Southwest Michigan Behavioral Health
2022 Quality Assurance and Performance Improvement Program
All SWMBH Business Lines

Year 2021 (October 1, 2021 - September 30, 2022)

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I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically AttachmentP.6.7.1.1.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities. The QAPIP describes the organizational structure for the SWMBH's administration of the QAPIP; the elements, components, and activities of the QAPIP; the role of service recipients in the QAPIP; the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels. SWMBH is a learning region where quality and cost are measured and improved.

SWMBH QAPIP is approved annually by the Southwest Michigan Behavioral Health (SWMBH) Board. The SWMBH EO and SWMBH Board grant the authority of the Quality Management (QM) department and the QM Committee. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, SWMBH Strategic Guidance Document, QMC Committee Charter, and other departmental plans.

II. Purpose

The QAPIP delineates the features of the SWMBH QM program. This QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical service delivery within the network as well as benefit management processes within SWMBH. The program addresses access, quality, and cost for services delivered, inclusive of administrative aspects of the system, service delivery, and clinical care. Populations served by the SWMBH include persons who experience mental illness, developmental disabilities, and substance use disorders.

Additional purposes of the QAPIP are to:

- Continually evaluate and enhance regional Quality Improvement Processes and Outcomes.
- Monitor, evaluate, and improve systems and processes for SWMBH.
- Provide oversight and data integrity functions.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, and integration of care and customer satisfaction.
- Improve the quality and safety of clinical care and services it provides to its customers.
- Promote and support best practice operations and systems that promote optimal benefits in service areas of service *accessibility, acceptability, value, impact,* and *risk-management* for all members.
- Conduct and report the results of ongoing performance monitoring and structure accountabilities for meeting performance standards and requirements.
- Promote best practice evaluation design and methodology in performance monitoring and outcomes research and push process improvement techniques throughout the system.
- Promote timely identification and resolution of quality-of-care issues.
- Conduct performance monitoring and improvement activities that will result in meeting or exceeding all external performance requirements.
- Meet the needs of external and internal stakeholders and provide performance improvement leadership to other departments.

III. Guiding Principles

During the December 11, 2020 Board Meeting, the SWMBH Board approved the 2021-2022 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for the development of annual Board Ends Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. Please see attachment (*Please see Attachment G - Strategic Alignment and Annual Goal Setting*)

Mega Ends

- **Quality of Life.** Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.
- **Improved Health.** Individual mental, physical health, and functionality are measured and improved.
- **Exceptional Care.** Persons and families served are highly satisfied with the care they receive.
- **Mission and Value-Driven.** CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public
    - mental health system.
- **Quality and Efficiency.** The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

IV. Strategic Imperatives

Strategic Imperatives: During the May 8, 2020 Board Retreat and Board Meeting, the Board voted on and established a new set of Strategic Imperatives. It is critical to the success of SWMBH and the Region that these Strategic Imperatives are tracked and monitored for success. The following are the approved 2020-2022 Strategic Imperatives:

- Public Policy and Legislative initiatives
- Uniformity of Benefit
- Integrated Health Care
- Population Health Management
- Revenue Maximization/Diversification
- Improve Healthcare Information Exchange, Analytics and Business Intelligence
- Managed Care Functional Review
- Proof of Value and Improved Outcomes

The SWMBH Strategic Imperatives also align with the 2021-2022 Michigan Department of Health and Human Services Strategic Pillars, which were released in June for review and feedback.

V: Core Values of Quality Assurance and Improvement

1. **Quality healthcare will result from a benefit management system embracing input from all stakeholders.**
    a. Educating all customers of SWMBH on continuous improvement methodologies, including providing support to other SWMBH departments and providers as requested. The inclusion of customers, families, stakeholders, and providers in the performance improvement design will promote optimalresults.
    b. Promoting a person-centered philosophy will promote customer satisfaction as well as optimal treatment outcomes.
2. **Poor performance is costly.**
    a. Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risk.
    b. Quality Improvement projects are best approached systemically; best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.
    c. Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making.
        i. Making data accessible will impact value and reduce risk to SWMBH.
3. **Data Collection Values.**
    a. Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
    b. Providers submitting data to SWMBH shall certify data integrity and have available for review the process used to collect the data.
    c. Performance that has demonstrated instability or significant variance to comparison performance on an ongoing basis will be monitored closely. Significant variation in results will indicate the need for a corrective action/performance improvement plan.

VI. Authority and Structure

The SWMBH Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPIP, receives periodic QAPIP reports, and the QAPI & UM Effectiveness Review/Evaluation throughout the year.

In addition, review by the SWMBH Board and SWMBH EO, the QAPIP, and QAPI & UM Effectiveness Review/ Evaluation will be taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement throughout the Region. The SWMBH Operations Committee consists of the Executive Officer (EO), or their designee, for each of the (8) participating Community Mental Health System Providers (CMHSP).

The general oversight of the QAPIP is given to the SWMBH's QAPI Department, with a senior management officer, the Director of QAPI, being responsible for the oversight of QAPIP Implementation. *(Please see attachment A – SWMBH organizational chart for more details)*

Internal Staffing and Resources of the QAPI Department
The SWMBH QAPI Department is charged with the purpose of developing and managing its program. This program plan outlines the current relationships and structures that exist to promote performance improvement goals and objectives. The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement, which oversees the QAPI Department, including the 2 Full-Time Quality Assurance Specialists. The QAPI Department also may utilize an outside contract consultant for special projects and preparation for accreditation reviews. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the; Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Committee (RUMC), and the Regional Clinical Practices Committee (RCPC).

As the primary data user, the QAPI Department works very closely with the IT Department to review and analyze data. In guiding the QAPI studies, the Business Data Analyst is tasked with performing complex analyses of data including statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets and performs factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to determine relationships between variables. Based on the data, the Business Data Analyst will develop reports, summaries, recommendations, and visual representations.

SWMBH staff will include a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner will provide supervisory and oversight of all SWMBH clinical functions to include Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment, and other clinical initiatives. The designated behavioral health care practitioner will also provide clinical expertise and programmatic consultation and will collaborate with QAPI Director to ensure complete, accurate, and timely submission of clinical program data, including Jail Diversion and the Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management Committee (QMC).

Adequacy of Quality Management Resources

The QAPI Department works collaboratively with many different functional areas. Although each position identified below is not assigned to the QAPI Department, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent on quality related activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	40%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management	UM	20%
Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	30%
Senior Software Engineer	IT	20%
Member Engagement Specialist	UM	15%
Waiver and Clinical Quality Manager	PNM	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner (primary through Regional Committees)	UM/PN	20%
Chief Compliance and Operations Officers	Com/Ops	15%

QAPI = Quality Assurance and Performance Improvement
PNM = Provider Network Management
UM = Utilization Management
IT = Information Technology

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, MI Health Link (MHL) & Duals, SUD Block Grant, PA 2 funds, and other grant funding. Completion of these functions require resources that include but are not limited to:

- Access to regional data
- Software and tools to analyze data and determine statistical relationships

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

The QAPI Department collaborates with the Quality Management Committee (QMC) and the SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/venders like Streamline Solutions and the Health Service Advisory Group (HSAG) to review data collection procedures. These relationships are communicated with the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the State
- Creating and maintaining QAPI policies, plans, evaluations, and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development of the Boards Ends Metrics and other Key Performance Indicators
- Communications and Reporting to our Integrated Care Organizations
- Analysis of reports and data; to determine trends and recommendations for process improvements

VII. Committees

Quality Management (QM) Committee

SWMBH has established the QMC to provide oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. SWMBH values the input of all stakeholders in the improvement process, and QMC is one method of participant communication, alignment, and advice to SWMBH. QMC allows regional input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the aims of both the QAPI Department and the QMC. Cooperationwith the QMC Program is required of all SWMBH staff, participants, customers, and providers.

CMHSPs are responsible for the development and maintenance of a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC. To assure a responsive system, the needs of those that use or oversee the resources, (e.g., active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever

possible. Training on performance improvement technology and methods, along with technical assistance, is provided as requested or asnecessary.

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC), and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed, which may include provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. The QMC will make efforts to maintain consumer representation, assist with review of reports/data, and provide suggestions for Regional process improvement opportunities. All QMC members are required to participate; however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

QMC Committee Commitments include:

1. Everyone participates.
2. Be passionate about the purpose.
3. All perspectives are professionally expressed and heard.
4. Support Committee and Agency decisions.
5. Members share relevant information with their colleagues.
6. Celebrate success.

Decision Making Process

Quality Management is one of the core functions of the PIHP. The QMC is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. Quarterly, QMC collaborates with the Regional Clinical Practices (RCP) and Regional Utilization Management (RUM) Committees on clinical and quality goals and contractual tasks.

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the QMC charter. *(Please see Attachment B– QMC Charter for more details)*

QMC Roles and Responsibilities

- QMC will meet regularly (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.
- Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. As conduits, it is expected that committee members attend all meetings by phone or in person. If members are not able to attend meetings, they should notify the QMC Chairperson as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures, including the Board, the Management team, other SWMBH committees, and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The primary task of the QMC is to review, monitor, and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input guidance and make suggestions for process improvement opportunities, with the goal

of improving consumer outcomes.

2022 Quality Management Committee Goals (Measurement period: May1, 2022 – November 30, 2022)

1. **Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By: 6/30/22)**
   i. Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project.
   ii. Identify common denominators and classify into strategic categories.
   iii. Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category).
   iv. Develop and target interventions to improve identify problem areas.
   v. Determine tracking mechanisms and targets goals for each identified area.
   vi. Share results with Operations Committee and other relevant committees.
   vii. Identify alternative electronic methods of gathering consumer responses, other than telephonic.
   viii. Identify tools/resources, which determine how many surveys have been completed and current scores.
   ix. Review individual Performance improvement projects for each CMHSP, during the Regional Quality Management Committee meetings.

2. **Select a new (NCQA approved) survey tool for the 2022 Consumer Satisfaction Survey Project, to replace the MHSIP and YSS tools (By: 9/30/2022)**
   i. Identify NCQA approved consumer satisfaction survey tools.
   ii. Seek approval from MDHHS to utilize the new tool, through the MDHHS Quality Workgroup
   iii. Review tools, questions and scoring methodology with relevant regional committees for feedback.
   iv. Identify survey distribution methods and possible process changes.
   v. Communicate project logistics to CMHSP survey point persons and regional committees.
   vi. Complete analysis of results and distribute to internal and external stakeholders.
   vii. Evaluate selected tools effectiveness and make modifications as necessary.

3. **Redesign structure/format of the annual QAPI-UM evaluation report. (By: 12/30/2022)**
   i. Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.
   ii. Identify program weaknesses and strengths for each category evaluated.
   iii. Identify detailed plans/timeline to remediate identified weaknesses.
   iv. Make sure all elements/standards/MDHHS recommendations are included in the redesigned report.

4. **Create a flow chart for each QAPI contractually obligated reporting requirement. (By 12/30/2022)**
   i. Each chart should provide processes and steps for collecting data, reporting data, timelines, project point persons and additional resources available.
   ii. Identified areas to include MMBPIS, Critical Incidents, Jail Diversion and BTRC.

*Please also see the 2022-2023 SWMBH Board Ends Metrics for additional Key Performance Metrics assigned to the Quality Management Committee.

VIII. MI Health Link Business Line Overview

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons with both Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan (*now Centene as of 2020*). As such, SWMBH will be held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS), CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment, and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and

Southwest Michigan Behavioral Health (SWMBH) has earned the one year Managed Behavioral Health Organization (MBHO) Accreditation for their MI Health Link Business Line from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations (MBHOs), preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs, and other health-related programs.

NCQA Accreditation is a nationally recognized evaluation that purchasers, regulators, and consumers can use to assess managed behavioral health organizations (MBHO). NCQA evaluates how well an organization manages all parts of its delivery system, including behavioral health professionals, other providers, and administrative services. NCQA also measures continuous quality improvement in health care for its members. NCQA MBHO Accreditation standards are intended to guide organizations to achieve the highest level of performance possible, reduce patient risk, improve outcomes, and create an environment of continuous improvement. NCQA reviews include rigorous on-site and off-site evaluations conducted by a team of physicians and managed care experts. A national oversight committee of physicians and behavioral health providers analyzes the team's findings and assigns an accreditation level based on the MBHO's performance compared to NCQA standards.

National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD, and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

The MHL Committee is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. The committee is one method of participant communication, alignment, and advice to SWMBH.

The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines, including the Three-Way Contract, ICO-PIHP Contract, and NCQA requirements. The MHL QMC is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The MHL QMC must provide evidence of review and thoughtful consideration of changes in its policies and procedures and work plan and make changes to its policies where they are needed. Analyzes and evaluates the results of QM activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. The MHL QMC will meet regularly (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.

