Quality Assurance and Performance Improvement Program (QAPIP) FY 2023 Plan

All SWMBH Medicaid Business Lines

SWMBH Policy 3.1

October 1, 2022 - September 30, 2023

Reviewed and Approved by:
SWMBH Board of Directors: January 13, 2023
SWMBH Quality Management Committee: January 26, 2023
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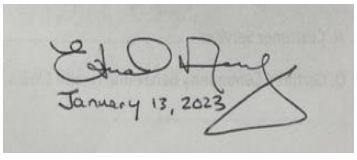

Signed by Board Chairman: Ed Meny

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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 Assurance and Performance Improvement Program (QAPIP) that meets the required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, and requirements outlined in the PIHP contract(s), specifically attachment P.6.7.1.1. and schedule 'E' of the PIHP reporting requirements.

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 and oversight of the 8 Community Mental Health Service Partners (CMHSPs) in the region. The QAPIP Plan 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's QAPIP Plan is approved annually by the SWMBH Board of Directors. SWMBH's Executive Officer (EO) and the Board of Directors 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 Plan delineates the features of the SWMBH QM program. The 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, integration of care, and member satisfaction.
- Improve the quality and safety of clinical care and services it provides to members.
- 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 internal and external stakeholders and provide performance improvement leadership to other departments.

III. Guiding Principles

During the November 11, 2022 Board Meeting, the SWMBH Board approved the 2023-2024 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. (*See Attachment A – Value Framework, Attachment B – 2023 Board Ends Metrics, and Attachment C – SWMBH Board Roster.*)

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 health, 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. Core Values of Quality Assurance and Improvement

1. Quality healthcare will result from a benefit management system embracing input from all stakeholders.
    - Education of all SWMBH stakeholders on continuous improvement methodologies, including providing guidance and support to other SWMBH departments, CMHSPs, and other providers as needed or requested. The involvement and inclusion of members, families, providers, and other internal and external stakeholders in the performance improvement design will promote optimal results.
    - Promoting a person-centered philosophy will promote member satisfaction as well as optimal treatment outcomes.
2. Poor performance is costly.
    - Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risk.
    - Quality Improvement projects are best approached systemically. The best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.
    - 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.

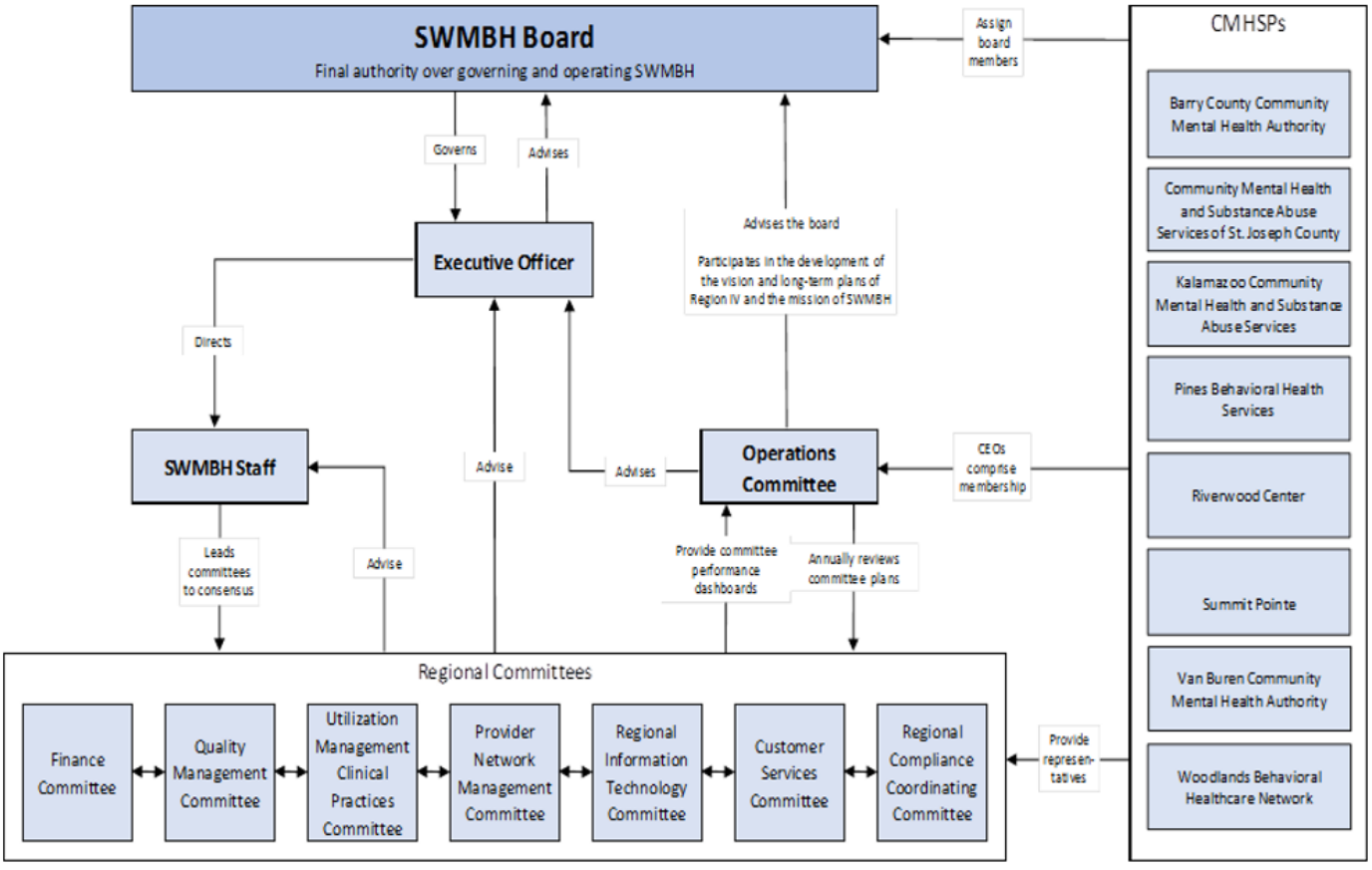
3. Data is valuable when the collection and analysis are done with integrity.
    - Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
    - Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making. Making data accessible will impact value and reduce risk to SWMBH.
    - Providers submitting data to SWMBH shall certify data integrity and have, available for review, the process used to collect the data.

V. 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 Plan, receives periodic QAPIP reports and updates, and reviews the QAPIP Evaluation.

In addition to the review by the SWMBH Board and SWMBH EO, the QAPIP Plan and Evaluation are 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 CEO, or their designee, for each of the 8 CMHSPs in the region. The program plan outlines the current relationships and structures that exist to promote performance improvement goals and objectives.

SWMBH Committee Structure



Committee members are expected to attend all meetings virtually, by phone, or in person. If members cannot participate in meetings, they should notify the committee Chairperson as soon as possible and send an alternative in their place. The committee representatives are required to communicate any information discussed during meetings, or included in meeting minutes, back to the appropriate parties within SWMBH and/or their CMHSP. Members who cannot attend committees/meetings are made aware of process and outcome improvements discussed by meeting minutes that are shared with the full committee after the meeting.

SWMBH QAPI Department

The general oversight of the development and implementation of the QAPIP is given to SWMBH's QAPI Department. The QAPI Department is staffed with a QAPI Director who oversees the QAPI Department, two full time Quality Assurance Specialists, and a Strategic Initiatives Project Manager. *(See Attachment D – SWMBH Organizational Chart for more details.)* The QAPI Department may also utilize an outside contract consultant for special projects as needed. 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 (RIT) Committee, Regional Utilization Management (RUM) Committee, and the Regional Clinical Practices (RCP) Committee. (See Attachment E – Organization and Committee Structure.)

The QAPI Department staff work closely with the SWMBH IT Department. The IT Department assists with providing internal and external data analysis and management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations including developing and maintaining databases, consultation, and technical assistance. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, conducting factor analyses to determine causes or contributing factors for outcomes or performance outliers, and correlates the analysis to assess relationships between variables. In addition, the IT Department assists with the development of reports, summaries, and visual representations of the data.

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 quality program data.

Adequacy of SWMBH Quality Management Resources

The QAPI Department works collaboratively with many different functional areas. The following table outlines the positions within the QAPI Department and other departments that have quality related tasks, listed with the percentage of their time that is allocated to quality management (QM) activities.

