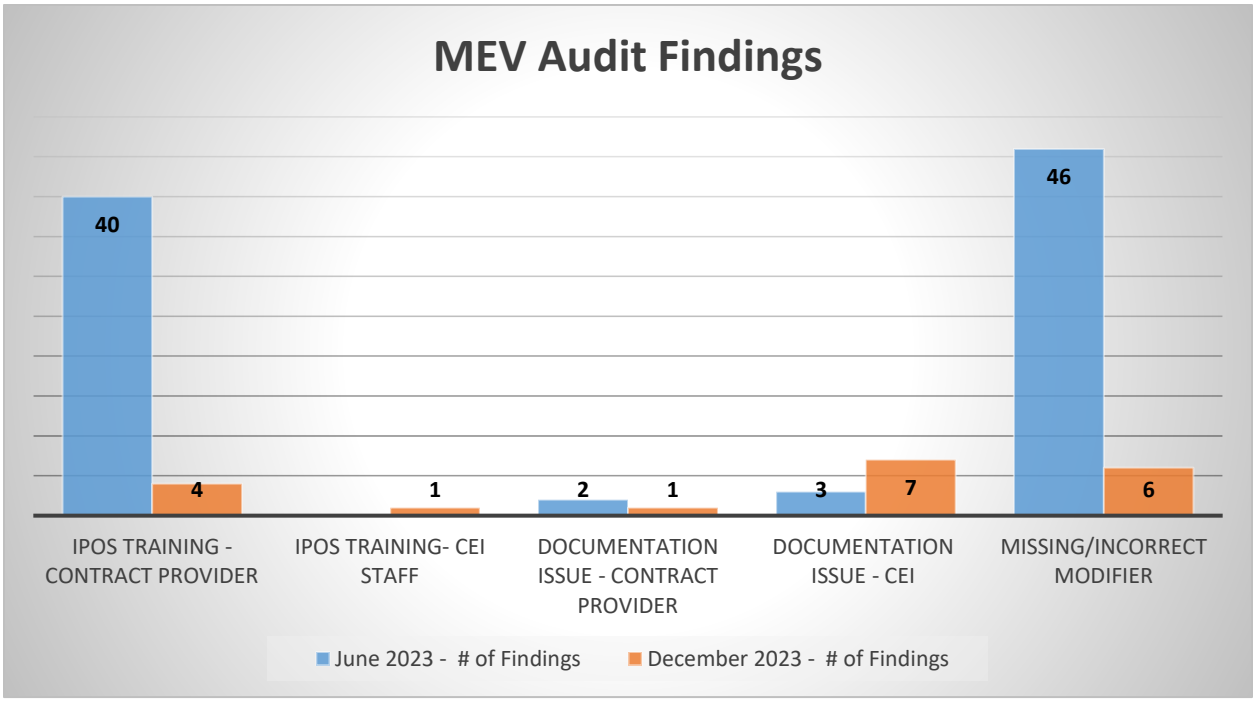
			Danielle Struble, Esperanza Leonard, Isaiah Alston, Jennie Edmond, Matilda Sipeolu, Milagros Martinez Saige Rice, Salome Solo Zano, Steven Parker, **WSA# 1353181:** Tiffany Sims	By 11/4/2024, cited staff for WSA **#1353195** will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA **#1353179** and **#1353197** will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA **#1353183** will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA **#1353191** will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA **#1353181** will receive required training in the IPOS for the consumer they are supporting. **☒ Systemic Remediation:** ☐ By (Date) _____, CMHSP/PIHP will review with/train CM staff the obligation to provide IPOS training to those providing supports to iSPA recipients, in a timely manner (upon update/amending of IPOS), . as well as the 4 elements required as evidence for training: • Date of Training • Content of Training (including date of IPOS) • Who was trained (legible names) • Who did the training (legible name/title) ☐ Effective (Date)_____ Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. ☒ Other: (See response below) By 12/30/2024, CEI will review with/train case managers on the obligation to provide IPOS training to staff working with the beneficiary. This training will occur in a timely manner upon creating/amending the IPOS. Training documentation will include the date of training, who was trained, who did the training, and content of the training (IPOS). Quality Advisors will review requirements related to IPOS documentation during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having