MI Health Link Committee Membership

The MHL Committee shall consist of the QAPI Department staff, a designated behavioral health care practitioner and ICO representatives. This designated behavioral health care practitioner shall have oversight of any clinical metrics and participates in or advising the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and may be a medical director, clinical director or, participating practitioner from the organization or affiliate organization. All other ad-hoc members shall be identified as needed and could include provider representatives, IT support staff, Coordinating Agency staff, and medical director and clinical representation.
Members of the committee are required to participate; however, alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.

Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that members will share information and concerns with SWMBH QAPI staff. As conduits it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation.

Decision Making Process

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the MHL QMC charter. *(Please see Attachment D – MHL Committee Charter for more details).* The MHL Committee is responsible for maintaining contact with other committees as well as identifying people, organizations, or departments that can further the aims of both the QAPI Department and the Committee. The MHL QAPI section of the Committee coordinates with the UM and Provider Network MHL Committees. The QAPI Director is a member of both the UM and Provider Network MHL Committees. The QAPI Director may call on other QAPI team members or CMHSP partners to participate in MHL Committee meetings as necessary.

---*See Attachment C, "MHL Charter – Decision Making."* ---

The following grid represents the MI Health Link Committee Functional Area Reporting Responsibilities:

Functional Area	Objectives	Lead Staff	Review Date
Committee	Approve last month's MHL Committee Meeting minutes.	All Committee Members	Monthly
UM	Grievances and Appeals	Member Engagement Specialist	Quarterly
Credentialing	Review and approval of MI Health Link policies and procedures.	Director of Provider Network	As needed
	Medical Director, Clean File Review Approvals Four clean file reviews since last meeting	Provider Network Specialist, or Director of Provider Network	Monthly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Monthly
	Practitioner Complaints	Provider Network Specialist, or Director of Provider Network	Quarterly
Quality	Policy and Procedure Review and Updates.	Director of QAPI or designated QAPI Specialist	As needed
	Annual Work plan Review (Quarterly).	Director of QAPI or designated QAPI Specialist	Quarterly, as indicated by QAPI work plan
	Annual Reviews/Audits (Recommendations for Improvement and review of results).	Director of QAPI or designated QAPI Specialist	As needed
	Practitioner Participation and Clinical Practice Guideline Review.	Director of QAPI or designated QAPI Specialist	Quarterly
	Performance Measures for Site Audit	Director of QAPI or designated QAPI Specialist	As needed
	Causal Analysis	Director of QAPI or designated QAPI Specialist	Quarterly
	Call Center Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly

UM/Clinical	Collaborative Initiatives Meridian ICT Update	Director of Utilization Management or Integrated Care Specialist	Monthly
	Complex Case Management	Director of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Director of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Director of Utilization Management or Manager of Utilization Management	As needed

MI Health Link Committee Roles and Responsibilities:

- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The secondary task of the Committee is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.
- The primary task of the Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program.
- Ensures follow-up as appropriate. Ensures practitioner participation in the QAPI program through planning, design, implementation, or review. Ensures discussion (and minutes) reflects:
    - Appropriate reporting of activities, as described in the QM program description.
    - Reports by the QM director and discussion of progress on the QM work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues.
- Ensures the organization describes the role, function and reporting relationships of the QM Committee and subcommittees.
- Ensures all MHL required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up.
- Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up.
- Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QM Committee or another clinical committee.
- Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QM Committee or another clinical committee.
- The organization annually:
- Documents and collects data about opportunities for collaboration.

- Documents and conducts activities to improve coordination between medical care and behavioral healthcare.
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities.
- Ensures a care management quality control program is always maintained.

The MI Health Link Committee and QAPI Department are also responsible for reporting and achieving all quality withhold performance measures identified in the Integrated Care Organization (ICO) and Michigan Department of Health and Human Services (MDHHS) three – way contracts. The quality performance measure data will be collected by the QAPI Department and a report analysis will be performed in collaboration with the UM Department, Provider Network Management Department and with the Integrated Care Specialist. The identified quality withhold measures will be used to reconcile payments between the SWMBH and the ICO on an annual basis via a calendar year schedule identified in the contract.

2022 Quality Performance Withhold Measures:

Each year, a set of Quality Performance Measures are reviewed and negotiated between the PIHP and the Integrated Care Organizations (ICOs). Pursuant to Section 3.4.3 of the Agreement, the quality-withhold measures and corresponding point values that will apply to PIHP in Demonstration Year 4 are as follows:

Domain	Measure	Source	Maximum Point Value	Benchmarks
Encounter Data	Encounter Data submitted timely, accurately, and completely in compliance with requirements in this Agreement	Encounter data file submissions	5-Timely 5-Complete 5-Accurate	-90% of paid claim encounters submitted by 15th of the month following payment -80% of paid claim encounters submitted within 180 days of the date of service -95% CMS initial acceptance rate of PIHP encounters
Assessments	Percentage of Enrollees with Level II assessments completed within 15 days of the Plan referral for Level II assessment	Monthly assessment status reports	30	95%+ - 30 90-94% - 25 85-89% - 20 80-84% - 15 75-79% - 10

Care Transition Record Transmitted to Health Care Professional	Percentage of Enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within twenty-four (48) hours of discharge to the facility or behavioral health professional designated for follow-up care	Care transition audit	10	80%+ - 10
Documentation of Care Goals	Percentage of Enrollees with documented discussions of care goals	Documented care plans in ICBR	20	95%+ - 20 90-94% - 10
Follow-up after Inpatient Admission	Percentage of Enrollees with a follow-up visit with a behavioral health practitioner within 30 days of BH inpatient discharge	HEDIS 2019 data (FUH)	20	56%
Governance board	Participation of members appointed by PIHP on the ICO's advisory board	Advisory Board meeting minutes	5	2 participating advisory board appointments

2022 MI Health Link Provider Performance Indicators and Objectives:

Each year, the Michigan Department of Health and Human Services and Integrated Care Departments formulate a set of Contractually obligated Key Performance Indicators. Each Performance Indicator has an established measurement period and Target/benchmark attached to it. The Performance indicator status is analyzed by SWMBH and is discussed during Regional Committees, which involve providers such as Utilization Management Committee, Clinical Practices Committee and the Quality Management Committee. The below Performance Indicators have been established for the 2022 reporting period:

1. Percentage of Enrollees who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment at least 180 days. Goal – 70%
2. Percentage of discharges from inpatient psychiatric hospitalization who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. Goal – 80%
3. Percentage of new Enrollees referred to Provider with Level II (PIHP/Provider) assessments completed within 15 days of Level I (ICO) assessment. Goal – 80%
4. The percentage of new Enrollees referred to Provider who start services within 14 days of completion of the initial IISCP for nonemergent needs. Goal – 80%
5. For SUD service providers: The percentage of Enrollees with a new episode of diagnosed SUD who received the following:
   1. Initiation of SUD Treatment - The percentage of Enrollees referred to Provider who initiate treatment through an outpatient visit or intensive outpatient encounter within 14 days of the diagnosis.
   2. Engagement of SUD Treatment- The percentage of Enrollees referred to Provider who initiated treatment and who had two or more additional services with a diagnosis of SUD within 30 days of the initiation visit. (Two-part measure) Goals – 70% and 70%

IX. MI Health Link Quality Standards and Philosophy

The SWMBH's QAPIP functions according to a Continuous Quality Improvement (CQI) methodology to provide sound benefits management strategy that will yield higher satisfaction for all stakeholders. The regional quality management system combines traditional aspects of quality assurance with quality improvement using a variety of process and improvement strategies including:

- ✓ Develop measures that are reliable, and meet related standards
- ✓ Establish thresholds/benchmarks,
- ✓ Achieve target performance levels,
- ✓ Identify and analyze statistical outliers
- ✓ Implement Performance Improvement Projects
- ✓ Evaluate effectiveness (e.g., QAPI Effectiveness Review/Evaluation)
- ✓ Develop a system that is replicable and adaptable (appropriate scalability of program)
- ✓ Promote integration of QAPI into PIHP management and committee activity
- ✓ Promote coordination internally and externally throughout the region
- ✓ Incorporate relevant process and quality improvement methodologies
- ✓ Predefined quality standards
- ✓ Formal assessment of activities
- ✓ Measurement of outcomes and performance
- ✓ Strategies to improve performance

Other methodologies are used to control process include:

- ✓ ***Define*** the current process performance**.**
- ✓ ***Measure*** the current process performance.
- ✓ ***Analyze*** to determine and verify the root cause of the focused problem.
- ✓ ***Improve*** by implementing countermeasures that address the root causes.
- ✓ ***Control*** to maintain the gains

X. Review of MI Health Link Activities (CY - January 1, 2022 – December 31, 2022)

The QAPI Department is responsible for a wide range of activities and monitoring contract requirements. The QAPI assessment consists of a variety of strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards. Reviews could be at a systematic, programmatic, or individual level. Some of the observed review activities include:

Review Activity	Activity Description
1. Annual QAPI Plan	The QAPI plan is a document that reflects the ongoing progress on QAPI activities throughout the year. The QAPI plan is developed by the QAPI Department with guidance from the QMC, RCP, and RUM. The Plan is reported annually to the EO, Operations Committee the SWMBH Board, and to customers and other stakeholders. The plan consists of the quality improvement, performance, and outcome goals to be achieved throughout the year and addresses: • Yearly planned QI objectives/goals for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Time frame for each objective/goal's completion. • Lead staff responsible for each objective/goal. • Monitoring of previously identified issues. • Evaluation of the QAPIP. ***--See Section XI, "2022 Quality Assurance Improvement Plan"***
2. Annual QAPI & UM Effectiveness Review & Evaluation	Monitoring, evaluation and reporting occurs on an on-going basis. Evaluation results will be shared annually with the EO, Operations Committee, the SWMBH Board, relevant Committees, customers, and other stakeholders. The QM department will on an annual basis will do an effectiveness review/evaluation of the QAPIP that will include: • A description of completed and ongoing objectives/goals that address quality and safety of clinical care and quality of service. • Trending of measures to assess performance in the quality and safety of clinical care and quality of service. • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the organization. • Identification of any performance improvement needs or gaps in service. • Adequacy of QAPIP resources and staff including practitioner participation and leadership involvement in the QAPIP. • Remediation and corrective action plans. • Analysis of overall results for MDHHS quality & UM reporting metrics, such as: • MMBPIS Performance Indicators, Critical Incidents, Jail Diversion, Call Center Performance Metrics, Inter-Rater Reliability testing, Consumer Satisfaction Survey Results, RSA-r Survey Results, Program and Service Audit results and more.
3. Annual Goals and Objectives – Reports, Dashboards,	• Annual Goals and Objectives are discussed, monitored, and reported as defined by the objective scope. All Department and Regional Committee goals should align with SWMBH Board Ends Metrics and SWMBH Strategic Guidance

Outcome monitoring	• Document, which is the overarching tool to maintain strategy and tactical objectives, as defined by the Board. • Key Performance indicators will be compared and monitored with reports created. (Board Ends Metrics, Dept. Goals, Regional Committee Goals) • Training and monitoring of best practice standards will be completed as necessary. ***see attachment (G) – "2022-2023 Board Ends Metrics"***
4. Access Standards	• SWMBH will monitor that customers will have a face-to-face level II assessment completed within 15 days. • Contracts with providers will be monitored to assess customer access to services within Medicare and Medicaid standards on geography and type. • Assessments against standards related to regular and routine appointments, urgent/emergency care, after-hours care, and call center rates. • Behavioral Health will meet the following standards: **1.** Routine Non-Life-Threatening Emergency within 6 hours **2.** Urgent Care within 48 hours **3.** Routine Office Visits within 10 business days **4.** Call Center calls will be answered by a live voice within 30 seconds **5.** Telephone call abandonment rate is within 5%
5. Key Administrative Functions	In keeping with the need to provide performance oversight across a broad array of PIHP administrative functions, key areas of performance are reviewed by the identified functional committee(s): • *Provider Network* • *Compliance* • *Customer Services* • *Utilization Management* • *Administrative Support* Performance measures for respective functional areas are further described in functional documents, which provides description of associated plans, performance measures, and tracking processes
6. External Monitoring Reviews	The QAPI department will coordinate the reviews by external entities, including ICO's, MDHHS, HSAG, NCQA review organization, and any accreditation organization as identified by the SWMBH Board. The QAPI department will also be available to assist affiliates in their external reviews.
7. Customer Provider Assessments	Surveys are collected throughout the year; and are reviewed by the QMC and MHL Committee and required by PIHP/MDHHS contract. Results are Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. The MHSIP survey is used for adult participants 17 years of age and over and the YSS survey is used for Youth under the age of 17.