Position Title	Department	Percent of Time Per Week Devoted to QM
Quality Assurance and Performance Improvement Director	QAPI	100%
Quality Assurance Specialists (2)	QAPI	100%
Strategic Initiatives Project Manager	QAPI	75%
Director of Clinical Quality	CQ	40%
Behavior Health & Integrated Care Manager	CQ	20%
Clinical Quality Specialists (3)	CQ	20%
Clinical Data Analyst	CQ	20%
Manager of Utilization Management and Call Center	UM	20%
Customer Service Manager	UM	20%
Chief Information Officer	IT	20%
Senior Systems Architect	IT	20%
Applications & Systems Analyst	IT	20%
Business Data Analysts (2)	IT	20%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PNM	20%
Chief Compliance Officer & Director of Provider Network Management	Compliance/PNM	15%
Chief Administrative Officer	Operations	15%

CQ = Clinical Quality
UM = Utilization Management
IT = Information Technology
PNM = Provider Network Management

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, SUD Block Grant, PA 2 funds, and other grant funding. To complete these functions, additional resources are utilized including access to regional data from the CMHSPs as well as software and tools to analyze the data to 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).

The QAPI Department works with other functional areas within the organization and external organizations/ vendors such as Streamline Solutions and the Health Service Advisory Group (HSAG) to review processes and data collection procedures. These relationships are communicated to the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state per contractual requirements.
- Creating and maintaining QAPI policies, plans, evaluations, and other reports.
- Implementing regional projects and monitoring of reporting requirements.

- Assisting in the development of Strategic Plans and Tactical Objectives.
- Leading the development of the Boards Ends Metrics and other Key Performance Indicators.
- Analyzing reports and data to determine trends and making recommendations for process improvements.
- Functioning as the liaison between different functional areas in the communication of audit requirements and timelines.
- Communicating, organizing, and submitting the annual Performance Bonus Improvement Program (PBIP) reports to MDHHS. (See Attachment F – PBIP Metrics.)

VI. Regional Quality Management Committee

SWMBH has established the regional QMC to provide oversight and management of quality management functions and to provide 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 and member 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. Cooperation with 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 members, families, 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 as necessary.

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 member 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 Commitments

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.

QMC Roles and Responsibilities

The QMC will meet regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., QAPIP, QAPIP Evaluation, and PIPs). Committee oversight is defined as reviewing data and approving projects. Committee members represent the regional needs related to quality. QMC members should be engaged in the discussion of performance improvement issues and bring challenges from their site to the SWMBH committee's attention for deliberation and discussion.

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 and guidance. Additionally, the QMC is responsible for:

- Maintaining connectivity to other internal and external structures, including SWMBHs Board of Directors and Leadership Team, other regional committees, and MDHHS.
- Providing guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Providing data review and recommendations related to efficiency, improvement, and effectiveness.
- Reviewing and providing feedback related to policy and tool development.
- Ensuring each CMHSP has developed and is maintaining a performance improvement program within their respective organizations.
- Ensuring coordination is achieved through standardization of indicator measurement and performance indicators.

QMC Decision Making Process

The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. When consensus cannot be reached a formal voting process will be used and a super majority will carry the motion. This voting structure may be used to determine the direction of projects or with other various topics requiring decision making actions. If a participant fails to send a representative to a meeting, they will forgo the right to participate in any votes that occur. All regional committees are advisory with the final determinations being made by SWMBH (see Attachment G – QMC Charter for more details).

FY 2023 Quality Management Committee Goals (Measurement Period: Oct 1, 2022 – Sept 30, 2023)

1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By 6/30/23)
   - Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project.
   - Identify common denominators and classify into strategic categories.
   - Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category).
   - Develop and target interventions to improve identify problem areas.
   - Determine tracking mechanisms and targets goals for each identified area.
   - Share results with Operations Committee and other relevant committees.
   - Identify alternative electronic methods of gathering consumer responses, other than telephonic.
   - Establish and maintain ‘new’ process to keep the survey open for consumer participation all year, opposed to isolated dates.

- Identify tools/resources, which determine how many surveys have been completed and current scores (real time).
- Each CMHSP should review their individual survey results and submit to the PIHP, a plan of action for improving identified areas of improvement. This should be well documented within CMHSP internal quality review, or other CMHSP workgroup meeting minutes/notes.
- Review individual Performance improvement projects for each CMHSP, during the Regional Quality Management Committee meetings.

2. Review current survey tool for the 2023 Consumer Satisfaction Survey Project, to ensure that it meets CCBHC and Best Practice Methodology for Measurement and Analysis (By 3/30/23)
   - Identify NCQA approved consumer satisfaction survey tools, to ensure we are using the best option.
   - Review tools, questions and scoring methodology with relevant regional committees for feedback.
   - Identify survey distribution methods and possible process changes.
   - Communicate project logistics to CMHSP survey point persons and regional committees.
   - Complete analysis of results and distribute to internal and external stakeholders.
   - Evaluate selected tools effectiveness and make modifications, as necessary.

3. Redesign structure/format of the annual QAPI-UM Plan and Evaluation report. (By 6/30/2023)
   - Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.
   - Utilize the MDHHS suggested template.
   - Identify program weaknesses and strengths for each category evaluated.
   - Identify detailed plans/timeline to remediate identified weaknesses.
   - Ensure all elements/standards/MDHHS recommendations are included in the redesigned report.

4. Create a flow chart for each quality related MDHHS contractually obligated reporting requirement. (By 12/30/2023)
   - Each chart should provide processes and steps for collecting data, reporting data, timelines, project point persons and additional resources available.
   - Identified areas to include such as MMBPIS, Grievance and Appeals, etc.

5. Work with the Quality Management Committee and other Regional Committees to improve Health Service Advisory Group (HSAG) External Quality Review (EQR) results and corrective action plans. (By 10/30/2023)
   - Establish a schedule of review for each section not receiving a score of “Met” within the relevant Regional Committees.
   - Identify action plans for improvement and assign functional area leaders.
   - Ensure CMHSP’s and SWMBH are compliant with any standards/elements indicated as ‘*Not Met’* within the 3-year audit cycle.
   - Ensure that all sections identified during each of the 3-year audit cycle meet compliance at a minimum of 90% or SWMBH is one of the top 2 performing PIHPs in Michigan.

See the 2023-2024 SWMBH Board Ends Metrics for additional Key Performance Metrics assigned to QMC.

VII. 2023 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 meeting on September 9, 2022. The following represent a list of those Strategic Imperatives: (See Attachment H for more details on completion of Strategic Imperatives.)

Goal 1: Strengthen Equity and Quality in Behavioral Health Care.
Goal 2: Improve access to substance use disorders prevention, treatment, and recovery services.
Goal 3: Ensure effective pain treatment and management.
Goal 4: Improve access and quality of mental health care and services.
Goal 5: Utilize data for effective actions and impact on behavioral health.

As SWMBH enters 2023, its tenth year of operations a reconsideration of strategic objectives and tactical actions for the period 2022-2025 based on past, present and future federal and state policy changes is necessary. These plans are based on the presumption of stability in Board Ends and their definitions which the Board is free to modify. This 2022 – 2025 Strategic Plan is intended primarily for the Board and will drive downstream operational actions at SWMBH. As is displayed above a long-standing construct for all healthcare efforts is The Quadruple Aim.