				to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation

Medicaid Event Verification Audit

For FY24, there were two Medicaid Event Verification audits held by MSHN during June and December 2024. MSHN tracks a variety of attributes of claims during each MEV review. The attributes tested during the Medicaid Event Verification review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service or in the treatment plan, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed does not exceed contractually agreed upon amount, G.) Amount paid does not exceed contractually agreed upon amount, and H.) Modifiers are used in accordance with the HCPCS guidelines.

In FY24, QI started to track the number of findings from MEV audits and their associated categories in order to identify trends and opportunities for targeted improvements. The summary of findings are identified in a chart below.



The June MEV audit included a review of SUD specific claims, which are identified separately below.

Findings from the June 2024 CMH MEV audit are as follows:

- Line 223. 9a-1:30p. Units billed (32) to do not agree with documentation (18).
- Lines 12, 17. Unable to verify IPOS training. (Training form says, "Type in "staff name" Please" for the Written Name and there is no staff signature/Signature field is blank.)
- Line 13. Unable to verify RBT training. (RBT training certificate says that staff completed "00 hours of instruction")
- Line 108. Unable to verify staff qualifications for to justify HN modifier as staff only signs with "MHA".
- Lines 129, 137. Missing staff credential modifier, HO. Provider uploaded evidence of voided/corrected encounter to Box. **No further action required.**
- Lines 247, 251, 253, 261. Staff signs as an RN, but AG modifier billed. TD modifier should be used for RN. Per CEI, this has been an ongoing issue within the EHR. They are still waiting on an internal correction to the system from the EHR vendor – the system issue has been identified and the vendor is working on the correction. The services have been temporarily voided until the fix is implemented. Provider uploaded evidence of voided encounter. **No further action required.**
- Lines 247, 251. Missing HH modifier. Per CEI, this has been an ongoing issue within the EHR. They are still waiting on an internal correction to the system from the EHR vendor – the system issue has been identified and the vendor is working on the correction. The services have been temporarily voided until the fix is implemented. Provider uploaded evidence of voided encounter. **No further action required.**

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Line 223. CMHA-CEI Finance department has completed a recoupment from the Provider for the over-payment. Uploaded the letter informing provider of the recoupment on July 11th. "Line 223_Dawns Early Light-MEV Audit Takeback 07.10.24" to Provider Supporting Documents > MEV in Box
- Lines 12, 17. CMHA-CEI Finance department has completed a recoupment from the Provider for the services associated with the staff that did not have a completed IPOS form. Uploaded to Provider Supporting Documents > MEV in

Box the letter informing provider of the recoupment on July 11th. "Line 12_17_Autism Spectrum -MEV Audit Takeback"
- Line 13. Uploaded supporting documentation to Provider Supporting Documents > MEV in Box.
- Line 108. Uploaded supporting documentation to Provider Supporting Documents > MEV in Box.

Findings from the June 2024 SUD MEV audit are as follows:

- Lines 8, 11, 12, 14, 17, 19, 20. Unable to verify Life Skills/Self Care hours for the week of 11/8/2023 - 11/14/2023 as there is no supporting documentation verifying that the required 20 hours were met (besides a consumer-attested log that contains no dates/times - only checkmarks noting the activities).
- Lines 22, 25, 27. Unable to verify Life Skills/Self Care hours for the week of 11/15/2023 - 11/21/2023 as there is no supporting documentation verifying that the required 20 hours were met (besides a consumer-attested log that contains no dates/times - only checkmarks noting the activities).

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- CMHA-CEI acknowledges these findings and understands that MSHN will complete the voids for the noted services.