8. Customer and Provider Assessments (MIHL)	Surveys are collected throughout the year; and are determined by the QMC and MHL Committee and required by PIHP contract. Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. When available; results are compared to State and National values, to provide performance benchmarks.
9. Michigan Mission Based Performance Indicators (MMBPIS)	A collection of state defined indicators that are aimed at measuring access, quality of service, and provide benchmarks for the state. Data is reported to Michigan Department of Health and Human Services (MDHHS), results are additionally communicated to the EO, the Operations Committee, the SWMBH Board, customers, and other stakeholders. The SWMBH maintains a dashboard to monitor the progress on each indicator throughout a year. The SWMBH QAPI Department reviews and approves plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time.
10. Critical Incidents/Sentinel Events/Risk Events	The state has provided definitions for three categories of events that the SWMBH monitors through the QAPIP. For further information see SWMBH Policy (3.5) Critical Incidents/Sentinel Events/Risk Events.
11. Customer Grievances and Appeals	Collected and monitored by the SWMBH and analyzed for trends and improvement opportunities. Categories will be used for reporting including: Quality of Care Complaints, Access, Attitude and Service, Bill/Financial, and Quality of Practitioner Office Site. These trends will be reviewed quarterly and annually.
12. Behavior Treatment Review Data	Collected by the SWMBH from the affiliates and available for review. For more information see SWMBH Policy Behavior Treatment Review Committee. The PIHP shall continually evaluate its oversight of "vulnerable" people to determine opportunities for improving oversight of their care and their outcomes.
13. Utilization Management	An annual Utilization Management (UM) Plan is developed, and UM activities are conducted across the Affiliation to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. UM data will be aggregated and reviewed by the Regional UM Committee as well as QMC for trends and service improvement recommendations. To ensure that the UM program remains current and appropriate, QM will do an annual evaluation of the UM program. The Utilization Management (UM) Plan Evaluation Components include: a) 2022 UM Program Description & Plan b) Policies and Procedures in compliance with contractual, state and regulatory and. accreditation requirement. c) Department Compliance with Established UM standards. d) Adequate Access a. Telephone Access to Services and Staff. e) Timeliness of UM Decisions a. Services b. Appeals f) UM Decision-Making a. Clinical Criteria

	g) Availability of Criteria h) Consistency of ApplyingCriteria i) Inter-rater reliability (IRR audit) j) Coordination of Care k) Quality of Care l) Outlier Management m) Over or under utilization n) Hospital Follow-Up o) Behavioral Healthcare Practitioner Involvement
14. Jail Diversion Data	Collected by the SWMBH from the participants and available for review. Collaborative program between participant CMHSPs and their County to provide mental health treatment and assistance, if permitted by law and considered appropriate, to people with serious mental illness who are considered at risk for 1 or more of the following; entering the criminal justice system; not receiving needed mental health services during incarceration in a county jail; not receiving needed mental health treatment services upon release or discharge from a county jail; and being committed to the jurisdiction of the Department of Corrections. SWMBH collects and reports the number of jail diversions (pre-booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities and co-occurring mental health and substance abuse disorders (DD & COD).
15. Call Center Monitoring Plan	The QM Department in collaboration with UM Department is responsible for ensuring a call center monitoring plan is in place. The monitoring plan includes National Quality Standards (NCQA) such as: providing routine quality assurance audits through random call monitoring and tracking call center service lines (crisis, emergent, immediate and routine) calls for timely responses. Call center performance measures may include: a) A call abandonment rate of 5% or less. b) Average call center answer time of 30 seconds or less. *c)* Service level standard of 75% or above. (*meaning 75% of calls are answered in 30 seconds or less and not abandoned)*
16. Collaborative Activities	To improve outcomes, the QM Department collaborates with multiple functional areas on a quarterly basis to provide quality updates and data reviews. Many of the QM Department functions overlap with Technology, Utilization Management and Clinical objectives/goals. The QM Department has an active present throughout all functional areas to enhance communication and feedback mechanisms between collaborative groups and Committee's. The QM Department also collaborates with other quality organizations, physical health organizations and venders to share information, to improve overall member outcomes.
17. Active Participation of providers and consumers in the QAPIP process	SWMBH QI Policy 3.2- III.D: Indicates that: "*Member feedback on QAPI activities will be sought and incorporated into the QAPI plan*". On a quarterly schedule, data is brought to Customer Service Committee by QAPI team members for presentation and feedback. Some of the reports that are shared with the Customer Service Committee and MI Health Link Committee's include: MMBPIS Performance Indicator reports; Customer Satisfaction survey planning and results; Grievance and Appeals reports; Critical Incident reports and the annual QAPI evaluation.

	Valuable feedback comes from these Regional Committees and affords the QAPI department the opportunity to receive consumer feedback on opportunities for improvement. QAPI Key Performance Indicators are also reported to consumers through quarterly newsletters and on the SWMBH website. The QAPI department actively seeks out consumer involvement and feedback to proactively improve programs, services and ultimately improved outcomes for our customers.

XI. 2022 Regional Strategic Imperatives

Each year the SWMBH Board of Directors reviews annual priorities based on current environmental factors and strategic growth of SWMBH. Each Department and Regional Committee will now work together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 10, 2020. The following represent a list of those Strategic Imperatives: (***See Attachment E for more details on completion of Strat.egic Imperatives.***)

1. Public Policy and Legislative Initiatives
2. Uniformity of Benefit
3. Population Health Management
4. Revenue Maximization
5. Improved Analytics and Business Intelligence
6. Managed Care Functional Review
7. Use of Level of Care Tools and Guidelines
8. Cost Reduction Strategies (MLR and ALR)
9. Proof of Value and Outcomes

XII. Data Management

As part of a productive and active Quality Improvement system it is critical that data integrity and collection is systemically monitored and improved. As such it is important to review the system for errors and ensure that the data is correct, accurate, and timely.

a. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
    i. Data Reviews before information is submitted to the state
    ii. Random checks of data for completeness, accuracy and that it meets the related standards.
    iii. Source information reviews to make sure data is valid and reliable.
b. The QMC and QM Department will address any issues identified in the system review.
c. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).
d. The Health Service Advisory Group (HSAG) and Michigan Department of Health and Human Services (MDHHS) complete annual audits on SWMBH data sources, to measure and validate the accuracy of all data transactions.
e. Maintaining and organization of the SWMBH portal and reports.
f. Maintaining and organization of reports in the Tableau Data Visualization system.

XIII. Data Management Continued

In May of 2019, the Managed Information Business Intelligence (MIBI) Steering Committee was formed.
The purpose of the committee is to oversee Business Intelligence strategy, resources, and priorities, including report development and maintenance, taxonomies, data dictionaries, data model development, and integrity of incoming data, to ensure organizational needs are met. The Directors of QAPI, IT and Clinical Quality meet on a monthly schedule to review prioritized and relevant data issues and policies. Since each department works cross functional with all available data sources, this meeting is a great way to minimize overlap and ensure identified tasks stay on track. The secondary purpose of the committee is to ensure all data sources are reports are in alignment with contractual requirements and exceeding metric benchmarks.

(Please see attachment J "*SWMBH Managed Information Business Intelligence Department Roles*")

XIV. Communication

The QAPI Department interacts with all other departments within SWMBH as well as the participant Community Mental Health Services Programs (CMHSPs). The communication and relationship between SWMBH's other departments and CMHSPs is a critical component to the success of the QAPI Department. The QAPI Department works to provide guidance on project management, technical assistance, and support data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through our Managed Information Business Intelligence system and through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real time status and analysis to the end user. At least annually, the QAPI department shares with relevant stakeholders and the SWMBH provider network in newsletter articles and on the SWMBH website its QAPI program information and results such as member survey and QAPI & UM evaluation results.

SWMBH acknowledges the importance of disseminating quality-related information and improvement outcomes. Communication of findings will be made to the following groups:

- Stakeholders (Including providers inside the provider network), Customers and family members of customers (when appropriate)
- SWMBH Board
- CMH staff and SWMBH staff
- Others – State representatives

These groups and others may be provided information through a variety of methods including but not limited to:

- Newsletters
- SWMBH Website
- SWMBH SharePoint Site
- Tableau Dashboards
- SWMBH QM Reports
- Meetings
- External Reports

XV. 2022 Quality Assurance and Performance Improvement Plan (Medicaid Business Line)

(FY - October 1, 2021- September 30,2022)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
1. Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS ➢ Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures reported to State.	➢ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ➢ Report indicator results to MDHHS on a Quarterly basis. ➢ Status updates to relevant Committees such as: QMC; RUM; RCP and Operations Committee. ➢ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ➢ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated benchmark. ➢ Ensure CMSHP Corrective Action Plans are achieved, and improvements are recognized. ➢ Participate in MDHHS Performance indicator workgroup and communicate any changes with indicator measurement or reporting to internal and external stakeholders.	January 2022 – December 2022	QAPI Director QAPI Specialist Clinical Quality Director SUD Manager	Quarterly Submissions to MDHHS: *Q1 - 3/31/22 *Q2 - 6/30/22 *Q3 - 9/30/22 *Q4 - 12/30/22 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs beginning in June 2022. Specific indicator cases and performance is reviewed during the annual CMHSP site reviews. CAPs are requested from any CMHSPS that are out of compliance, against the pre-established benchmarks.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
2.Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	➢ Event Reporting- trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualified events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	➢ Event Reporting Quarterly reports to QMC; RUM, RCP and MHL committees as part of process. ➢ Quarterly Reports of any qualified events to MDDHS including: o Suicide o Non-Suicide Death o Emergency Medical Treatment Due to medication error o Hospitalization due to injury or medication error o Arrest of a consumer that meets population standards	October 2021 - September 2022	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for review.
3.Uniformity of Benefits (Cross functional Goal)	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	➢ Perform analysis on tool scores relative to medically necessary level of care (LOC). ➢ Identify and schedule reports on functional assessment tool scores. ➢ Ensure functional assessment data related to the LOCUS, SIS, CAFAS and ASAM are being received in the SWMBH data warehouse.	October 2021 – September 2022	Utilization Management Director Clinical Quality Manager Data Analyst Director of QAPI QAPI Specialist	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
4.Behavioral Treatment Review Committee Data (Cross Functional Goal)	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify ➢ opportunities for improving care.	➢ The QMC Committee will review the data collected from CMHs for trends and outliers on a quarterly basis. ➢ If trends are identified the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ➢ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2021 – September 2022	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly
5. Jail Diversion Data Collection	➢ SWMBH collects and reports the number of jail diversions (pre- booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities	➢ The QMC will evaluate data trends and specific CMHSP results. ➢ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ➢ Identified Trends and suggestions for policy change are share with Regional Entities through the Operations Committee and Utilization Management Committee as needed. ➢ Review Trends related to co-occurring MH/SUD events.	October 2021 – September 2022	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
6.External Monitoring Reviews	➢ Ensure that the participant has achieved each Quality element, as identified in the 2022 site review tool with satisfactory results. ➢ Help to formulate Corrective Action Plans for any Quality Review Elements scored out of compliance.	➢ Participant written Quality Improvement Plan for the fiscal year. ➢ Review participants Sentinel event and Critical Incident policy. ➢ Ensure participant has a BTRC that meets MDHHS requirements. ➢ The participants Jail Diversion Policy is compliant. ➢ Review of MMBPIS Performance Indicators, primary source verification documentation and protocols. ➢ Call Data Reports are submitted on a quarterly schedule (*i.e., call abandonment rate, average answer time in seconds and total incoming call volume*) ➢ Assist with formulation of the Regional audit results presentation.	October 2021 – September 2022	QAPI Specialist QAPI Director	Annually or as needed, depending on Corrective Action Plans (CAPs)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
7.Review of Provider Network Audits, Guidelines, and Medicaid Verification (Cross functional Goal)	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities. ➢ Assist with automating reports needed for compliance dept. review.	➢ Annual report to QMC Committee on any findings or opportunities for improvement. ➢ Corrective Action Plans (CAP) developed, issued and tracked as needed. ➢ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the QAPI annual Evaluation report. ➢ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2021 – September 2022	QAPI Specialist QAPI Director Chief Compliance Officer Director of Clinical Quality	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
8.Monitor the Complaint Tracking System for Providers and Customers (Cross functional Goal)	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints for all business lines ➢ Work through Regional Committees if trends are identified to improve outcomes	➢ At a minimum, quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUM Committee and RCP Committee are reviewed. ➢ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: ➢ Billing or Financial Issues ➢ Access to Care ➢ Quality of Practitioner Site ➢ Quality of Care ➢ Attitude & Service	October 2021 – September 2022	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
9.External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ICOs, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics or meets the reviewing organizations expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations and other contractual standards and provide education and resources to SWMBH and CMHSPs.	➢ The Quality Department will ensure all documentation is returned to the external monitoring agency in a timely manner. ➢ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ➢ The SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2022 – December 2022	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Annually or audits as scheduled