VIII. 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. It is important for SWMBH to review the system for errors and ensure that the data is correct, accurate, and timely. Monitoring occurs in the following ways:

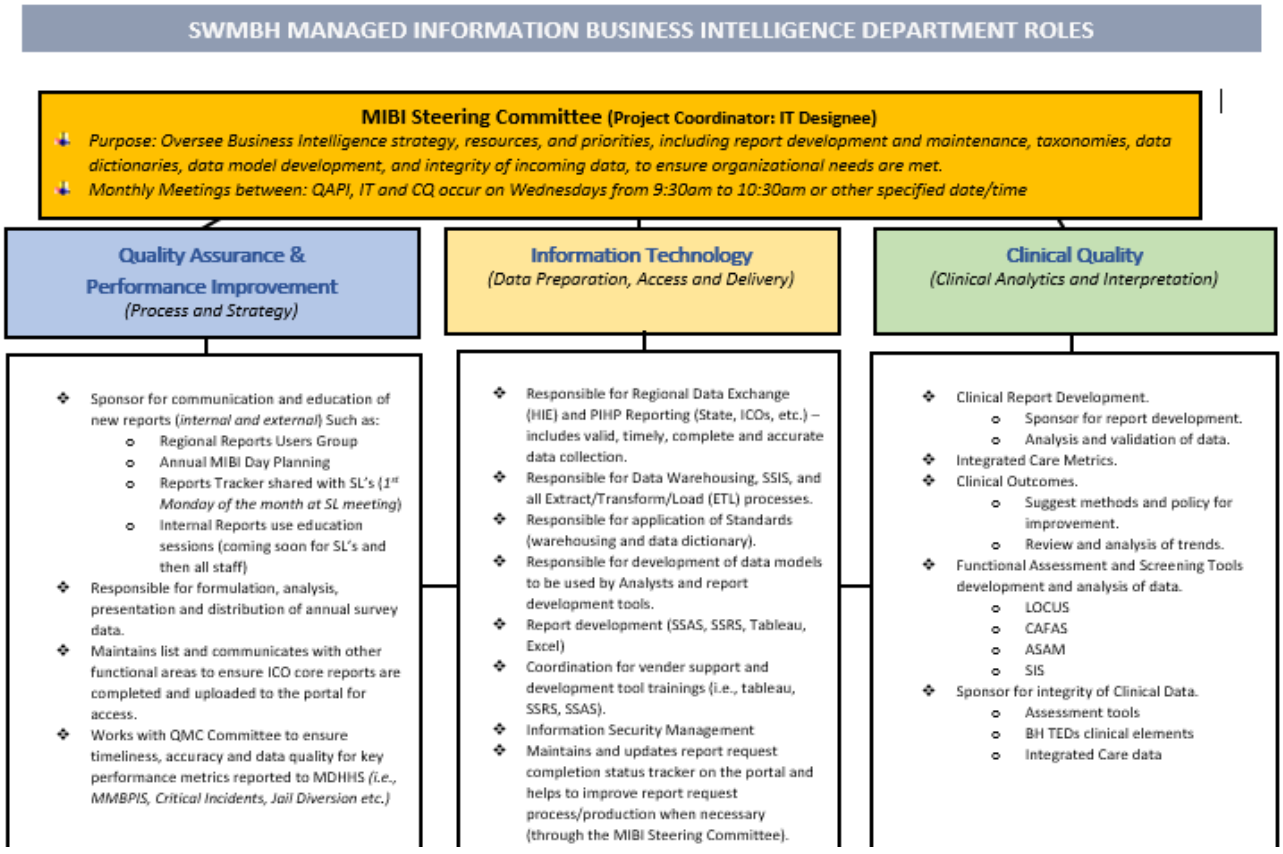
- System Reviews- the QAPI Department along with IT is responsible for ensuring that there are:
  - Data reviews completed before information is submitted to the state
  - Random checks to ensure data is complete, accurate, and that it meets the related standards.
  - Source information reviews to make sure data is valid and reliable.

- The QMC and QAPI Department address any issues identified in the system review.

- Ensuring processes are clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Remeasurements happen as often as determined necessary for the identified project(s).
- 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.
- Maintaining and organization of the SWMBH portal and reports.
- Maintaining and organization of reports in the Tableau Data Visualization system.

IX. Managed Information Business Intelligence (MIBI) Steering Committee

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.



X. 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 QAPIP. 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 information related to the QAPIP, survey results, and other relevant information in newsletter articles and on the SWMBH website for all stakeholders to review.

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

- Providers inside the provider network
- Members and their families (when appropriate)
- The SWMBH Board of Directors
- CMHSP staff
- SWMBH staff
- State representatives
- Others when appropriate

Information is provided through a variety of methods including but not limited to:

- Member and Provider newsletters
- The SWMBH website
- The SWMBH SharePoint site
- Tableau Dashboards
- SWMBH QM reports
- Meetings
- Other external reports

XI. Definitions/Acronyms

BTRC	Behavior Treatment Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.
Behavioral Health	Referring to an individual diagnosed with a mental illness, intellectual developmental disability, and/or substance use disorder, or children diagnosed with serious emotional disturbance.
CMHSP	Community Mental Health Services Program is a program operating under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended. Refers to one of the eight Community Mental Health Services Programs (CMHSPs) in Region 4.
Contractual Provider	Refers to an individual or organization under contract with the SWMBH Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.
EQR	External Quality Review is an audit conducted annually by HSAG on behalf of CMS and

	MDHHS.
HCBS	Home and Community Based Services provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HSAG	Health Service Advisory Group is a vendor contracted by MDHHS to audit the PIHPs and CMHSPs for compliance with CMS regulations and MDHHS contractual requirements.
LTSS	Long Term Supports and Services which are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identifies the Home and Community Based Services (HCBS) Waiver. MI-Choice as recipients of LTSS.
Member	For SWMBH purposes "member" includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used interchangeably within this definition: clients, customers, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.
MMBPIS	Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).
MDHHS	Michigan Department of Health and Human Services, along with 46 regional CMHSPs and 10 PIHPs, contacts public funds for mental health, substance abuse prevention and treatment, and developmental disabilities services.
OIG	The Office of Inspector General is the oversight division of a federal or state agency aimed at preventing inefficient or unlawful operations. They are charged with identifying, auditing, and investigating fraud, waste, abuse, embezzlement, and mismanagement of any kind within the executive department.
PBIP	The Performance Bonus Incentive Program is a platform for PIHPs to earn additional funding for achieving specific goals or hitting predetermined benchmarks established by MDHHS.
PIP	Performance Improvement Projects are projects that are conducted to address clinical and non-clinical services, that can be expected to have a beneficial effect on health outcomes.
PIHP	A Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities, and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.
Provider Network	Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the SWMBH PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.
QAPI	Regional efforts made toward Quality Assurance and Performance Improvement.

QAPIP	Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.
Research	(As defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.
RCA	A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998).
Sentinel Event	An “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.
Stakeholder	A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
Subcontractor	Refers to an individual or organization that is directly under contract with a CMHSP to provide services and/or supports.
SUD Provider	Refers to substance use disorder (SUD) providers directly contracted with SWMBH to provide SUD treatment and prevention services.
SWMBH	Southwest Michigan Behavioral Health. The PIHP for Region 4.
Veteran Navigator	The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.
Vulnerable Person	A person in need of special care, support, or protection because of age, disability, or risk of abuse or neglect.

FY 2023 Quality Assurance and Performance Improvement Program Descriptions & Work Plan

A. Michigan Mission Based Performance Indicator System (MMBPIS)

Description

Access, efficiency, and outcome measures are established by the Michigan Department of Health and Human Services (MDHHS). SWMBH is responsible for ensuring that its CMHSPs and Substance Use Disorder (SUD) Providers are measuring performance through the Michigan Mission-Based Performance Indicator System (MMBPIS) per its contract with MDHHS. SWMBH maintains a dashboard tracking system to monitor individual CMHSP and Regional progress on each indicator throughout the year.

Each CMHSP is responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH via FTP by the 25th of every month for analysis. SWMBH promotes data integrity by using electronic controls within the spreadsheets used for reporting MMBPIS data. SWMBH has a QAPI Specialist dedicated to reviewing the data to ensure it is complete and accurate, based on the MMBPIS PIHP and CMHSP Code Book, prior to submission to MDHHS. SWMBH submits the data to MDHHS quarterly according to the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH may request the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). The PIHP ensures the action plans are achieved and improvements are recognized. Status updates are given, and regional trends are identified and discussed at relevant committees such as QMC, RUM, RCP and Operations Committee for further planning and coordination. SWMBH also participates in MDHHS Performance Indicator workgroups and communicate any changes with indicator measurement or reporting to internal and external stakeholders.

Oversight and monitoring will be conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. Provider Network monitoring desk audit and site reviews occur at least annually. The SWMBH Quality Department completes a review of MMBPIS Performance Indicator data, primary source verification documentation and protocols during this annual site audit, and CAPs are requested from any CMHSPs that are out of compliance against the pre-established benchmarks.