Findings from the December 2024 MEV are as follows:

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

MSHN Audit

MSHN developed a Delegated Managed Care Review cycle that spans over 3 years and consolidates MSHN reviews with external reviews (when possible). The 3-year review cycle was implemented starting in FY24, and is intended to improve agency monitoring and corrective action implementation.

MSHN conducted a virtual desk audit of CMHA-CEI in June 2024. CMHA-CEI scored 100% in the Administrative Review and did not have any findings.

National Core Indicators Survey

The NCI Survey is a collaboration between participating states, Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. Information about specific 'core indicators' are gathered to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The NCI survey aims to assess family and adult consumer perceptions of and satisfaction with their community mental health system and services.

Consumers are selected at random and asked if they would like to participate in the in person survey. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritize quality improvement initiatives.

During the 2024-2025 survey, a total of 44 consumers consented to participate in the survey. This was a 23% decrease compared to the previous survey year.

ICDP and CC360 Data

To assist CMHA-CEI Departments with Performance Improvement QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. In FY24, QI accessed the Integrated Care Delivery Platform (ICDP) to pull Service Utilization data for consumers enrolled in CCBHC services. QI increased access to monitor CCBHC specific measurements and address Care Alerts noted in the program. The Care Alerts identified as priorities to be addressed in FY24 were Adherence to Antipsychotics for Patients with Schizophrenia, Diabetes Monitoring, Cardiovascular Screening, Follow-Up after Hospitalization for Mental Illness - Adults, Follow-Up after Hospitalization for Mental Illness – Child, and Access to Primary Care for Children. In FY25 QI will continue to monitor CCBHC specific measurements and address priority Care Alerts noted in the program.

References

Behavior Treatment Plans: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines/behavior-treatment-plans

CARF International: https://carf.org/

Certified Community Behavioral Health Clinics Demonstration Program: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc

CMHA-CEI Quality and Compliance: http://ceicmh.org/about-us/quality-and-compliance

Health Services Advisory Group: https://www.hsag.com/en/about/what-we-do-services/

MDHHS Reporting Requirements: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

MSHN Delegated Managed Care Reviews: https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/cmhsps/delegated-managed-care-reviews

MSHN QAQIP: https://midstatehealthnetwork.org/stakeholders-resources/quality-compliance/compliance-reports

Michigan's Mission Based Performance Indicator System: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/reportsproposals/michigans-mission-based-performance-indicator-system

National Core Indicators: https://www.nationalcoreindicators.org

Agenda Item: Program and Planning Committee
Agenda Item #P-6

Month, Year: February, 2025

Major Program: Quality, Customer Service, Recipient Rights (QCSRR)

Component Program: Customer Service

Agenda Item Title: New Expense Contract: Trusted Translation

SUMMARY OF CONTRACT/PROPOSAL:
Under this contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase written translation services on an on-demand basis to assist in communicating clearly with individuals' and families who have a Non-English Language Preference (NELP). This service will be purchased from Trusted Translations, in Boston, MA and CEI agrees to pay rates that are listed below for the period of March 1, 2025 to through September 30, 2025.

The revenue and expense of this contract are reflected in CMHA-CEI's FY 25 budget. Each department utilizing this service will transfer budgeted money from their Contract Interpreter account as needed for this service. The revenue sources that support this contract are state general funds, Medicaid, and local funding sources. This contract does not cover the administrative costs incurred with the operation of this program. This contract will not affect CMHA-CEI's fund balance.

DESCRIPTION OF GOODS OR SERVICES REFERENCED IN CONTRACT
Trusted Translation will perform translation services of written materials on a scheduled basis to assist CMHA-CEI employees in communicating clearly with consumers and families who have a Non-English Language Preference (NELP).

STAFF RECOMMENDATION:
Staff recommend that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, Ingham Counties Board of Directors authorize CMHA-CEI

to enter into a new contract with Trusted Translations to purchase written translation services to assist in communicating clearly with individuals' and families who have a Non-English Language Preference (NELP) at the rates below for the period of March 1, 2025 through September 31, 2025.