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
10. Utilization Management (Cross functional Goal) (please see UM section of the Plan for further details on page 39-43)	➢ UM data will be aggregated and reviewed by the Regional UM Committee and Quality Management Committee for trends and service improvement recommend actions. ➢ Identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	❖ Annual UM Evaluation (FY 2022): o Department Compliance with Established UM standards o Adequate Access/Telephone Access to Services & Staff o Timeliness of UM Decisions: Service & Appeal o UM Decision-Making: Clinical Criteria; Availability of Criteria; Consistency of Applying Criteria; Inter-rater reliability (IRR audit) o Coordination of Care o Quality of Care o Outlier Management o Over or under utilization o Hospital Follow-Up o Level II Assessments o Customer Satisfaction on service experienced with UM Department	October 2021 – September 2022	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
11. Emergent and Non – Emergent Access (Cross functional Goal)	➢ Emergent and non-emergent cases are periodically monitored to ensure compliance with standards.	➢ All crisis/emergent Calls are immediately transferred to a qualified practitioner. ➢ Non-emergent time on-hold must not exceed three minutes. ➢ All non-emergent call backs should occur within one business day. ➢ Individuals with emergent needs, shall be provided an immediate intervention.	October 2021 – September 2022	QAPI Specialist QAPI Director Director of Clinical Quality Chief Operations Officer Utilization Manager	Monthly
12. Call Center Monitoring (SWMBH reporting) *for MI Health Link and Medicaid Business Lines*	➢ Ensure that a call center monitoring plan is in place. ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ➢ Tracking and monitoring of all internal service lines (crisis, emergent, immediate, and routine) ➢ Collect and analyze quarterly call reports submitted by CMHSPs	➢ A review of calls and agent performance to meet a scoring criterion of 96.25% performance rate is completed and evaluated. (*not required)* ➢ Achieve a call abandonment rate of 5% or less. ➢ Monitor number of calls received for each service line. ➢ Average answer time is confirmed as; 30 seconds or less. ➢ Service level standard of 75% or above. ➢ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	October 2021 – September 2022	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly Reviews during Regional QMC and MI Health Link Committee Meetings

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
13. Management of Quality Related Systems and Data Review/Reporting (Cross functional Goal)	➢ Quality Department; QMC and MHL Committee to review quality and timeliness of data reporting. ➢ Ensure Reports are timely and accurate for internal/ external stakeholders.	➢ Ensure timeliness and accuracy of Quality Indicator submissions to MDHHS. ➢ Grievance and Complaint tracking analysis. ➢ Tracking and analyzing services, cost by population groups and special needs categories. ➢ Access to care tracking (Level II Timeliness report). ➢ Monitor Data Quality, Timeliness and Completeness: ➢ Volume: Encounters submitted at 85% of monthly rolling average. ➢ Completeness: 99.8% of encounters are submitted and accepted by MDHHS (CMHSP to supply the num/denom. ➢ Timeliness: 95% of encounters adjudicated through submission cycle within 30 days or less. ➢ Assessments: 90% of consumers received the appropriate assessment ➢ 97% of Encounters have a BH TEDs match or close match	October 2021 – December 2022	QAPI Director Chief Information Officer Chief Operations Officer Senior Systems Architect Applications and systems Analyst	Monthly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
14. Coordination of Care (Cross functional Goal)	➢ Quality Dept. Assists with relevant care measures related Performance Bonus Incentive Project (PBIP) and Quality Withhold Performance Measures. ➢ Assists with Quantitative and causal analysis of data to identify improvement opportunities	➢ Administration and analysis of Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ➢ Identification of beneficiaries who may be eligible for services through the Veteran's Administration ➢ Increased data sharing with providers using ADT messages. ➢ Submission of annual PBIP narrative report related to: Comprehensive Care, Patient Centered Medical Homes, Coordination of Care and Accessibility of Services.	October 2021 – September 2022	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant Chief Compliance Officer	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
15. Safety of Consumer Care (Cross functional Goal)	➢ Track patient safety/risk events and make recommendation for regional improvement. ➢ Provide a comparative report using current year and previous year's data to identify safety/risk concerns and trends. ➢ Analysis of reported risk events to identify trends.	➢ Complete an annual analysis of patient safety activities. ➢ Track and provide analysis on patient safety concerns, risk incidents including Adverse incidents, Critical Incidents or Sentinel Event that are reported by CMHSPs monthly. ➢ Monitoring and collect minutes during the BRTC meetings. ➢ Cover and identified network-wide safety issues during Regional Clinical and Quality meetings.	October 2021 - September 2022	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
16. Member Experience	➢ Develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints. ➢ Data is used to identify trends and make improvements for the customer experience and improved outcomes.	➢ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey period. ➢ Distribution, collection and analysis of annual Person in Recovery Survey (RSA-r). ➢ Medicaid Member Service Satisfaction Surveys. ➢ Medicare Member Service Satisfaction Surveys. ➢ MI Health Link – Dual Eligible Member Satisfaction Surveys. ➢ Complex Case Management Member Experience Survey. ➢ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys. ➢ Causal analysis of grievance and appeal data broken into categories including: Quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site.	January 2022 - December 2022	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
		➢ Member Grievance and Appeals data ➢ Complex Case Management. ➢ Grievance and Appeals data ○ Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RCP, RUM, SWMBH Board and other stakeholders annually.			
17. Sharing and Communication of Information	➢ The Quality Department will demonstrate Sharing of information and communicate through various internal and external resources to its membership and providers.	➢ Ensure availability of information about QI program and results through newsletter, mailings, website, and member handbook and practitioner agreements. ➢ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ➢ Provide access to QMC and MHL meeting minutes and materials to internal customers. ➢ Access to the SWMBH website for various publications and Provider Directory. ➢ Access to the SWMBH SharePoint Portal	January 2022 - December 2022	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Newsletter Editor Chief Information Technology Officer	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
		for internal and external stakeholders, as a collaborative information sharing resource and report delivery system.			
18. Serving Culturally and Linguistically Diverse Members (Cross functional Goal)	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership. ➢ Review the annual Network Adequacy Plan and provide feedback for improvement projects/ ➢ Interventions	➢ Ensure that Cultural Competency policies are being followed. ➢ Review Cultural Competency Plan on an annual basis to address any identified barriers to care. ➢ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ➢ Work with Provider Network to perform analysis on the network adequacy report and support identification of culturally diverse provider resources. ➢ Review Annual Cultural Competency Policies and Plan. ➢ Annually review and update Cultural Competency Goals and work plan. ➢ Annually review CMHSP partner Cultural Competency Plans.	October 2021 - September 2022	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
19. Serving Members with Complex Health Needs (*function of Clinical Quality*) (Cross functional Goal)	➢ The Quality Management Department will work with the Utilization Management and Clinical Departments to use process and outcome measures to improve quality and performance.	➢ Measure program effectiveness, process, member satisfaction data and outcomes to help improve the Complex Care Management Program. ➢ Causal Analysis of Complex Case Management Grievance and Appeal Data ➢ Monitor and Evaluate Access to care standards to ensure members are receiving timely services. ➢ Help to identify population health trends and plan programs and services accordingly. ➢ Qualitative and Quantitative Analysis ➢ Evaluate and monitor efforts to identify eligible CCM members.	October 2021 – September 2022	Integrated Care Nurse QAPI Director Medical Director or Consultant Director of Clinical Quality Director of Utilization Management	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
20. CCBHC Program and Evaluation *(Please see identified metrics in attachment M)*	➢ The Quality Department will help track and perform data analysis on identified (QBP) metrics.	➢ Ensure that correct tracking mechanisms are in place to achieve pre-established benchmarks. ➢ Ensure that identified (QBP) reports are submitted timely and via correct methods. ➢ Ensure correct forms and reporting methodologies are being utilized by CCBHC sites. ➢ Perform evaluation of tracking mechanisms and implement CAP's when/as necessary.	January 2022 - December 2022	QAPI Specialist QAPI Director CCBBHC Program Manager CCBHC Data Workgroup	Quarterly

XVI. QAPI – Utilization Management Plan and Evaluation

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the annual QAPIP and will be completed at the end of the fiscal year, or shortly thereafter. The QAPI & UM Effectiveness Review/Evaluation assesses the overall effectiveness of the QAPI and UM Programs including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths, and accomplishments of the program with special focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals is also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation, other gaps may be incorporated into the next year's QAPI plan. The findings within the QAPI Effectiveness Review/Evaluation will be reported to the QM Committee, Operations Committee, SWMBH EO, and SWMBH Board.

A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement plan could be requested of a SWMBH department, CMHSP, or Provider Organization. When a provider within the network is required to complete such a plan, the Provider Network department will be involved and a notification of the needed action and required response will be given to the provider. A sanction may be initiated based on the level of deficiency and/or failure to respond to a Performance Improvement/Corrective Action Plan request.

Utilization Management Activities

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight, monitoring and activities are conducted across the region and provider network to assure the appropriate delivery of services. The MHL Committee members and Provider Network practitioners review and provide input regarding policy, procedure, clinical protocols, evidenced based practices, regional service delivery needs and workforce training. Policy and procedure is reviewed annually or as needed to perpetuate necessary change. The Medical Director and a physician specializing in Addictionology meets weekly with UM staff to review challenging cases, monitor for trends in service, provide oversight of application of medical necessity criteria. Case consultation with the Medical Director, Addictionologist and/or a psychiatrist is available 24 hours a day. SWMBH provides review of over and under-utilization of services. Inter-rater reliability testing is conducted at least annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes. Based upon the UM Program review, annual audits and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable providers or SWMBH departments.

Review and Approval Process

A Pre-service Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service delivery. Postservice/Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

SWMBH UM staff obtain review information from any reasonably reliable source. The purpose of review is to obtain the most current, accurate, and complete clinical presentation of the member's needs and whether the services requested are appropriate, medically necessary, sufficient, and cost-effective to achieve positive clinical outcomes. Only information necessary to make the authorization decision, service determination length of stay, frequency and duration

is requested. That information includes but isn't limited to age, comorbid conditions, complications, progress of current or past treatment, social determinants.

Level of Intensity of Service Determination Decision

At the time a member accesses the system, it is determined if the member requires emergent, urgent, or routine services.

LEVEL OF INTENSITY/DECISION TYPE	DEFINITION	EXPECTED DECISION/ RESPONSE TIME
EMERGENT/PRESERVICE – PSYCHIATRIC	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 2hours of request; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 2 hours of request.
URGENT CONCURRENT	A request for extension of a previously approved ongoing course of treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment; or in the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.	Within 24 hours of request; prior authorization required
URGENT PRESERVICE	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services is denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
ROUTINE/PRESERVICE NONURGENT	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 calendar days of request; Prior authorization required
RETROSPECTIVE/POSTSERVICE	Accessing appropriateness of medical necessity on a case-by-case or aggregate basis after services were provided	Within 30 calendar days of request

Determination of Medical Necessity

Treatment under the member's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria before being authorized and/or provided. Guidelines identifying medical necessity criteria and clinical pathways for Medicare and Medicaid mental health, intellectual/developmental disability and substance use supports, and services and provider qualifications are found in various documents; contracts between the ICO and SWMBH and SWMBH and the Michigan Department of Health and Human Services (MDHHS), Medicare Manual Chapter 13, the MDHHS Medicaid Provider Manual, MCG medical necessity criteria and the NICE Clinical Pathways. Uniformity of benefit, Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, MCG medical necessity criteria, SWMBH Clinical Pathways, and utilization management standards are reviewed annually by the MHL committee with final approval by the SWMBH Medical Director. The MHL committee members are experienced have clinical and educational experience treating persons with mental health or substance use disorders.

Services selected based upon medical necessity criteria are:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the member.
2. Responsive to needs of multi-cultural populations and furnished in a culturally relevant manner.
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance use, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience; and
5. Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential.

Service Determination Decisions of Medically Necessary Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP shall make all determinations regarding approval for medically necessary services in a timely fashion reviewing available current and historical physical and behavioral health documentation and via conversation with the member, treating physician or provider.
   a. Access, Triage, Screening and referral functions are performed by licensed and credentialed staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT) and have been deemed capable by the Medical Director in making decisions requiring clinical judgement and determining the appropriate level of service in a timely manner.
   b. Routine/Pre-service Non-urgent service determination reviews and approval decisions are performed by licensed and credentialed staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT) and have been deemed capable by the Medical Director in making decisions requiring clinical judgement and determining the appropriate level of service in a timely manner.
   c. Retrospective service determinations and approval decisions are performed by licensed and credentialed staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or

temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT) and have been deemed capable by the Medical Director in making decisions requiring clinical judgement and determining the appropriate level of service in a timely manner.

d. Emergent/Pre-service, Urgent Concurrent and Urgent Preservice approval determinations and approval decisions are performed by licensed and credentialed staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT) and have been deemed capable by the Medical Director in making decisions requiring clinical judgement and determining the appropriate level of service in a timely manner.

e. The Medical Director (MD, psychiatrist) and contract Physician (MD, Addictionologist) are available for consultation and provide review functions for services requiring a physician (Inpatient Psychiatric, Crisis Residential, Substance Abuse Residential, Community Based Medical, Methadone and ECT Peer Review). The Medical Director, psychiatrist make all determinations that result in medical necessity denials, for behavioral health and substance use disorder authorization requests. Cases that require a medical necessity determination but present a real or perceived conflict of interest if reviewed by the SWMBH Medical Director, are reviewed by an external board-certified consultant.