FY22 Goals

SWMBH will meet or exceed the MDHHS-indicated benchmark for each of the access and follow-up MMBPIS performance measures (Indicators 1, 4 and 10). SWMBH's Board Ends Metrics target that 85% of MMBPIS Indicators will achieve the State-indicated benchmark for four consecutive quarters for FY 2023. An additional target is set for Indicator 3a, b, c, and d to achieve a 3% combined improvement (though FY23, all four quarters) over the 2022 baseline.

Indicators	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	Quality	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	Quality	QMC	Monthly

Indicator 2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.	Quality	QMC	Monthly
Indicator 2b - Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.	Quality/SUD	QMC, Clinical Quality	Monthly
Indicator 3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).	Quality	QMC	Monthly
Indicator 4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	Quality/SUD	QMC	Monthly
Indicator 4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	Quality	QMC	Monthly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	Quality	QMC	Monthly
Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%).	Quality	QMC	Monthly
Indicator 10b - e-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%).	Quality	QMC	Monthly

B. Performance Improvement Projects

Description

MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

The following are steps used to identify, implement, and evaluate the progress of a PIP.

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

The State of Michigan requests that each PIHP select a project topic to address healthcare disparities. This specific topic was selected through an evaluation of SWMBH performance and utilization data, which assessed for the presence of racial and ethnic disparities. The evaluation included racial and ethnic stratifications of: utilization rates of behavioral health services, access to medication-assisted opioid treatment, timely access to behavioral health services (measured by Michigan-specific performance metrics), and CMS Core Set/HEDIS quality metrics (including Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)), Follow Up After Psychiatric Hospitalization (FUH), and Initiation and Engagement of Alcohol and Other Drug Treatment (IET)).

There are currently (3) primary Performance Improvement Projects that SWMBH has targeted for progress in 2023. Those PIPs include:

1. "A decrease in the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates." (HSAG)
2. The percentage of adolescents and adults with a new episode of alcohol or other drug 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 initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit.
3. SWMBH will select a Performance Improvement Metric related to our Annual Customer Satisfaction Survey Scores in the *'Improved Outcomes'* category for adults and the *'Improved Functioning'* category for Youth. The identified categories have been our 2 lowest scoring categories over the past 5 years.

The details of each of the 3 identified PIPs can be found below:

FY23-24 PIPs

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Performance Improvement Project #1 To reduce racial disparities in follow-up after Emergency Department (ED) visits for alcohol and other drug abuse or dependence. Monitoring: 1. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual
Performance Improvement Project #2 The percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following: 1. Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. Engagement of AOD Treatment, the percentage of beneficiaries who initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit. 3. SWMBH will participate in DHHS planned data validation activities and meetings. SWMBH will be provided IET data files by 1/31/23 and have 120 calendar days to return the completed validation template to DHHS.	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual
Performance Improvement Project #3 SWMBH will select a Performance Improvement Metric related to our Annual Customer Satisfaction Survey Scores in the '*Improved Outcomes*' category for adults and the 'I*mproved Functioning*' category for Youth. The identified categories have been our 2 lowest scoring categories over the past 5 years. The target categories that have been targeted for improvement during the 2023 survey period are: 1. Access and Timeliness to Care 2. Expanding Treatment, Program and Group Therapy options.	Quality	Regional Quality Management Committee	Bi-Annual

C. Event Reporting – Critical Incidents

Description

SWMBH's process for identifying, reporting, and following up on incidents and events is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents are defined by MDHHS as suicide, non-suicide deaths, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrests. Hospitalization or EMT due to an injury will be further classified to include whether the injury resulted from physical management. SWMBH is responsible for reporting qualifying incidents to MDHHS in a timely manner, as defined in the contract language, via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM).

SWMBH delegates the responsibility of the process for the identification, review, and follow-up of sentinel events, critical incidents, and risk events to its contracted CMHSPs and SUD Providers. All unexpected deaths (UDs) are classified as sentinel events and are defined as deaths resulting from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect, for members who at the time of their deaths were receiving specialty supports and services. SWMBH ensures that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been identified and addressed, including the proper identification of a sentinel event and the commencement of a root cause analysis. Following completion of a root cause analysis, or investigation, the CMHSP or SUD Provider is required to develop and implement either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or to document the rationale of why corrective actions are not needed. A random sample is reviewed annually during the CMHSP Delegated Function Site Reviews to ensure each CMHSP is following the process as intended.

SWMBH analyzes critical incidents, sentinel events, and risk events at least quarterly during the regional QMC meetings. The risk events reviewed minimally include actions taken by individuals who receive services that cause harm to themselves, actions taken by individuals who receive services that cause harm to others, and two or more unscheduled admissions to a medical hospital (unrelated to a planned surgery or natural course of a chronic illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or events are reviewed and discussed to remediate the problems and prevent similar occurrences of additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes.

SWMBH contracts with four SUD residential treatment providers – Gilmore Community Healing Center (CHC), Freedom Recovery Center (FRC), Kalamazoo Probation Enhancement Program (KPEP), and Sacred Heart Center. The process for SUD residential treatment providers reporting sentinel events to SWMBH changed as of the new fiscal year on 10/01/2022, with the transition to the new MDHHS reporting process. SUD residential treatment providers that SWMBH contracts with are required to notify SWMBH as sentinel events occur and SWMBH submits the information into the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). The SUD residential treatment providers are also required to prepare and submit a sentinel events data report semiannually to SWMBH that includes the number of sentinel events by event category, and plans of action or interventions, which occurred during the 6-month period. SWMBH aggregates the data and submits it to MDHHS by the designated due dates outlined in the contract requirements.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	Quality	Through submission to MDHHS in the new CRM	As SEs Occur
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who were hospitalized due to an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who received emergency medical treatment (EMT) for an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	Quality	QMC	Monthly

SWMBH Incident and Event Flowchart

D. Behavior Treatment Monitoring

Description

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Only the techniques permitted by the Technical Requirement for and have been approved during person-centered planning by the member or his/her guardian may be used with members. SWMBH delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of the effectiveness of the Behavior Treatment Review Committee by stakeholders. Each CMHSP is also required to submit their BTRC data to SWMBH on a quarterly basis where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. The data includes the numbers of interventions and length of time the interventions were used per person. Tracking this data provides important oversight to the protection and safeguard of vulnerable individuals, including those receiving long term supports and services (LTSS). The data is available to MDHHS upon request. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. Based on the analysis, SWMBH requests the behavior plans for individuals as needed to review further. The criteria for further review may include, but is not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, and other critical incidents. SWMBH also utilizes the data during the administrative and delegated site reviews to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP. Additionally, SWMBH evaluates each CMHSP BTRC process annually and participates in at least one BTRC meeting for each CMHSP each year.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The percentage of individuals who have an approved Behavior Treatment Plan, per 1,000 people served, will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The number of behaviors being addressed in a BTP per person will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The percent of emergency interventions (911 calls and physical management) will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly

E. Member Experience - Customer Satisfaction Surveys

Description

The QAPI Department will administer an annual Member Experience Satisfaction Survey. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement at the CMHSP and PIHP levels. SWMBH will ensure the incorporation of individuals receiving long-term supports or services, case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY23 SWMBH will utilize a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS) and the Experience of Care and Health Outcomes Survey (ECHO). All adopted survey methods and categories are certified through the National Council of Quality Assurance (NCQA) as best practice survey tools to gage member experience of care. During FY23 the SWMBH Quality Department plans to collect consumer survey responses throughout the year, with the goal of achieving 2000 completed surveys. Surveys can be accessed by consumers via: QR codes in waiting/lobby areas, tablets in the waiting/lobby areas, through the SWMBH website, by text message, by email, by mobile device or by paper copy.

At the conclusion of the survey project, a full analysis report will be produced, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The results and survey analysis will be shared with internal/external stakeholders, SWMBH Consumer Advisory Committee, SWMBH Clinical Practices Committee, SWMBH Utilization Management Committee, the Regional Operations Committee, Quality Workgroups, and the Board of Directors. SWMBH informs practitioners, providers, members, internal/external stakeholders, and the SWMBH Board of survey analysis results. The results will be shared via SWMBH website, newsletters, Annual QAPI Evaluation and other SWMBH annual publications. The results will be presented to the SWMBH Consumer Advisory Committee for feedback on survey process, questions, content and distribution plan.