Service Description	Unit	Rate*
Spanish Translation	Word	$0.12
Arabic Translation	Word	$0.17
Other languages	Word	TBD depending on client request/need

*provides 75% discount for repetitions

Agenda Item: Program and Planning Committee
Walk-In

Month, Year: February, 2025

Major Program: Department of Quality Improvement, Customer Services and Recipients Rights and General Administration

Component Program: Customer Services

Agenda Item Title: CMHA-CEI Consumer Advisory Council Recommended Appointees

SUMMARY OF CONTRACT/PROPOSAL:
The development of a Consumer Advisory Council (CAC) was previously approved by the Board in July, 2017. The CAC provides the opportunity for consumer and community partner involvement in shaping policy and practice. The proposed objectives for the Consumer Advisory Council is as follows:

- To provide a consumer voice in determining needs, concerns, and priorities in policy, service provision, service delivery, and accessibility.
- To help identify issues, problems or need areas within provided services.
- To make recommendations to resolve problems or to embrace the opportunities needed to improver system processes.
- To promote community endeavors related to consumer empowerment and self-determination.

The Consumer Advisory Council is comprised of current and past recipients of services, and family members of those who have received services from CMHA-CEI.

The following submitted an application, was interviewed by the members or the committee. CAC members voted and recommend for approval to serve a 2-year term, to expire on 3/31/2027.

- Taperra Riddle, for a 2-year term, to expire on 3/31/2027

STAFF RECOMMENDATION:
Staff recommend that the Program and Planning Committee of Community Mental Health Authority of Clinton, Eaton, Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, Ingham Counties Board of Directors appointment the following individuals named to serve as members of the Consumer Advisory Council.

- Taperra Riddle, for a 2-year term, to expire on 3/31/2027

Agenda Item: Program and Planning Committee
Agenda Item #P-7

Month, Year: February, 2025

Major Program: All Programs

Component Program: Inpatient and Partial Hospitalization Services

Agenda Item Title: New Expense Contract: Henry Ford Behavioral Health Hospital

SUMMARY OF CONTRACT/PROPOSAL:
Under this new expense contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase inpatient psychiatric hospital services from Henry Ford Behavioral Health Hospital, 7100 Berryhill Street, West Bloomfield, MI 48322 in accordance with the schedule of services shown below. This is a new contract and makes no guarantee of a minimum number of patient referrals for hospital services. The contract will be for the term of March 1, 2025 through September 30, 2025.

The revenue and expense of this contract is reflected in CMHA-CEI's FY 2025 budget. The revenue sources that support this contract are Medicaid plans, State General Funds, federal or state contracts, or local funding sources. The expenses of this contract are reflected in the various contract line items of the AMHS, CSDD and Families Forward budgets. This contract will not affect CMHA-CEI's fund balance.

SUMMARY OF GOODS OR SERVICES REFERENCED IN THE CONTRACT/PROPOSAL:
Inpatient services include hospitalization, professional fees, comprehensive psychiatric assessment and diagnosis, neurological and/or psychological testing, individual, group and family psychotherapy, specialized education, activity therapy, dietary and specialized nutritional services, medications, speech and hearing evaluation and treatment, laboratory services, discharge planning, and coordination of care with CMHA-CEI.

STAFF RECOMMENDATION:

Staff recommend that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties authorize CMHA-CEI to enter into a new contract with Henry Ford Behavioral Health Hospital to purchase hospital services at the rates indicated below for the period of March 1, 2025 through September 30, 2025.