2. Efforts are made to obtain all necessary information, through interview with the member, documentation review, accessing pertinent current and historical clinical and medical information, and consultation with treating physician or provider as appropriate
3. The reasons for decisions are clearly documented and available to the member.
4. Well-publicized and readily available appeals mechanisms are available for both providers and patients. Notification of a denial includes a description of how to file an appeal. Only an MD, fully licensed psychologist, or certified addictions medicine specialist, all with unrestricted licenses may render behavioral health service denials.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

Outlier Management

An integral part of SWMBH's Performance Improvement Based Utilization Management Program is continued development and implementation of its outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focus by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan members covered by the PIHP. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved provider(s).

1. Outlier Definition

An "Outlier" is generally defined as significantly different from the norm. SWMBH defines an outlier as:

A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

2. Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are

available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus on extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures

A. As outliers are identified, protocol driven analysis will determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.

Adverse Decisions and Appeals

In the event of an adverse UM decision, the denial notice to the practitioner contains information on how to file an appeal (addressed in SWMBH Grievance and Appeal Policy). Providers may also request reconsideration by telephone or in writing and are conducted between the provider and the reviewer who made the adverse determination.

Appeals of an adverse UM action may be requested by the member or the member's legal representative. SWMBH has established policies and procedures with specific timelines by business line which are outlined in Member Handbooks

Data Management

Data management and standardized functional assessment tools and subsequent reporting tools are an integral piece to utilization management and application of uniform benefit. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for members can be assigned. This work allows for people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It's a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

and can be accessed on the SWMBH website or provided at the request of the member or legal representative. Management/monitoring of common data elements are critical to identify and correct over-utilization and under-utilization as well as identify opportunities for improvement, member safety, call rates, Access standards and member quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Central Care Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of member level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

XVII. UM Program References:

BBA Regulations, 42 CFR 438.240
MDHHS –PIHP Contract Attachment P 6.7.1.1 et al SWMBH Quality Management Policies 3.1 and 3.2 NCQA – 2019 MBHO Accreditation Standards – QI 11B Quality Management Committee Charter

XVIII. Preparations for Certified Community Behavioral Health Clinic (CCBHC) Demonstration Project

Background of CCBHCs in Michigan

In 2016, MDHHS applied to the Centers for Medicare & Medicaid Services (CMS) to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The two-year period begins upon implementation. CMS requires a state to implement the demonstration in at least two sites – one rural and one urban. Moreover, per CMS, only the 14 prospective CCBHC Demonstration Sites named in Michigan's 2016 application are eligible to participate in the state's demonstration. These sites include 11 Community Mental Health Services Programs (CMHSPs) and 3 non-profit behavioral health entities, together serving 18 Michigan counties. CCBHC Demonstration Sites are selected in accordance with federal requirements, including the attainment of state based CCBHC certification, and available funding.

The CMS CCBHC Demonstration requires states and their certified sites to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder diagnosis. Moreover, the demonstration requires and emphasizes 24/7/365 crisis response services (e.g., mobile crisis services). Other critical elements include but are not limited to strong accountability in terms of financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems; and an emphasis on providing services to veterans and active-duty service members. To account for these requirements, the state must create a PPS reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michiganders regardless of insurance or ability to pay.

MDHHS will effectuate the demonstration with prospective CCBHC sites, the relevant Prepaid Inpatient Health Plans (PIHPs), and a multi-disciplinary team-based structure reflective of a collaborative care model. At the end of the demonstration, MDHHS will evaluate the program's impact and assess the potential to continue or expand the initiative under the CMS State Plan option.

PIHP and CCBHC Requirements

CCBHC General Requirements

PIHPs must adhere to the CCBHC contractual and policy requirements with MDHHS. CCBHCs must meet the requirements indicated in CCBHC certification. PIHPs and CCBHCs must adhere to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

PIHP Requirements

PIHPs share responsibility with MDHHS for ensuring continued access to CCBHC services. PIHPs are responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring and reporting on CCBHC measures, and coordinating care for eligible CCBHC recipients as described below.

Minimum Requirements

- PIHPs must be a regional entity as defined in Michigan's Mental Health Code (330.1204b) or organized as the three standalone CMHSPs (i.e., Macomb, Oakland, and Wayne Counties).
- PIHPs must contract or develop a Memorandum of Understanding with all CCBHCs in their region and ensure access to CCBHC services for their enrollees.
- PIHP contracts with CCBHCs must permit subcontracting agreements with DCOs and credentialing of DCO entities

and/or practitioners.

- PIHP contracts with CCBHCs must reflect the CCBHC scope of services and ensure compensation for CCBHC services equates to clinic-specific PPS-1 rates.
- PIHPs must understand the CCBHC certification process and certification requirements.
- PIHPs must have the capacity to evaluate, select, and support providers who meet the certification standards for CCBHC, including:
    - Identifying providers and DCOs who meet the CCBHC standards,
    - Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services
    - Collecting and sharing member-level information regarding health care utilization and medications with CCBHCs
    - Providing implementation and outcome protocols to assess CCBHC effectiveness
    - Developing training and technical assistance activities that will support CCBHC in effective delivery of CCBHC services.
- MDHHS recommends that PIHPs provide training and technical assistance on certification requirements, including helping other potential CCBHC sites in preparing to meet CCBHC requirements.
- PIHPs must utilize Michigan claims and encounter data for the CCBHC population.
- PIHPs must use CareConnect360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.
- PIHPs must provide support to CCBHCs related to Health Information Technology, including WSA, CareConnect360, EHR, and HIEs.
- PIHPs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC. If a PIHP delegates managed care functions to the CCBHC, the PIHP remains the responsible party for adhering to its contractual obligations.

CCBHC Monitoring and Evaluation

CCBHC Monitoring & Evaluation Requirements

CMS has defined reporting requirements and guidance for the CCBHC Demonstration. There are two broad sets of requirements – CCBHC Reported Measures and State Reported Measures. A state-lead measure is calculated by the state for each CCBHC, usually relying on administrative data. A CCBHC-lead measure is calculated by the CCBHC and sent to the state. The measures are not aggregated by the state. To the extent necessary to fulfill these requirements, providers must agree to share all CCBHC clinical and cost data with MDHHS. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers. The data will be reported annually by MDHHS to CMS within 12 months of the end of Demonstration Year 1. CCBHCs must report measures to MDHHS within 6 months of the end of Demonstration Year 1.

State Reported Measures

Measure Name	Measure Steward	Technical Specification Authority and Reference	Technical Specification Page Number
Housing Status (HOU)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	101
Patient Experience of Care Survey (PEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	109
Youth/Family Experience of Care Survey (Y/FEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	111
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	SAMHSA Metrics and Quality Measures (2016)	113
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA	SAMHSA Metrics and Quality Measures (2016)	118
Plan All-Cause Readmission Rate (PCR-AD)^	NCQA	CMS Adult Core Set (2021)	116
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^	NCQA	CMS Adult Core Set (2021)	145
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	CMS Adult Core Set (2021)	138
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	CMS Adult Core Set (2021)	66
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	CMS Child Core Set (2021)	71
Follow-up care for children prescribed ADHD medication (ADD-CH)^	NCQA	CMS Child Core Set (2021)	15
Antidepressant Medication Management (AMM-AD) ^	NCQA	CMS Adult Core Set (2021)	14
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	SAMHSA Metrics and Quality Measures (2016)	193

^Denotes updated technical specification from the original 2016 measure
*Denotes the measure is both a quality measure AND a quality bonus payment measure

CCBHC Metric Specifications

CMS is currently updating the CCBHC Quality Measure Technical Specifications. In the interim, states must report using existing technical specifications cited in the *2016 SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications Manual* or, for select measures, using more current technical specifications cited in the *2021 CMS Adult and Child Core Set Manuals*. Select measures for which technical specification updates have been made are denoted with the ^ symbol.

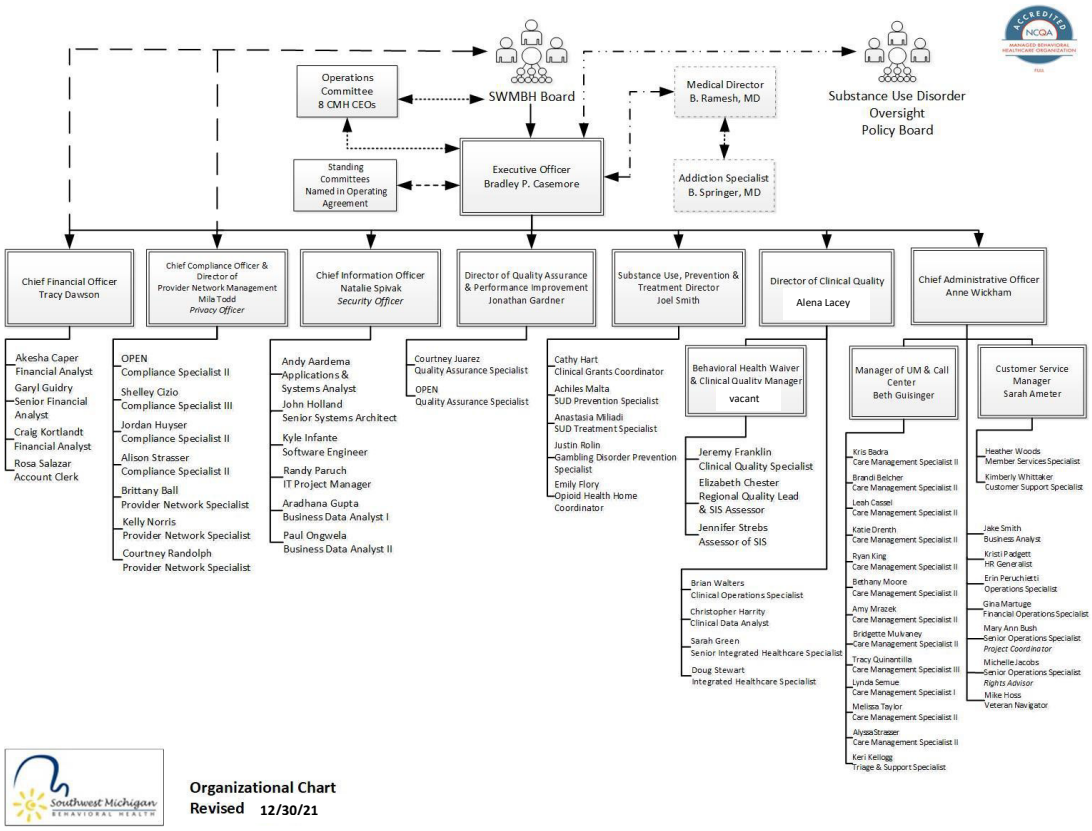
The two technical specification documents encompassing the CCBHC quality measures are as follows:

- SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (2016)

Please find the CCBHC - Quality Based Payment Metrics Under Attachment L

XIX. Attachments

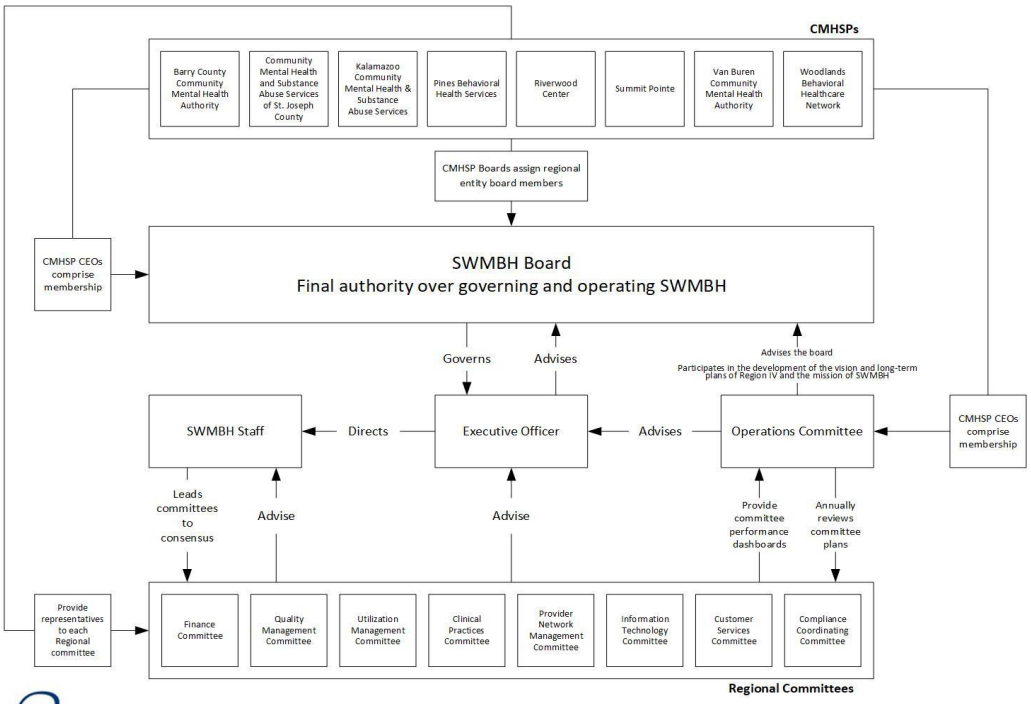
Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Organizational Chart
Revised 12/30/21