The Evaluation Report will outline the results of the survey project, identify any barriers, and provide recommendations for improvement for the following years survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, will be evaluated and discussed during the Regional QMC meeting. The survey analysis will address issues of quality and availability of care. Sources of member dissatisfaction will be investigated and identified and each CMHSP will be required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic action steps will be outlined to follow up on the findings.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1000 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Quarterly
Achieve at least 500 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Annually
Achieve a minimum of 350 completed surveys for each CCBHC site, utilizing MDHHS questions, criteria, and results/analysis reporting guidance.	QAPI	QMC and CCBHC Data and Reporting Workgroup	Annually

Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QAPI	QMC, CAC, CPC, and RUM Committees	Bi-Annual
Ensure that CMHSP develops improvement plans, specific to their findings/results/analysis.	QAPI	QMC, CAC, CPC, and RUM Committees	Bi- Annual
Present and receive feedback from the SWMBH Consumer Advisory Committee on survey process, questions, content, and distribution plan.	QAPI	QMC and CAC Committees	Annually

F. Member Experience – RSA-r Survey

Description

The QAPI Department, in conjunction with the SUD Department, will administer the Recovery Self-Assessment Survey, Person in Recovery version (RSA-r) to Medicaid and SUD Block Grant consumers within the region. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement in SWMBH's recovery-oriented care. At the conclusion of the survey project, a full analysis report will be produced, providing qualitative and quantitative analysis for each of the five subcategories measured (Life Goals, Involvement, Diversity of Treatment, Choice, and Individually Tailored Services). The results and survey analysis will be shared with internal/external stakeholders, SWMBH Consumer Advisory Committee, SWMBH Clinical Practices Committee, SWMBH Utilization Management Committee, the Regional Operations Committee, Quality Workgroups and the SUD Board of Directors, and feedback strategies will be implemented. The results will be shared via SWMBH website, newsletters, Annual QAPI Evaluation and other SWMBH annual publications.

The Evaluation Report will outline the results of the survey project, identify any barriers, and provide recommendations for improvement for the following years survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, will be evaluated and discussed during the Regional QMC and the SUD Directors Subgroup meetings. The survey analysis will address issues of quality and availability of care. Sources of member dissatisfaction will be investigated and identified and each SUD and CMHSP participant will be required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic action steps will be outlined to follow up on the findings.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase the number of completed surveys compared to the previous year.	QAPI	QMC, SUD Directors Subgroup	Annually
Improve scores in at least four out of five survey categories from previous year's results.	QAPI	QMC, SUD Directors Subgroup	Annually
Revise the survey to collect SUD service program type to enable further analysis and process improvement of recovery-oriented care.	QAPI	QMC, SUD Directors Subgroup	Annually

G. Provider Experience – Communication and Access to Services Survey

Description

SWMBH ensures consumers access to behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements. SWMBH directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered.

To ensure SWMBH is meeting the needs/obligations of our delegated providers, SWMBH conducts an annual "*Provider Communications and Access to Services Survey*". This survey is used to guide planning and performance improvement strategies for practitioner experiences in the following categories:

- Communications Process
- Timeliness of Care (*authorization of Routine, Urgent and Emergency Services*)
- Technical Assistance
- SWMBH Business Processes

The results/data from the annual survey process are reviewed by the Regional Utilization Management Committee, Regional Clinical Practices Committee, and the Regional Quality Management Committees. Goals are created around areas of improvement, noted by the provider/practitioner feedback. Progress on identified goals are reviewed and monitored by the said Regional Committees and compared against the previous year's survey data to identify trends and noted improvements. The following suggestions for improvement were identified during the 2022 survey cycle.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Provide better access to CMHSP reporting obligations and reporting requirements.	QAPI	QMC and RUM Committees	Annually
SWMBH to provide additional information on authorization for services for dually enrolled consumers.	UM and CP	RUM and RCP Committees	Annually
Provide further/clarification on who providers should contact for support or assistance authorizing a service.	UM and CP	RUM and RCP Committees	Annually
Provide more access for case consultation or peer review of complex cases.	UM and CP	RUM and RCP Committees	Annually
Provide a pathway for better communications between Social Workers and Care Coordinators.	UM and CP	RUM and RCP Committees	Annually

H. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance department performs the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to members by its Participant CMHSPs, providers, and subcontractors. This review is performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performs this review immediately after the end of each Fiscal Year Quarter to have real time results and an opportunity to effectuate change quickly. SWMBH submits its findings from this process to MDHHS annually and provides follow up actions that were taken because of the findings. SWMBH also presents the findings to the Board of Directors.

For completing the fiscal year verification of sampled Medicaid claims, SWMBH uses the random number function of the Office of Inspector General's (OIG) statistical software package, RAT-STAS, and conducts quarterly audits of service encounters for each CMHSP and reviews claims from contracted substance use disorder (SUD) providers and non-SUD providers subcontracted with Participant CMHSPs. SWMBH utilizes a standardized verification tool, which includes the following elements against which all selected encounters and claims are evaluated:

1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?
5. Is there documentation on file to support that the service was provided to the consumer?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	Compliance	SWMBH Compliance Committee and SWMBH Regional Compliance Committee	Monthly

I. Provider Network/Administrative and Delegated Function Site Reviews

Description

Provider Network Adequacy
SWMBH completes an annual report during the first quarter of the applicable fiscal year, assessing provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The areas that are assessed include enrollee-to-provider ratios, crisis residential beds-to-enrollee ratios, time and distance standards, SUD services based on ASAM LOC, timely appointments, languages spoken, cultural competence, and physical accessibility. Each section contains a regional analysis and identifies opportunities for improvement that will be addressed during the fiscal year. The report is submitted to MDHHS for review and feedback.

FY23 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the 2020 MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	Provider Network	SWMBH Assessment of Medicaid Network Adequacy Report	Annually

Description

Site Reviews
SWMBH either directly performs or ensures that its Participant CMHSPs perform annual monitoring of all providers in its network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality.

Participant CMHSP Site Reviews
SWMBH performs annual Site Reviews of its Participant CMHSPs. These reviews consist of a review of each CMHSP's administrative processes and procedures in the following functional areas: Access and Utilization Management, Claims, Compliance, Credentialing, Customer Services, Grievances & Appeals, Provider Network, Quality, Staff Training, SUD EBP Fidelity and Administration, and Clinical Administration.

In addition to reviewing administrative processes, the annual site review process also includes file reviews for the following administrative functions:

- Denial File Review
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review
- Appeals File Review
- MMBPIS and Critical Incident File Review
- Staff Training File Review

To monitor clinical service quality, SWMBH performs a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that is focused on a specific population or service (consistent across all

Participant CMHSPs). The population or service focus is determined annually by SWMBH's Clinical Quality Department based on several factors which may include State or PIHP-audit results, member complaints, or other identified concerns. SWMBH also performs an SUD Clinical Quality clinical record review of CMH SUD services.

SUD Providers

SWMBH does not allow for subcontracting of SUD services, and therefore directly holds each contract with its network SUD Providers. SWMBH directly performs annual site reviews for each of its contracted SUD providers. These reviews consist of a review of each SUD Provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor SUD Provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered.

To monitor clinical service quality, SWMBH performs a clinical file review as part of the annual site review process.

Subcontracted Providers

For non-SUD subcontracted providers that are contracted with one or more of SWMBH's Participant CMHSPs, SWMBH ensures that monitoring is performed annually either directly by SWMBH or by a Participant CMHSP. SWMBH directly performs the annual site reviews for the following provider types:

- Autism Service Providers
- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)

SWMBH's Participant CMHSPs perform annual monitoring of the remaining subcontracted provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviews standardized subcontracted provider review tools which are used for completion of subcontracted provider site reviews to ensure consistency and foster reciprocity. The RPNMC also maintains a spreadsheet of all "shared providers", subcontracted providers that are contracted with more than one Participant CMHSP and assigns a responsible Participant CMHSP to perform the annual site review each year, to reduce the burden on shared providers. Completed reviews are uploaded to SWMBH's Portal so they are accessible to all Participant CMHSPs.