CPT Code	Service		Rate
0100	Inpatient Care: Children (ages 5 and up), Adolescent, Adult and Geriatric (All Inclusive).	Per Diem	$1,250
0100	1:1 Enhanced*	Per Diem	$1,450

*On rare occasions, consumers may be admitted to the hospital who require substantially higher amounts of one to one staffing than is typical, due to highly aggressive or self-injurious behavior. Payor shall prior authorize up to two days Enhanced Staffing Inpatient Psychiatric Services for Consumers in this situation on a case by case basis. Criteria for Enhanced Staff Inpatient Psychiatric Services are as follows:

1. The Consumer must meet all of the Inpatient Admission Certification Criteria listed above (Diagnosis, Severity of Illness, and Intensity of Service).
2. The Consumer is failing at least restrictive placement despite active treatment, with no expectation of improvement in a timely manner, combined with risk factors to Customers or Hospital such as: Swallowing behavior on unit, aggression towards others, and/or extreme property destruction at such a level that Consumer requires constant attention from staff in order to prevent self-harm, harm others, or extreme property destruction.

Agenda Item: Program and Planning Committee
Agenda Item #P-8

Month, Year: February, 2025

Major Program: Adult Mental Health Services

Component Program: Crisis Services

Agenda Item Title: New Revenue Contract: Ingham County 911 Central Dispatch (Full-Time Crisis Call Taker Services)

SUMMARY OF CONTRACT/PROPOSAL:
Under this new revenue contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) shall provide crisis call taker services to Ingham County Central Dispatch, to handle emergency call related to mental health crises. These services shall be provided by two (2) full-time employees of the Contractor designated as Crisis Call Takers, who shall be located at the 911 Center at 710 E. Jolly Rd., Lansing, MI 48910. As appropriate, emergency callers to the County's 911 Central Dispatch will be diverted to a Crisis Call Taker for assistance, including triage screening, crisis de-escalation, developing safety plans, and potentially coordinating a mobile crisis team response or other resources and community referrals for the retroactive period of January 1, 2025 to December 30, 2025.

The revenue of this contract is reflected in CEI-CMHA's FY 2025 budget. CEI will, over the term of this agreement, invoice the county for expenses incurred in performance of its services under this agreement. It is expressly understood and agreed that the combined total of all sums that CEI may invoice and that the County will pay under this agreement shall not exceed the sum of $309,012.00.
This contract will not affect CEI-CMHA's fund balance.

DESCRIPTION OF GOODS OR SERVICES REFERENCED IN CONTRACT/PROPOSAL:
CMHA-CEI will provide services by answering the 9-1-1 dispatch line to handle emergency calls and help prioritize the well-being and safety of individuals experiencing mental health crisis, while ensuring the effectiveness and efficiency of public safety responses.

STAFF RECOMMENDATION:

Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties Board of Directors authorize CMHA-CEI to enter into a new contract with the Ingham County 9-1-1 Central Dispatch to provide the clinical support at the 9-1-1 Call Center for the retroactive period of January 1, 2025 through December 31, 2025 and receive up to $309,012.00.

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Agenda Item: Program and Planning Committee
Agenda Item #P-9

Month, Year: February, 2025

Major Program: Community Services for the Developmentally Disabled (CSDD)

Component Program: Residential

Agenda Item Title: New Expense Contract: Anikare Inc.

SUMMARY OF CONTRACT/PROPOSAL:
Under this new contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase Community Living Supports from Anikare Inc. for the period of February 1, 2025 through September 30, 2025.

The expense of this contract is reflected in CMHA-CEI's FY2025 budget. The revenue sources that support the contracts are Medicaid, Healthy Michigan Plan (HMP), Habilitative Supports Waiver (HSW), Medicaid Spend-down/Deductible, State General fund dollars and other Community Mental Health Services Programs (CMHSP) through County of Financial Responsibility (COFR) agreements, and local funding. The expense of the contract is reflected in the various contract residential line items of the AMHS and CSDD residential budgets. The contract will not affect CMHA-CEI's fund balance.

SUMMARY OF GOODS OR SERVICES REFERENCED IN THE CONTRACT/PROPOSAL:
Community Living Supports are provided by aides in the home or community setting to increase or maintain personal self-sufficiency, increase skills, build social skills and relationships, as well as participate in the community.