Attachment B: SWMBH Regional Committee Structure

SWMBH Organizational and Committee Structure



SWMB Organizational and Committee Structure
Updated 3/19/19

Attachment C: MI Health Link Quality Management Committee Charter

☒ **MI Health Link**
☒ **SWMBH Committees: Quality Management (QMC);** ☒ **Provider Network Credentialing (PNCC);** ☒ **Clinical and Utilization Management (CUMC);** ☒ **Cultural Competency Management**
Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Charter Effective Date: 6/1/15
Charter last Review Date: 10/17/21

Approved By:
_____
Signature:
_____
Date:
_____

Purpose:	SWMBH MI Health Link Committees are formed to assist SWMBH in executing the MI Health Link demonstration goals and requirements, NCQA requirements, and contractual obligations and tasks. MI Health Link Committees ensure a care management quality control program is always maintained and that the PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physicians for all behavioral health emergency inpatient admissions in authorized timeframes. The committee ensures the PIHP and ICO conduct regular and ongoing collaborative initiatives that address methods of improved clinical management of chronic medical conditions and methods for achieving improved health outcomes. The organization approves and adopts preventive health guidelines and promotes them to practitioners to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, the ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH Executive Officer and is responsible for assisting SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committees Purposes:	**Quality Management Committee:** • The QI Committee must provide evidence of review and thoughtful consideration of changes in its QI policies and procedures and work plan and make changes to its policies where they are needed. *NCQA, MBHO, QI 1: Program Structure: Quality Improvement Program Structure, Element A; QI 2: Program Operations: QI Committee Responsibilities, Element A.* • Analyzes and evaluates the results of QI activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. Ensures follow-up as appropriate.

	NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5) • Ensures practitioner participation in the QI program through planning, design, implementation or review. *NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).* • Ensures discussion (and minutes) reflects appropriate reporting of activities, as described in the QI program description. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).* • Reports by the QI director and discussion of progress on the QI work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).* • Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).* • Ensures all MI Health Link required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 1: Program Structure; QI 2: Program Operations, QI Committee Responsibilities, Element A.* • Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 6: Member Experience; 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1); UM 10 Experience with the UM Process.* • Review of current status and upcoming MHL audits • Review of demonstration year quality withhold measures **Credentialing Committee:** • Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Aetna Contract-Attach C4; Meridian Contract.* • Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Aetna Contract; Meridian Contract.* • Implements and conducts a process for the Medical Director review and approval of clean files. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Aetna Contract; Meridian Contract.* • Reviews and authorizes policies and procedures.

	NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4; Meridian Contract • Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Aetna Contract & Meridian Contract* • Ensures reporting of practitioner suspension or termination to the appropriate authorities. *NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.* • Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service. *NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 6: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.* • Ensures the organization's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following: o Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7) Aetna Contract & Meridian Contract* o Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7). Aetna Contract& Meridian Contract* • Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination. *NCQA, MBHO, CR 5: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract; Meridian Contract.* **Utilization Management Committee:** • Reviews and authorizes policies and procedures. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.* • Is involved in implementation, supervision, oversight and evaluation of the UM program. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.* • Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B. Aetna Contract; Meridian Contract.*

	• Ensures review of tools/instruments to monitor quality of care are in meeting minutes. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.; Meridian Contract.* • Ensures annual written description of the preservice, concurrent urgent and non-urgent and post service review processes and decision turnaround time for each. *NCQA, MBHO, UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Aetna Contract; Meridian Contract-Attach C.* • Ensures at least annually the PIHP review and update BH clinical criteria and other clinical protocols that ICO may develop and use in its clinical case reviews and care management activities; and that any modifications to such BH clinical criteria and clinical protocols are submitted to MDCH annually for review and approval. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27); Meridian Contract* • Ensures the organization: o Has written UM decision-making criteria that are objective and based on medical evidence. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Aetna Contract; Meridian Contract-Attachment C.* o Has written policies for applying the criteria based on individual needs. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2). Aetna Contract; Meridian Contract.* o Has written policies for applying the criteria based on an assessment of the local delivery system. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3). Aetna Contract; Meridian Contract.* o Involves appropriate practitioners in developing, adopting and reviewing criteria. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Aetna Contract; Meridian Contract-Attachment C.* o Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B; Aetna Contract; Meridian Contract* **Cultural Competency Management Committee:** • Has written policies, procedures, and plan for promoting and ensuring a culturally competent, sensitive and inclusive environment. • Conducts an annual review of the Network Adequacy Report to ensure that the data covers all members' language, race and ethic needs as well as ensure that there is data available for practitioner race, ethnic background and language skills. There will be a comparison of the two data sets to determine if the provider network is enough to meet its members' needs, identify areas of improvement and set interventions if needed. Will review internal and provider organizational systems to determine level of compliance with the Culturally & Linguistic Appropriate Services (CLAS) standards and other pertinent requirements for MI Health Link. *NCQA, MBHO, QI 4: Availability of Practitioners and Providers.*

	Integrated Care/Clinical Quality Committee: • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. *NCQA, MBHO, QI 10: Clinical Practice Guidelines-Element A; 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Monitors the continuity and coordination of care that members receive across the behavioral healthcare network and acts, as necessary, to improve and measure the effectiveness of these actions. • The organization collaborates with relevant medical delivery systems to monitor, improve, and measure the effectiveness of actions related to coordination between behavioral and medical care. *NCQA, MBHO, CC 1 & 2: Collaboration between Behavioral Healthcare and Medical Care Aetna Contract-Attachment C.2; Meridian Contract* • Ensures assessment of population health needs, including social determinants and other characteristics of member population, is completed annually, and the CCM program is adjusted accordingly. *NCQA, MBHA, QI 9A: Complex Case Management, Population Assessment* • Ensures member survey results feedback is reviewed and follow-up occurs as appropriate. *NCQA, MBHO, QI 9J: Complex Case Management, Experience with Case Management* • The organization demonstrates improvements in the clinical care and service it renders to members. *QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Monitors performance for all HEDIS/NQF measurements minimally annually. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Selects 3 or more clinical issues for clinical quality improvements annually. Ensures that appropriate follow up interventions are implemented to improve performance in selected areas. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Approves developed logic for calculating HEDIS measure and ensure it follows HEDIS specifications. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program*
Relationship to Other Committees:	These three committees will sometimes plan and likely often coordinate together. The committees may from time-to-time plan and coordinate with the other SWMBH Operating Committees.
Membership:	The SWMBH Executive Officers and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. Members are representing the regional needs related to Provider Network Credentialing; Quality Management and Clinical/Utilization Management as it relates to MI Health Link. It is expected that members will share information and concerns with the committee. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges to the attention of the SWMBH committee for possible project creation and/or assistance.

Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from deciding and acting. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they also lose the right to participate in the voting structure on that day.

Attachment D: Quality Management Committee Charter

Quality Management Committee Charter

☒ **SWMBH Committee** **Quality Management Committee (QMC)** ☐ **SWMBH Workgroup:_____Duration:**
☒**On-Going** ☐ **Deliverable Specific**

Date Approved: 5/1/14

Last Date Reviewed: 11/19/21

Next Scheduled Review Date:11/18/22

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.

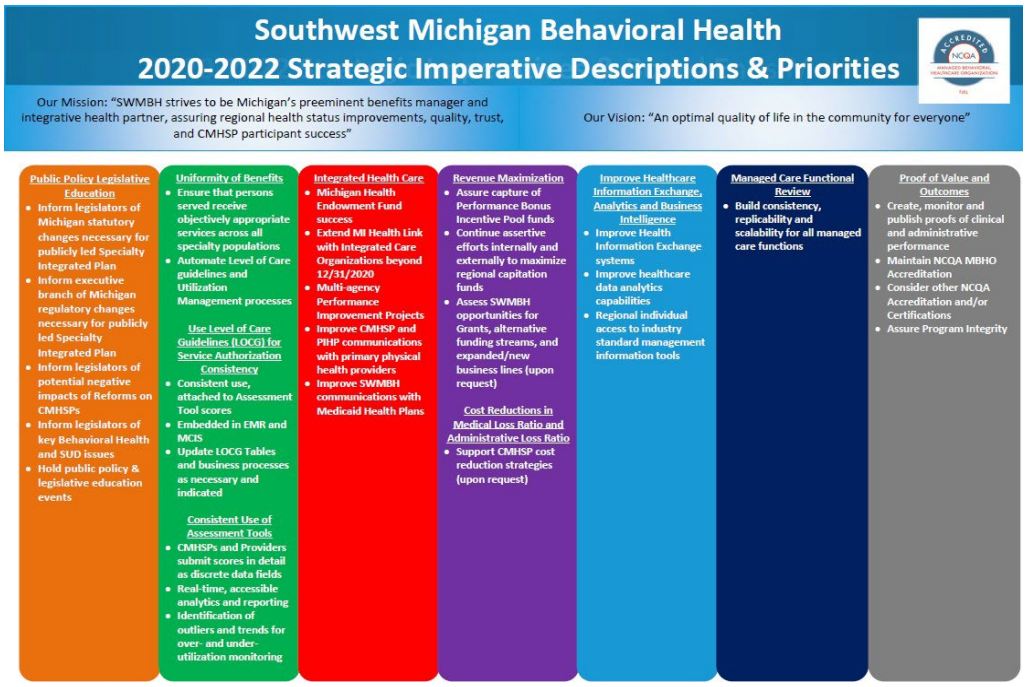
Committee Purpose:	• *The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.* • *The QMC will implement the QAPI Program developed for the fiscal year.* • *The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.* • *The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.* • *The QMC will review and provide feedback related to policy and tool development.*

	• *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *Assist the RITC Committee with management and oversight of the Data Exchange sub-workgroup related to regional strategic imperatives and CMH data submission quality and completeness.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees including: • Finance Committee • Utilization Management Committee • Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee

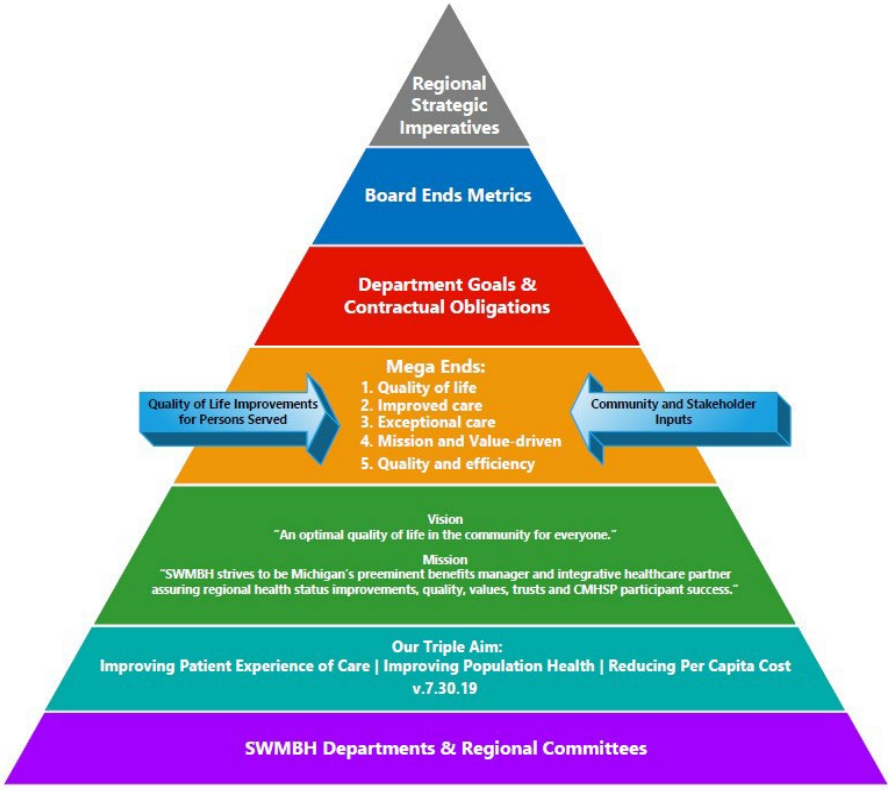
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits, it is expected that committee members attend and are engaged in issues and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from deciding and taking action. Voting is completed through formal committee members and a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they will lose the right to participate in the voting structure for that meeting.

Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dashboard • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback, and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment E: 2022 SWMBH Strategic Imperatives and Descriptions



Attachment F: 2022 Regional Strategic Imperative Planning Flow Chart



Strategic Alignment – Annual Goal Planning
Revised 7/30/19

Attachment G: 2022 Board Member Roster

2022 Board Member Roster

Barry County
- Ruth Perino
- Robert Becker (Alternate)

Berrien County
- Edward Meny - Chair
- Randy Hyrns (Alternate)

Branch County
- Tom Schmelzer – Vice Chair
- Jon Houtz (Alternate)

Calhoun County
- Marcia Starkey
- Kathy-Sue Vette (Alternate)

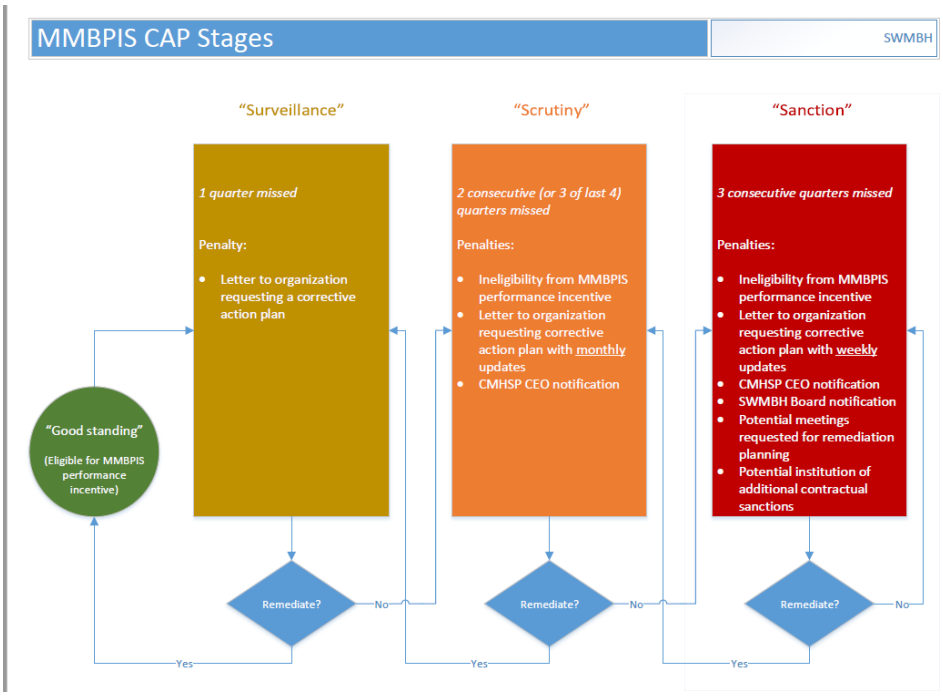
Cass County
- Vacant
- Vacant (Alternate)

Kalamazoo County
- Erik Krogh
- Patricia Guenther (Alternate)

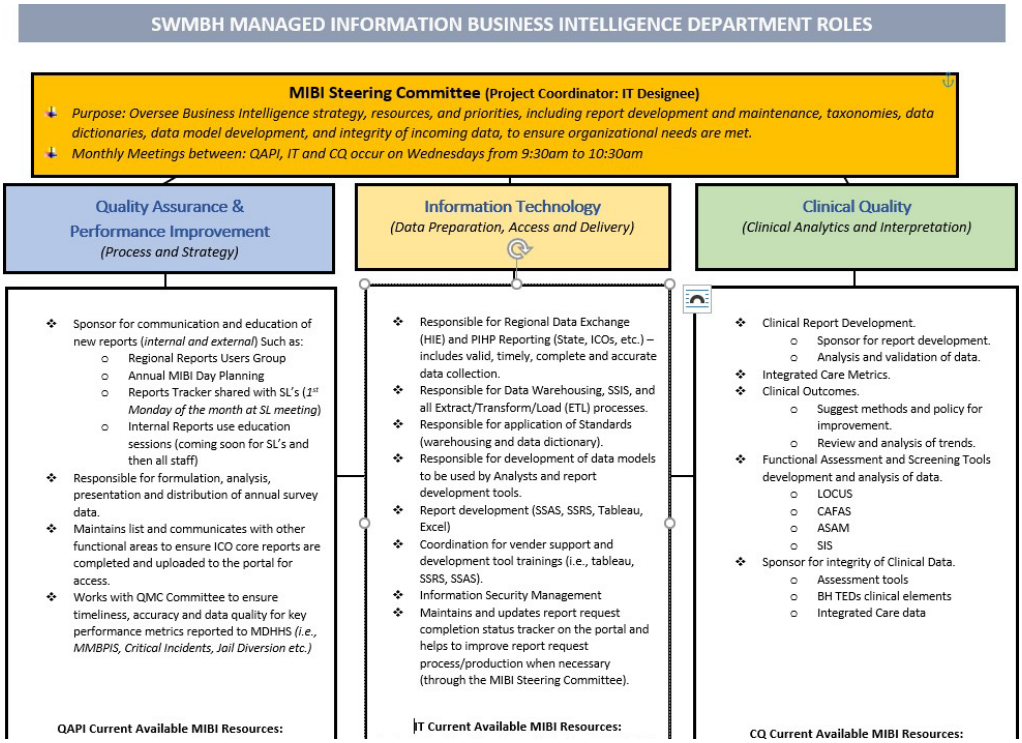
St. Joseph County
- Carole Naccarto
- Cathi Abbs (Alternate)

Van Buren County
- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

Attachment H: 2022 MMBPIS CAP Stages



Attachment I: Managed Information Business Intelligence Department Roles



Attachment J: SWMBH Value Framework

Value Framework

Our Mission

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Mega Ends

Quality of Life	Improved Health	Exceptional Care	Mission and Value-Driven	Quality and Efficiency
Persons with Intellectual Developmental Disabilities, Serious Mental Illness, Autism Spectrum Disorder, Serious Emotional Disturbances and Substance Use Disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.	Individual mental health, physical health and functionality are measured and improved.	Persons and families served are highly satisfied with the care they receive.	CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	The SWMBH region is a learning region where quality and cost are measured, improved and reported.

Triple Aim

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Our Vision

"An optimal quality of life in the community for everyone".

Attachment K: 2022-2023 Board Ends Metrics

2022 – 2023 SWMBH Board Ends Metrics
(Board Approved on 12/10/2021)
Fiscal and Calendar Year Metrics

2022-2023 Board Ends Metrics Review and Approval Schedule:

- Quality Management Committee Review and Endorsement: 10/28/2021*
- Clinical Practices Committee Review and Endorsement: 11/8/2021*
- Operations Committee Review and Endorsement: 11/17/2021*
- Board Review and Approval: 12/10/2021*

Strategic Imperative Category: Quality of Life

Persons with Intellectual Developmental Disabilities (I/DD);
Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD), and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery and family preservation.

PERFORMANCE METRIC DESCRIPTION	STATUS
1. Achieve 95% of Veteran's Metric Performance-Based Incentive Program monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: December 10, 2022 **Monitor, analyze and improve data quality and discrepancies between VSN and BH TEDs Veteran data fields.** a. A resubmission of October 1 through March 31 of FY21 **comparison** of the total number of individual veterans reported on BHTEDS and the VSN form. • Submission of April 1 through September 30 of FY21 **comparison** of the total number of individual veterans reported on BHTEDS and the VSN form. • Narrative comparison of the above time periods, identifying any areas needing improvement and actions to be taken to improve data quality is due by January 1, 2022. b. The contractor must compare the total number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. *By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality.* Timely submission constitutes metric achievement. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded.	**Result will be provided by MDHHS in final PBIP Report received in January 2023** Executive Owners: Anne Wickham and Natalie Spivak

PERFORMANCE METRIC DESCRIPTION	STATUS
2. Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: January 13, 2023 A. **Increased data sharing with other providers**: i. Send ADT messages for purposes of care coordination through the health information exchange. *Deliverable 1*: Two or more CMHSP within a contractor's service area (or the contractor) will be submitting ADT messages through the MIHIN EDI pipeline daily by the end of FY22. ii. *Deliverable 2:* By July 31, 2022, the contractor must submit, to BHDDA, a report no longer than 2 pages listing the CMHSPs sending ADT messages, barriers for those who are not, along with remediation efforts and plans. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. If MIHIN cannot accept or process the contractor's ADT submissions, this shall not constitute a failure of the metric and will be communicated to the Board and updated appropriately. **Possible Points:** 1 point will be awarded.	**Result will be provided by MDHHS in final PBIP Report received in January 2023** Executive Owner: Natalie Spivak

PERFORMANCE METRIC DESCRIPTION	STATUS
3. SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2022, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to the following areas: 1. Comprehensive Care 2. Patient-Centered Medical Homes 3. Coordination of Care 4. Accessibility to Services 5. Quality and Safety Metric Measurement Period: (10/1/21 - 11/15/22) Metric Board Report Date: January 8, 2023 **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded.	**Result will be provided by MDHHS in final PBIP Report received in January 2023** **Report is due on 11/15/22** (50 points) and 50% of the total withhold amount Report not to exceed 10 pages Executive Owners: *Mila Todd – Contractual Obligations *Sarah Green – Clinical Information *Jonathan Gardner – Assemble Narrative Report, CMHSP Communications and submission

PERFORMANCE METRIC DESCRIPTION	STATUS
4. Achieve 95% of possible points on collaboration between entities for the ongoing coordination and integration of services for shared MHL consumers. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: January 13, 2023 A. Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk, who have been identified as receiving services from both entities. B. Risk stratification criteria are determined in writing by the contractor in consultation with the State. MDHHS will select beneficiaries quarterly at random and review their care plans in CC360 for accuracy and compliance. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded.	**Result will be provided by MDHHS in final PBIP Report received in January 2023** For each PIHP in J.2.2 , and J.3.2 the PIHP metric scoring will be aggregate of/for all of their MHPs combined, not each individual MHP-PIHP dyad. This metric is largely based on combination calculations between the MHP and PIHP in CC360. Executive Owner: Sarah Green

PERFORMANCE METRIC DESCRIPTION	STATUS
5. Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) for beneficiaries six year of age and older and show a reduction in disparity with one minority group. Metric Measurement Period: 1/1/22 - 12/31/21) Metric Board Report Date: January 13, 2023 A. Plans will meet set standard for follow-up within 30 days for each rate (ages 6-17) and (18 and older). Plans will be measured against the adult minimum standard of 58% and child minimum standard of 70%. The measurement period will be calendar year 2022. B. Data will be stratified by race/ethnicity by MDHHS and delivered to PIHP's. PIHP's will be incentivized to reduce a disparity between the index population and at least one minority group. The measurement will be a comparison of calendar year 2021 with calendar year 2022. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded. ½ point each, child and adult.	**Result will be provided by MDHHS in final PBIP Report received in January 2023** **Current 2021 SWMBH Rates:** • Adult: 67.13% • Child: 77.51% Link to FUH and Disparity Specifications Executive Owners: Sarah Green, Clinical Quality Director and Jonathan Gardner

Strategic Imperative Category: Exceptional Care

Persons and families served are highly satisfied with the services they receive.

PERFORMANCE METRIC DESCRIPTION	STATUS
6. 2022 Customer Satisfaction Surveys collected by SWMBH are at or above the 2021 results for the following categories: Metric Measurement Period: (1/1/22 - 9/30/22) Metric Board Report Date: December 19, 2022 A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning – baseline: 85.1%) 1 point.* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes – baseline 81.3%) 1 point.* C. Complete a series of Consumer oriented focus groups and work with the Consumer Advisory Committee to document, understand and act upon potential improvement efforts that impact overall Consumer Satisfaction. **Measurement:** Confirmation via selected survey vender of a valid process, survey data, and results report. **Possible Points:** 2 points will be awarded, 1 for each A & B.	• **Surveys scheduled to begin in October of 2022** • Working with Kiaer Research to administer the surveys Improved Functioning and Improved Outcomes Categories have been the lowest-scoring categories over the past 4 years. Executive Owners: Jonathan Gardner, Sarah Ameter and Anne Wickham

Strategic Imperative Category: Improved Health

Individual mental health, physical health, and functionality are measured and improved.

PERFORMANCE METRIC DESCRIPTION	STATUS
7. SWMBH will achieve 225 enrollees for the Opioid Health Homes Program (OHH) during year 1 of implementation. Metric Measurement Period: (1/1/21 - 12/30/21) Metric Board Report Date: February 11, 2022 A. Target: 225 total enrollees 1/1/21 – 9/30/21. 1 point B. Based on 2021 baseline enrollment data, SWMBH will establish a retention value for enrollees starting 1/1/22 who remain in OHH program for six months or more. ½ point. Note: Insufficient data to calculate. 1/2point was removed from denominator. **Possible Points:** 1 point will be awarded.	Baseline Measurement Period Concludes on 9/30/21 A. 344 Enrollees in the OHH Program as of 9/17/21 B. TBD# has been established as the OHH program retention value. (1/1/22) Metric Specifications www.michigan.gov/OHH. **Measurement Year 1**: 10/1/2020 through 9/30/2021 **Performance Year 1**: 10/1/2021 through 9/30/2022 **Performance Year 2**: 10/1/2021 through 9/30/2022

Strategic Imperative Category: Mission and Value Driven

CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.