Subcontracted provider site reviews consist of a review of each provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY23 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete site reviews for the region (for Participant CMHSPs, SUD Providers, and Subcontracted Providers), and areas of non-compliance will require a corrective action plan.	All SWMBH Departments; Participant CMHSPs	Site Review Tools and CAP Documents	Annually

J. Credentialing and Re-Credentialing

Description

SWMBH either directly performs or ensures that its Participant CMHSPs and network providers perform credentialing and re-credentialing in compliance with SWMBH's Credentialing and Re-credentialing Policies, which are annually approved by the SWMBH Board of Directors. The credentialing process (inclusive of re-credentialing) ensures that organizations, physicians, and other licensed health care professionals are qualified to perform their services. SWMBH utilizes standardized credentialing and re-credentialing applications throughout its Region to ensure consistent application of required standards. These applications are periodically reviewed by the Regional Provider Network Management Committee. SWMBH utilizes a checklist to assist in processing credentialing applications. The checklist includes the following components for re-credentialing files:

- QI Data Check
    - Compliance F/W/A or other billing issues
    - Customer Services issues (other than formal Grievances/Appeals)
    - Utilization Management issues/concerns

SWMBH directly performs credentialing for the following in its network:

- Applicable SWMBH employees/contractors (individual credentialing)
- Participant CMHSPs (organizational credentialing)
- SUD Providers (organizational credentialing)
- Autism Service Providers (organizational credentialing on behalf of the Region)
- Financial Management Service Providers (organizational credentialing on behalf of the Region)
- Crisis Residential Providers (organizational credentialing on behalf of the Region)
- Inpatient Psychiatric Service Providers (organizational credentialing on behalf of the Region)
- Large Specialized Residential Providers – Beacon, ROI, Turning Leaf, and Hope Network
    - SWMBH performs organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegates, under Delegation MOUs, credentialing activities to its Participant CMHSPs for the following:

- CMHSP network providers, other than those listed above

SWMBH includes credentialing requirements consistent with its policies in its subcontracts with its Participant CMHSPs, SUD providers, and network providers via the CMH-provider subcontract boilerplate, for the following:

- Individual practitioner credentialing of directly employed/contracted staff

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and its Participant CMHSPs monitor compliance with credentialing requirements through the annual site review process. Each site review includes a file review of a sample of the provider's credentialing files. See "Provider Network Monitoring" for additional information on the annual site review process. Additionally, SWMBH and its Participant CMHSPs require clinician information for any clinician to be listed as a "rendering provider" in the applicable agency's billing system. This is another way SWMBH and its Participant CMHSPs monitor to ensure licensed professionals are qualified to perform their services. While it is not "credentialing", when SWMBH receives a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performs basic screening checks including exclusions screening and licensure verification to ensure that the clinician is only assigned billing rights to service codes they are qualified to deliver.

Monitoring Activities – Non-licensed Providers

SWMBH and its Participant CMHSPs monitor non-licensed provider staff qualifications through the annual site review process. Standardized site review tools for all provider types include a Staff Training file review, which evaluates whether a sample of the provider's staff completed all required trainings within required timeframes. Standardized site review tools that are specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) include review elements that evaluate the provider's process for ensuring non-licensed direct care staff meet the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network	Provider Network Team Meeting Minutes	Annually
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated site reviews.	Provider Network	Site Review Tools	Annually

K. Clinical Practice Guidelines

Description

Southwest Michigan Behavioral Health (SWMBH) reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract and Medicaid Managed Care rules.

SWMBH and its Medicaid subcontracted provider network has adopted these guidelines and assures that information related to the guidelines is made available to members and providers.

It is policy that the employees of SWMBH, Community Mental Health Service Providers (CMHSP), and the provider network must assure that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines found here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.

SWMBH's Clinical Protocols and Practice Guidelines meet the following requirements:

- Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
- Consider the needs of the SWMBH members.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or Director Clinical Quality.
- Guidelines are disseminated to all applicable providers through provider orientation/the provider manual and to members upon request. Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks. Additionally, implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
- Any decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

SWMBH's adopted practice guidelines include:

- Inclusion Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- Employment Works! Policy

Practices Guidelines are adopted, developed, and implemented by the SWMBH Regional Clinical Practices Committee, which consists of representatives from SWMBH and the eight CMHSPs in Region 4. This group works together to decide which guidelines are most relevantly matched to the individuals in this region by eliciting responses from CMHSP representatives who are close to the issues. They ensure that the essence and intention of these guidelines are filtered through the behavioral health system in via meaningful discussion, policy, procedure, training, and auditing/monitoring. Practice guidelines are monitored and evaluated through SWMBH's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

Information and outcomes regarding evidence-based practices is reported from the SWMBH Regional Clinical Practices Committee, down to local clinical meetings at the county level. Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the SWMBH website.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The Employment Works! Practice Guideline will be added to the CMH annual site review tool for 2023. It is expected that there is clear documentation that employment has been discussed with all members at least annually. The intended outcome is described in the Michigan Employment First Executive Order No. 2015-15 which "recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability…"	Clinical Quality	Delegated Function Site Review	Annually
Information sharing about Practice Guidelines, and SWMBH's commitment to Practice Guidelines, will be added to the SWMBH Provider Newsletter at least once/year.	Clinical Quality	Provider Newsletter	Annually

L. Long-Term Services and Supports (LTSS)

Description

"Long term services and supports (LTSS)" means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).

Long Term Services and Supports (LTSS) are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; or
- Physical, cognitive, developmental, or chronic health conditions; or
- other functional limitations that restrict their abilities to care for themselves; and
- Receive care in home and community-based settings or facilities such as nursing homes.

MDHHS identifies Medicare and Medicaid participants in its HCBS Waivers as recipients of Long-Term Services and Supports (LTSS). Michigan currently hosts the following HCBS Waivers:

- Children's Waiver Program
- MI Health Link Waiver
- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
    - 1915(i)- (formerly known as 1915(b)(3))
    - 1115 Behavioral Health Demonstration

Southwest MI Behavioral Health manages funding for Michigan's specialty behavioral health Medicaid population through delegation and contracting with the eight CMHSPs and their provider networks in Region 4. SWMBH and its network serves members receiving LTSS through the following HCBS Waivers:

- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
    - Children's Waiver Program
- 1915(i)- (formerly known as 1915(b)(3))
    - 1115 Behavioral Health Demonstration

The Centers for Medicare & Medicaid Services (CMS) works closely with MDHHS to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services and assure optimal outcomes, such as independence health and quality of life.

SWMBH is dedicated to ensuring the quality and appropriateness of care to all its members. However, persons receiving LTSS are some of our most vulnerable citizens; therefore, additional analyses, both quantitative and qualitative, of the quality and appropriateness of care for the LTSS populations in Michigan are warranted.

The quality, availability, and accessibility of care furnished to members receiving LTSS will be quantitatively assessed using an analysis of new LTSS sections and breakouts of the existing MHSIP and YSS surveys. SWMBH's QAPI department will incorporate a question to the annual MHISP and YSS surveys that will identify individuals who are receiving LTSS. This will allow for a separate analysis of the LTSS population. Quality and availability of care are assessed in the MHSIP and YSS. Additional questions will be developed to assess accessibility. In 2023,

we will establish baseline assessments of member experiences and identify areas of dissatisfaction needing improvement.

Furthermore, the CMH site review tool that has been adopted by all 8 CMHSPs in Region 4 includes items monitoring the appropriateness of care of members receiving. For reference, these items in the CMHSP site review tool currently state:

- In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. This should include minimally – making available the primary assessment, treatment plan updates, changes in level of care, med changes etc. to the PCP. Actual contact (phone or in person) with the physician is also counted/encouraged. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate releases for exchange of information must be present if SUD information I shared. There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.
- Clinical analysis and interpretive summary of the customer's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.
- Level of Functioning/Daily Living is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment completed annually and when there is significant change in individual's status.
- The psychosocial assessment clearly identifies the customer's strengths and barriers (may also be addressed in the plan of service).
- Plan is individualized based upon assessment of the customer's needs and preferences. The plan (or assessment) describes his/her strengths, abilities, plans, hopes, interests, preferences and natural supports.
- All needs identified in the assessment are addressed or deferred (including health/safety risks); needs not identified in the assessment are not included in the plan.
- The treatment plan identifies natural supports that will be used to assist the customer in being able to accomplish goals and objectives.
- Plan contains clear, concise, and measurable statements of the objectives the customer will be attempting to achieve.
- Individuals are provided with ongoing opportunities to provide feedback on supports and services they are receiving, perceived barriers or strengths during treatment, and their progress towards goal attainment. (May be documented in Progress notes and/or Periodic Reviews.)
- Services and intervention identified in the IPOS are provided as specified in the Plan - including measurable goals/objectives, the type, amount, scope, duration, frequency, and timeframe for implementing. Individual has received all services authorized in plan. If services are not being utilized as planned, and an appropriate reason for the lack of service provision is not present in the documentation, the IPOS has been amended. (Lack of provider is not an acceptable reason for not providing a medically necessary service.)