STAFF RECOMMENDATION:
Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties Board of Directors authorize CMHA-CEI to enter into a new contract with Anikare Inc. to purchase Community Living Supports at the rates below for the period of February 1, 2025 through September 30, 2025.

Fee Schedule				
Service Description	**Billing Code**	**Modifiers**	**Unit**	**Rate**
Community Living Supports	H2015	UN/UP/UQ/ UR/US	15 Minute	$9.12
Overnight Health and Safety	T2027	UN/UP/UQ/ UR/US	15 Minutes	$9.12

For consumers that are not enrolled in the Habilitation Supports Waiver, modifier UJ must be used with H2015 for CLS provided during the consumer's usual sleep hours.
For consumers with the Habilitation Supports Waiver, T2027 must be reported during the consumer's usual sleep hours.

Agenda Item: Program and Planning Committee
Agenda Item #P-10

Month, Year: February, 2025

Major Program: Community Services for Developmentally Disabled (CSDD)

Component Program: Clinical Services

Agenda Item Title: New Expense Contract: Mercy Plus Healthcare

SUMMARY OF CONTRACT/PROPOSAL:
Under this contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase ABA services from:

Company	Address
Mercy Plus Healthcare Main Contact: Gregory Mantei(CEO) (810)487-5571	Corporate Address: 5451 Hampton Place Saginaw, MI 48604 Local Address: TBD

CMHA-CEI will pay the rates as outlined in the chart below for assessments, direct therapy, required supervision, and family guidance by a Board Certified Behavior Analyst (BCBA) or other appropriately credentialed individual for the period of February 1, 2025-September 30, 2025.

ABA Service Rates									
Code	**Modifier**	**Service Description**	**Reporting Units**	**Provider Type**	**BCBA**	**BCaBA**	**QBHP**	**LP/LLP**	**BT**
97151	AH, HN, HO, HP, U5	ABA Behavior Identification Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
0362T	AF, AG, AH, HN, HO, HP, SA	ABA Behavioral Follow-up	Per 15 minutes	BCBA, BCaBA, QBHP,	$30.00	$21.25	$30.00	$30.00	

		Assessment		or LP/LLP					
97153	AF, AG, AH, HM, HN, HO, HP, SA, TD, U7	ABA Adaptive Behavior Treatment, individual	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$16.01	$16.01	$16.01		$14.14
97154	AF, AG, AH, HM, HN, HO, HP, TD, SA, UN, UP, UQ, UR, US, U7	ABA Group Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$5.30	$5.30	$5.30		$4.94
97155	AH, HN, HO, HP, AF, AG, SA	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00		
97156	AH, HN, HO, HP, AF,AG, SA	ABA Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00		
97157	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Multiple Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$12.00	$8.50	$12.00		
97158	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Adaptive Behavior Treatment Social Skills Group	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$8.57	$6.07	$8.57		
0373T	AF, AG, AH, HM, HN, HO, HP, SA	ABA Exposure Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$31.01	$22.26	$31.01		$28.51

The CMHA-CEI FY25 budget contains approximately $9M for contracted autism services. The Autism benefit, is an entitlement benefit, requiring CMHA-CEI to serve those that meet the criteria for the service. The administration of this program will be included in the costs to be reimbursed by the Michigan Department of Health and Human Services (MDHHS). This contract will not affect CMHA-CEI's fund balance.

DESCRIPTION OF GOODS OR SERVICES REFERENCED IN CONTRACT/PROPOSAL:

ABA is an intensive face to face therapy, designed to assist the child to develop age appropriate skills and to address the key symptoms of ASD. While symptoms vary in severity; common symptoms of ASD include deficits in the area of communication and interactional skills. In addition, some children may exhibit repetitive, disruptive and/or intrusive, behavior. ABA is typically provided several hours a week in a clinical setting, community, and/or in the child's home. Hours authorized per week are dependent on the needs of the child. The Medicaid policy requires that supervision of the therapy occurs by a Board Certified Behavior Analyst, (or other appropriately credentialed individual supervised by a BCBA) one hour for every 10 hours of therapy provided. Family training and involvement in the therapy, is a key component of the intervention. A CMHA-CEI psychologist will designate the level of service for which the child is eligible. In addition, MDHHS will verify the eligibility for each child.