PERFORMANCE METRIC DESCRIPTION	STATUS
8. 85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 22. a. 24/28 indicators meet the State Benchmark, throughout all FY22. 1pt. b. Indicator 3a,b,c & d achieve a 3% combined improvement (*through FY 22 all 4 Quarters*) over 2021 baseline (1/2 pt. each) 2pts. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: January 14, 2023 **Measurement:** Results are verified and certified through the quarterly consultative draft report produced by MDHHS. Total number of indicators that met State Benchmark Total number of indicators measured **Possible Points:** 2 points will be awarded. (*1 point for (a) and 1/2 point each for (b)).*	Projected 26/28 achieved in FY21. ▪ Metric Benchmarks Provided by MDHHS. 7/16 indicators currently have benchmarks. Indicator 3 FY21 Baseline Values: (%) value represents metric goal. SWMBH / PIHP Ave. A. 57% (62%) 79% B. 62% (67%) 80% C. 75% (80%) 84% D. 68% (73%) 82% Executive Owners: Jonathan Gardner and Joel Smith

PERFORMANCE METRIC DESCRIPTION	STATUS
9. Regional Habilitation Supports Waiver slots are full at 98% throughout FY22. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: October 8, 2022 (*or when MDHHS posts yearend report*). Interim Board Report with (CQD) in April 2022 **Measurement:** Results are verified and certified through the MDHHS HSW performance dashboard. (%) of waiver slots (months) filled x 12 (#) of waiver slots (months) available **Possible Points:** 1 point awarded. +1 bonus point awarded for (5) or more *new* slots awarded to SWMBH by MDHHS during FY22.	▪ FY21 Result: 99.9% ▪ FY20 Result: 99.86% Executive Owners: Alena Lacey

Strategic Imperative Category: Quality and Efficiency

The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

PERFORMANCE METRIC DESCRIPTION	STATUS
10. 2022 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and final corrective action plan evaluated will receive a score of 90% or designation that the standard has been "Met." Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: November 12, 2022 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. The number of standards/elements identified as "Met." Total number of standards/elements evaluated **Possible Points:** 1 point awarded.	▪ FY 21 – 86% (56/65) ▪ FY 20 – 90.6% Executive Owners: All SL's

PERFORMANCE METRIC DESCRIPTION	STATUS
11. 2022 HSAG Performance Measure Validation Audit Passed with (90% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/2022 - 6/30/22) Metric Board Report Date: September 12, 2022 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. Number of Critical Measures that achieved the status of "Met," "Achieved," or "Reportable." Total number of critical measures evaluated **Possible Points:** 1 point awarded.	2021 Results: 34/38 (89.4%) of measures evaluated achieved full compliance. Executive Owners: Natalie Spivak and Jonathan Gardner

PERFORMANCE METRIC DESCRIPTION	STATUS
12. for *observation only*; track CCBHC Demonstration Year 1 *Quality Bonus Payment* Metrics, against the States indicated Benchmarks. 1. Child and Adolescent Major Depressive Disorder; Suicide Risk Assessment *(SRA-BHC - 23.9%)* 2. Major Depressive Disorder, Suicide Risk Assessment *(SRA-A - 12.5%)* 3. Adherence to Antipsychotic Meds for Individuals with Schizophrenia *(SAA-AD – 58.5%)* 4. Follow-up after Hosp. for mental illness, ages 18+ *(FUH-AD – 58%)* 5. Follow-up after Hospitalization for Children *(FUH-CH – 70%)* 6. initiation and Engagement of Alcohol and other drugs *(IET-14 – 42.5% & IET-34- 18.5%)* Metric Measurement Period: (10/1/2021 - 9/30/22) Metric Board Report Date: November 11, 2022 **Measurement:** Results are verified through MDHHS annual Performance Bonus Report. Number of CCBHC key performance metrics achieved, as verified by MDHHS Total number of key performance metrics evaluated **Possible Points:** 1 point awarded.	Performance benchmark targets taken source: CCBHC Handbook v.10/1/21 – Table 1.A.1. – QBP Measures and Benchmarks SWMBH will establish Regional CCBHC targets/benchmarks starting in Year 2 for CCBHC sites, based on Year 1 analysis/results. Executive Owners: Jonathan Gardner and Sally Weigandt

PERFORMANCE METRIC DESCRIPTION	STATUS
13. SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY22. Metric Measurement Period: (1/1/2022 - 12/31/22) Metric Board Report Date: January 13, 2023 A. 97% of applicable MH served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. ½ point B. 97% of applicable SUD served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. ½ point **Measurement:** Results are verified, certified by the MDHHS quarterly BH TEDS Regional compliance reports. Number of reportable MH/SUD encounters Number of MH/SUD encounters with a matching BH TEDS record **Possible Points:** 1 point will be awarded.	MDHHS's current benchmark is a 95% compliance rate. **Status as of 9/27/21:** • MH: 96.18% • SUD: 98.45% • Crisis: 97.68 **2020 Results:** • MH: 94.63% • SUD: 97.03% Regional Impact: BH TEDS compliance rates and other metrics are factored into the annual rate-setting calculations by Milliman/MDHHS. Executive Owners: Natalie Spivak

PERFORMANCE METRIC DESCRIPTION	STATUS
14. SWMBH will achieve 90% of the available CY21-22 monetary bonus award to achieve (*contractually specified*) quality withhold performance measures, agreed upon by the Integrated Care Organizations (ICO's). Metric Measurement Period: (1/1/2022 - 12/31/22) Metric Board Report Date: January 14, 2023 or upon finalization with ICO's A. 90% of claims processed submitted by the 15th of the following month. B. 80% of claims per final reconciliation were timely received. C. 95% CMS initial acceptance rate. D. 95% of enrollees will have a completed level II assessment within 15 days of ICO referral unless previously completed within 12 months. E. 80% of enrollees with an inpatient psychiatric admission for whom a transition record was transmitted to SWMBH via fax or EHR within 48 hours of discharge. F. 95% of enrollees will have documented discussions of care goals documented in the ICBR system. G. 56% of enrollees will have a follow-up visit with a behavioral health practitioner within 30 days of release from an inpatient setting. **Measurement:** Results will be verified through the SWMBH/ICO settlement agreement. **Possible Bonus Points:** 2 points will be awarded. 1 point each for Aetna and Meridian.	This would be for MIHL Demonstration Year 6 settlement. 2020-2021 Rates: • Meridian: 100% • Aetna 90% Executive Owners: Natalie Spivak, Anne Wickham, Sara Ameter, Beth Guisinger and Jonathan Gardner

PERFORMANCE METRIC DESCRIPTION	STATUS
15. SWMBH will achieve Recertification of National Committee for Quality Assurance (NCQA) – Managed Behavioral Healthcare Organization Medicare Service Line. Metric Measurement Period: (4/1/2022 - 4/31/2023) Metric Board Report Date: June 11, 2022 A. SWMBH will prepare all required evidence for each standard/element and submit through the IRT tool to NCQA by 12/15/22. B. SWMBH will prepare and complete the on-site survey review process by 4/31/23. **Measurement:** Results are verified, certified by the NCQA final compliance report to be received by June 2023. **Possible Points:** • 1 point will be awarded for (1-year reaccreditation). • 1 bonus point awarded for achievement of (Full – 3 years) Accreditation.	SWMBH was awarded a 1-year reaccreditation by NCQA on March 25, 2021. SWMBH's Current Accreditation is through June 25, 2022 Executive Owners: All SL's

PERFORMANCE METRIC DESCRIPTION	STATUS
16. SWMBH will pursue and apply for a Substance Abuse and Mental Health Services Administration (SAMHSA) or other non DHHS Grant by 12/31/22 *Stretch Goal - Bonus Metric not to be counted in denominator* Metric Measurement Period: (1/1/2022 - 12/31/22) Metric Board Report Date: January 8 , 2022 A. SWMBH will prepare all documents/evidence/communication required for application submission. **Measurement:** Results are verified through the SAMHSA website and official notification from SAMHSA. **Possible Points:** • 1 point awarded upon official Board approval. (*stretch goal*) • +1 bonus points awarded for a successful Grant award (above $500,000 for duration of Grant).	Executive Owners: Joel Smith and Brad Casemore

Each Board End Metric current status will be placed into one of (3) categories.

LEGEND: **COMPLETED GOAL/ON TARGET: GREEN GOAL NOT MET/BEHIND SCHEDULE: RED PENDING: BLUE**

Pending: could represent that;

- More information is needed.
- The event/program/intervention has been scheduled, but not taken place (i.e., audits or final data submissions).
- Data has not been completed yet (i.e., due quarterly or different timetable/schedule).
- The Metric is on hold until further information is received.

Not Met: could represent that;

- The proof is behind its established timeline for being completed.
- Reports or evidence for that proof have not been identified.
- The identified metric proof has passed its established timeline target.

Achieved: could represent that;

- Evidence/proof exists that the Metric has been successfully completed.
- The Metric has been presented and approved by the SWMBH Board.

Commented [JG1]:

Attachment L: 2022 Performance Bonus Incentive Program – Quality Based Payment Metrics

The State will provide a Quality Based Payment (QBP) to CCBHCs through a 5% withhold of the total CCBHC annual costs based on federally defined metrics to be disseminated in FY22.

Measure	Description	Deliverables
P.1. PA 107 of 2013 Sec. 105d (18): Identification of beneficiaries who may be eligible for services through the Veteran's Administration (25 points). The State acknowledges that not all Veterans interacted with by the Veteran Navigator and on the VSN will have a CMHSP contact and thus will not have a BH-TEDS file.	a. Improve and maintain data quality on BH-TEDS military and veteran fields. b. Monitor and analyze data discrepancies between VSN and BH-TEDS data.	a. Due January 2022: • a resubmission of October 1 through March 31 of FY21 **comparison** of the total number of individual veterans reported on BHTEDS and the VSN form. • submission of April 1 through September 30 of FY21 comparison of the total number of individual veterans reported on BHTEDS and the VSN form. • Narrative comparison of the above time periods, identifying any areas needing improvement and actions to be taken to improve data quality. . b. The contractor must compare the total number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality. Timely submission constitutes metric achievement number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality. Timely submission constitutes metric achievement
P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers (25 points)	Send ADT messages for purposes of care coordination through health information exchange.	For multi-county PIHPs, two or more CMHSPs within a Contractor's service area, or the Contractor, will be submitting Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY22. By July 31, the Contractor must submit, to the State, a report no longer than two pages listing CMHSPs sending ADT messages, and barriers for those who are not, along with remediation efforts and plans. In the event that MiHIN cannot accept or process Contractor's ADT submissions this will not constitute failure on Contractor's part.
P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (50 points)	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. -Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication	1. The points will be awarded based on contractor participation in IET measure data validation work with MDHHS. Contractor will submit an IET data validation response file by March 31 in accordance with instruction provided by MDHHS. Note: The State recognizes the Contractor does not have a full data set for analyses.

Measure	Description	Deliverables
	Assisted Treatment (MAT) within 34 calendar days of the initiation visit.	
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (20% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

MHP/Contractor Joint Metrics (30% of total withhold)
Joint Metrics for the Integration of Behavioral Health and Physical Health Services
To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Contractor, the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

Category	Description	Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the Contractor-MHP Collaboration Work Group in consultation with the State.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be calendar year 2021. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with Calendar year 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

J3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	1. The Contractor must meet set standards for follow-up within 30 Days. The Contractor will be measured against a minimum standard of 27%. Measurement period will be calendar year 2021. 2. Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with calendar year 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Schedule E
CONTRACTOR REPORTING REQUIREMENTS - No changes needed.

Due Date	Report Title	Report Period	Reporting Mailbox
November 15	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics".	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Attachment M: CCBHC Quality Bonus Payment Metrics and Reporting

MDHHS affords a QBP for CCBHCs meeting CMS-defined quality benchmarks.* To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. The QBP is based on 5% of the total CCBHC Medicaid Demonstration Year Costs. QBP for Demonstration Year 2 will also be calculated at 5% of total CCBHC Medicaid Demonstration Year Costs but will be based on DY2 Benchmarks (to be defined).

(*Please note: the QBP is only pertinent to Medicaid CCBHC costs and beneficiaries.)

1.A.1. QBP Measures, Measure Stewards, and DY1 Benchmarks

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Benchmark	Technical Specification Document (see 5.D.3. for link)	Technical Specification Document Page Number
1.	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)*	AMA-PCPI	23.9%	SAMHSA Metrics and Quality Measures (2016)	74
2.	Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	AMA-PCPI	12.5%	SAMHSA Metrics and Quality Measures (2016)	82
3.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	58.5%	CMS Adult Core Set (2021)	138
4.	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	58%	CMS Adult Core Set (2021)	66
5.	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	70%	CMS Child Core Set (2021)	71
6.	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	IET-14 (Initiation) - 42.5% IET-34 (Engagement)-18.5%	SAMHSA Metrics and Quality Measures (2016)	193