Aggregated annual audit outcomes are regularly monitored and analyzed by clinical and quality assurance departments at both the CMHSP and PIHP levels and used to inform annual provider training that is offered to the LTSS provider network on an annual basis by CMHSP-level quality improvement efforts. A future addition will be to develop a regional approach to assess care between settings.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Identify method to obtain LTSS status in MHSIP and YSS surveys, add questions related to accessibility in the 2023 surveys, and establish baseline LTSS survey results assessing the quality, availability, and accessibility of care.	Clinical Quality/QAPI	Clinical Quality	Annually
Add the topic of LTSS to at least two regional clinical meeting agendas to educate the Region 4 Network on how the LTSS population is defined, and how it can be better supported according to HSAG guidance.	Clinical Quality	Clinical Quality	Annually
Add information about LTSS to the provider newsletter once/year for the purpose of further educating the Region 4 Network and bring attention to the population.	Clinical Quality	Clinical Quality	Annually
Research and develop a regional approach to assessing care between LTSS settings that expands on current PIHP activities by 12/31/23. It will include a comparison of services and supports received with those set forth in the member's treatment/service plan.	Clinical Quality	Clinical Quality	Annually

M. Utilization Management

Description

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

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 and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and some CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone. 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 CMHSP's, providers or SWMBH departments. Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs and workforce training. Each CMHSP is required to have their own utilization management/review process. The Medical Director and a Physician specializing in Addictionology meets weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director who holds an unrestricted license is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. For the purposes of utilization control, SWMBH ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

- Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer.
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.
- 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).
- Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience.
- Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential.
- Provided with consideration for and attention to integration of physical and behavioral health needs.

Process Used to Review and Approve the Provision of Medical Services

- Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the member.
- Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
- The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
- Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
- Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
- There are mechanisms to evaluate the effects of the program using data on customer satisfaction,

provider satisfaction or other appropriate measures.

- Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Review Process

A Prospective 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. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

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

Access Standards

- The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
- The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services. F
- The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)
- 4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
- 4b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less

Level of Intensity of Service Determination Decision

Level of Intensity	Definition	Expected Decision/Response Time
Emergent - 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 3 hours of the request. Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request.
Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given.	Within 72 hours of the request. Prior authorization is required. If services are denied/ appealed and deemed urgent, an Expedited Appeal is required within 72 hours of denial.
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given.	Within 14 days of the request. Prior authorization is required.
Retrospective	Accessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided.	Within 30 calendar days of the request.
Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition.	Within 1 hour of the request.

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/ Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals.

Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions:

- *Access and Eligibility.* To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see Policy Access Management). SWMBH ensures that the Access Standards are met including MMBPIS.
- *Clinical Protocols.* To ensure Uniform Benefit for Customers, consistent functional assessment tools, medical necessity, level of care and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
- *Service Authorization.* Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness
- *Utilization Management*. Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH Utilization Management Plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization Management Plan endorses two core functions.

1. Outlier Management of identified high cost, high risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions.

The Utilization Review (UR) process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, HSAG EQR, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

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 focused by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan customers 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 CMHSP(s).

Outlier Definition

"Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:

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.

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 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.

Outlier Management Procedures

As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to 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.

Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.

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.

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, patient safety, call rates, Access standards and customer quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/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 customer level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

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 of care. As part of data management, Levels of Care for customers can be assigned. This work allows people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It is a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will create a Utilization management Plan per MDHHS guidelines.	UM	RUM	Annually
Aggregate and review UM data to identify trends and service improvement recommendations and identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	UM, Clinical Quality, SUD	RUM, QMC	Monthly
Identify the levels of care and subsequent reports to manage utilization and uniform benefit.	UM, Clinical Quality, QAPI	RUM	Monthly
Ensure Inter-rater reliability (IRR) audits are completed by each CMHSP for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. Create IRR training and distribute regionally.	UM	RUM	Annually Due by 3/31/22
SWMBH will meet or exceed the standard for compliance with Adverse Benefit Determination notices completed in accordance with the 42 CFR 438.404 and verify compliance during Delegated Managed Care Reviews.	UM and Provider Network	RUM	Annually (or Interim, as needed)

Emergent and non-emergent cases will be periodically monitored to ensure compliance with standards.	UM, QAPI, Clinical Quality	RUM	Monthly
Ensure a call center monitoring plan is in place and provide routine quality assurance audits.	UM, QAPI	RUM, QMC	Monthly
Tracking and monitoring of all internal service lines (crisis, emergent, immediate, and routine).	UM, QAPI	RUM, QMC	Quarterly
Collect and analyze quarterly call reports submitted by CMHSPs.	UM, Customer Services, QAPI	RUM, QMC	Quarterly

N. Customer Services

Description

Customer Service provides a welcoming environment and orientation to services. Customer Service provides information about benefits and available provider network. Customer Service provides information about how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Service assists members with obtaining information about how to access Due Processes when benefits are denied, reduced, suspended, or terminated. Customer Service oversees grievances and appeal process and tracks/reports patterns of problems for each organization and regionally including over/under service utilization.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Implement HSAG Corrective Action Plans and Recommendations to ensure contractual and federal requirements are met.	Customer Services	Regional Customer Service Committee	Annually
Update and Improve Advance Directives and Due Process materials/trainings in partnership with Building Better Lives project.	Customer Services	Regional Customer Service Committee	Annually
Review Grievance and Appeal files regionally for analysis of trends related to service utilization.	Customer Services	Regional Customer Service Committee	Semi-Annually

O. Certified Community Behavioral Health Clinics (CCBHC)

Description

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 began 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 were 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.

June 25, 2022, the Bipartisan Safer Communities Act approved expansion of the CCBHC Demonstration. This act enables Michigan to extend the duration of the demonstration to 6 years, allows current Demonstration agencies to expand with new locations, and additional agencies may be brought on as a part of the demonstration. By July 1, 2024, up to ten additional states may also join the Demonstration, and by 2030, all states will have had the opportunity to join. This Act also Contains a "rule of construction" allowing States to continue to cover items and services in the CCBHC bundle under the authority of the State plan using the PPS rate.

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.

SWMBH currently has two participating CCBHCs (Community Mental Health and Substance Abuse Services of St. Joseph County and Integrated Services of Kalamazoo). While other CMHSPs within the region have CCBHC Expansion Grants, SWMBH is not responsible for monitoring these 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.

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. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers.

Metric Name	Benchmark	State or CCBHC Reported Measure
Time to Initial Evaluation (I-EVAL)	n/a	CCBHC
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	n/a	CCBHC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	n/a	CCBHC
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	n/a	CCBHC
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	n/a	CCBHC
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) **	**23.90%**	**CCBHC**
Major Depressive Disorder: Suicide Risk Assessment (SRA-A) **	**12.50%**	**CCBHC**
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	n/a	CCBHC
Depression Remission at Twelve Months (DEP-REM-12)	n/a	CCBHC
Housing Status (HOU)	n/a	State
Patient Experience of Care Survey (PEC)	n/a	State

Youth Family Experience Survey (Y/FEC)	n/a	State
Follow up after ED Visit for MI (FUM)	n/a	State
Follow up after ED Visit for Alcohol and Drugs (FUA)	n/a	State
Plan All-Cause Readmission Rates (PCR-BH)	n/a	State
Diabetes Screening Schizophrenia/Bipolar using antipsychotics (SSD)	n/a	State
Adherence to Antipsychotic Meds with Schizophrenia (SAA-BH) **	**58.50%**	**State**
Follow up after Hosp for Mental Illness, ages 21+ (FUH) **	**58%**	**State**
Follow up after Hosp for Mental Illness, ages 6-21 (FUH) **	**70%**	**State**
Follow-up care for children prescribed ADHD meds (ADD)	n/a	State
Antidepressant Medication Management (AMM-BHH)	n/a	State
Initiation and Engagement of Alcohol and other Drug Treatment (IET-BH) **	**14 day- 42.5%; 34 day- 18.5%**	**State**

**Quality Bonus Payment (QBP) Metric

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).