STAFF RECOMMENDATION:

Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, Ingham Counties Board of Directors authorize CMHA-CEI to enter into a contract with Mercy Plus Healthcare to provide the services at the rates listed below, for the period of February 1, 2025 through September 30, 2025.

ABA Service Rates									
Code	**Modifier**	**Service Description**	**Reporting Units**	**Provider Type**	**BCBA**	**BCaBA**	**QBHP**	**LP/LLP**	**BT**
97151	AH, HN, HO, HP, U5	ABA Behavior Identification Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
0362T	AF, AG, AH, HN, HO, HP, SA	ABA Behavioral Follow-up Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97153	AF, AG, AH, HM, HN, HO, HP, SA, TD, U7	ABA Adaptive Behavior Treatment, individual	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$16.01	$16.01	$16.01		$14.14
97154	AF, AG, AH, HM, HN, HO, HP, TD, SA, UN, UP, UQ,	ABA Group Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$5.30	$5.30	$5.30		$4.94

	UR, US, U7								
97155	AH, HN, HO, HP, AF, AG, SA	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00		
97156	AH, HN, HO, HP, AF,AG, SA	ABA Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00		
97157	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Multiple Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$12.00	$8.50	$12.00		
97158	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Adaptive Behavior Treatment Social Skills Group	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$8.57	$6.07	$8.57		
0373T	AF, AG, AH, HM, HN, HO, HP, SA	ABA Exposure Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$31.01	$22.26	$31.01		$28.51

Agenda Item: Program and Planning Committee
Agenda Item #P-11

Month, Year: February, 2025

Major Program: Integrated Treatment and Recovery Services (ITRS)

Component Program: Integrated Treatment and Recovery Services (ITRS) Admin

Agenda Item Title: New Revenue Contract: Ingham County Health Department (ICHD) - Opioid Crisis Response Grant

SUMMARY OF CONTRACT/PROPOSAL:
Under this new revenue contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will provide follow up care for individuals in Ingham County who had a nonfatal overdose and receive $77,718.00 for the retroactive period of January 1, 2025 through December 31, 2026.

The revenue and expense of this contract are not reflected in CMHA-CEI's FY25 budget. The revenue source that supports this contract is Ingham County Resolution to Adopt an Opioid Settlement Spending Plan. This contract does not cover the administrative costs incurred with the operation of this program. In this collaborative initiative administrative costs such as supervision and office space will be shared between the Ingham County Health Department and CMHA-CEI. This is an opportunity for survivors of nonfatal overdoses to easily access both physical and behavioral health services. This contract will affect CMHA-CEI's fund balance.

DESCRIPTION OF GOODS OR SERVICES REFERENCED IN CONTRACT/PROPOSAL:
This is a long- standing partnership through the Ingham County Health Department. The purpose of this agreement will be for CMHA-CEI to create one 0.50 FTE Peer Recovery Coach position to expand the current activities and capacity of the Ingham County Rapid Response Team. The Ingham County Rapid Response Team formed in 2020 and is a cross-sector, multi-agency collaborative that works to reach individuals experiencing non-fatal overdoses to provide comprehensive harm reduction and recovery supports within 24-72 hours of overdose.

STAFF RECOMMENDATION:

Staff recommend that the Program and Planning Committee of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties Board of Directors authorize CMHA-CEI to enter into a new contract with the Ingham County Health Department to provide follow up care for individuals in Ingham County who had a nonfatal overdose and receive $77,718.00 for the retroactive period of January 1, 2025 through December 31, 2026 for those services.