Reporting Requirements

CCBHC-reported measures will be compiled by the CCBHC using the SAMHSA 2016 Data Reporting Template (XLSX file). CCBHCs are responsible for completing the "Case Load Characteristics" sheet and the reporting sheets for the clinic-reported measures (green colored tabs).

During DY2, CCBHCs should complete their reporting template quarterly. PIHPs should assist with validation and review of measures. Templates should be sent to PIHPs by the end of the month following the measurement period. PIHPs will also make the quarterly templates available to MDHHS or external evaluators throughout DY2 for purposes of monitoring and evaluation planning.

FY23 Goals

Goal	Responsible Department/Person	Where Progress Will Be Monitored	Frequency of Monitoring
Track QBP measures and CCBHC-Reported Measures at least quarterly. Report to all CCBHC subgroups.	QAPI, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly, and as needed

Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBP measures.	QAPI, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
Establish and document the criteria that will be used to validate the measures routinely submitted to MDHHS and update process as needed.	QAPI, CCBHC Coordinator	CCBHC Subgroup Meetings	Due by 1/31/23, and as needed
PIHPS will collect, validate clinic-reported data templates and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	QAPI, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly by 1/31/23, 4/30/23, 7/31/23, 10/31/23 Annually by 3/31/2023 (DY1) 3/31/2024 (DY2)
Document and track stages of readiness for mandatory CCBHC Evidence Based Practices (EBP). Additional documentation of how and why CCBHCs self-scored to get a regional operational definition.	Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly and by 06/2023 for documentation
Respond to all financial requests to MDHHS related to CCBHC Finance by stated deadlines (agenda, forms, handbook versions) and following all conversations and communications with MDHHS, report back to workgroup at the next scheduled meeting.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Document year-end financial reporting, reconciliation, and cost settlement processes as soon as able to ensure 2023 processes are efficient and in compliance with MDHHS expectations.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
Maintain current frequency of subgroup meetings to continue close collaboration with current CCBHC sites.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Develop written guidelines and process maps to support new regional CCBHC sites.	QAPI, Clinical Quality, Finance, CCBHC Coordinator	All CCBHC Subgroup Meetings	Due 06/2023

P. External Monitoring and Audits

Description

The SWMBH Quality Department will coordinate the reviews by external audit venders/entities including Michigan Department of Health and Human Services (MDHHS), Health Service Advisory Group (HSAG), and all other requests for audits, as necessary. The Quality Department will review all requests/documents/tools and other resources and communicate to the appropriate SWMBH functional area leaders. The Quality Department will work to ensure that SWMBH achieves established Board Ends Metric and Strategic Initiative benchmarks/targets. Results of SWMBH external audits will be presented to the Board of Directors. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities and Evaluation Report for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be made available to MDHHS upon request.

FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will demonstrate an improvement in overall compliance scores (*90% or top 2 scoring PIHP's*) during the 2023 HSAG External Quality Review (EQR).	QAPI	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate a minimum of (90% compliance score) on the annual HSAG Performance Measure Validation Review (PMV).	QAPI	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate an improvement in compliance and number of Corrective Action Plans during the annual MDHHS 1915 (SEDW, CWP, HSW, HCBS, Autism) review.	QAPI/Clinical Quality	QMC, CPC and other Regional Committees as necessary	Annually
SWMBH will demonstrate Full Compliance with MDHHS Substance Use Disorder Administrative Protocols/Review.	QAPI/SUD	QMC, SUD workgroup and Board	Annually
SWMBH will demonstrate Full Compliance with the MDHHS 1915c Administrative Protocols/Review.	QAPI Lead with other SWMBH Functional Areas to Assist	QMC, SWMBH Senior Leadership	Annually
SWMBH will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy Standards.	Provider Network	Regional Provider Network/Compliance Committee, Regional Utilization Management Committee	Annually

Q. Cultural Competency

Description

SWMBH and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competency that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services. Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment, and economic factors, etc. SWMBH has outlined many of these initiatives within the 2023-2024 Strategic Plan and provided detail on each strategy within our 2023 Cultural Competency Plan. SWMBH also outlines strategies and business Practices within the Cultural and Linguistic Competency Policy 3.7.

FY23 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Implement an annual staff/provider Cultural Accelerator survey to gauge organizational level of internal and external Cultural Competence.	SWMBH Operations	SWMBH Senior Leadership Meetings and Staff Meetings	Annually
Perform and utilize analysis on feedback received from consumers during annual Consumer Satisfaction and Recovery Services Surveys.	QAPI	QMC, RUM and RCP Committees	Annually
Promote continued Education throughout the organization and community by participating in or contributing to local organizations and public events.	Customer Services	Customer Services, Provider Network and Clinical Practices Committees	Annually
Complete an annual Network Adequacy analysis, which will identify deficiencies and interventions for providers' cultural competence as well as how the region collects and tracks languages spoken within the provider network.	Provider Network	Customer Services, Provider Network and Clinical Practices Committees	Annually
The Network Adequacy Plan, survey results and cultural competency plan will be shared with the SWMBH Board of Directors.	Provider Network and QAPI	SWMBH Operations Committee and Board of Directors	Annually
Confirm during CMHSP annual site reviews, that each CMHSP has an active and current Cultural Competency Plan in place. Plans should include goals and targeted initiatives for the current year.	QAPI	Customer Services, Provider Network and Clinical Practices Committees	Annually

ATTACHMENT A – 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 B – BOARD ENDS METRICS

Metric	Description	Deliverable/Goal	Date Range & Current Status
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.			
Metrics 1-5 are from the 2023 Performance Bonus Incentive Program			
1. Achieve 95% of Veteran's Metric Performance -Based Incentive Program monetary award based on FY23 MDHHS specifications. (25 pts. via MDHHS Contract) *1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023. SWMBH Metric Owner: Sarah Ameter and Natalie Spivak	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.1. PA 107 sec 105d) Identification of beneficiaries who may be eligible for services through the Veteran's Administration.	a. Timely submission of Veteran Services Navigator collection form by the last day of the month following the end of each quarter. b. Submit BH TEDs data quality monitoring narrative report by 1/1/2023. c. Submit VSN – BH TEDs comparison narrative report by 7/1/2023.	Pending Reporting Period 10/1/22 – 9/30/23 Metric Board Report Date: October 13, 2023
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
2. Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. *1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023. SWMBH Metric Owner: Natalie Spivak	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.2. PA 107 sec 105d) Sending ADT messages for purposes of care coordination through health information exchange.	SWMBH will submit to MDHHS a narrative report by 7/31/2023, listing CMHSP's 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.	Pending Reporting Period 10/1/22 – 9/30/23 Metric Board Report Date: October 13, 2023

Metric	Description	Deliverable/Goal	Date Range & Current Status
3. SWMBH will achieve the FY23 Initiation and Engagement State Specified benchmarks and participate in DHHS led data validation activities. SWMBH Metric Owner: Joel Smith Supporting SLs: Jonathan Gardner Alena Lacey	This metric is listed under section P.3. PA 107 sec 105d in the 2023 MDHHS PBIP specification table. This metric is also utilized for the 2023 PBIP, CCBHCC and OHH bonus incentive programs. The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within ***14 calendar*** days of the diagnosis. 2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within ***34 calendar days*** of the initiation visit.	a. The PIHP must participate in DHHS-planned and DHHS-provided data validation activities and meetings. PIHPs will be provided IET data files by January 31 each year, and within 120 calendar days, return their data validation template, completed, to DHHS. 1 point b. CCBHC Goal – Participating CCBHC sites achieve IET- 14-day metric at 42.5% and the IET-34-day metric at 18.5% per state indicated benchmarks. ½ point each	Pending Data Collection Period 10/1/22 – 9/30/23 Metric Board Report Date: November 10, 2023
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
4. SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2023, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to Patient-Centered Care activities and programs throughout the PIHP region. *1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023. SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Alena Lacey	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.4. PA 107 sec 105d) 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 15, 2023 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	Pending Reporting Period 10/1/22 – 9/30/23 Metric Board Report Date: February 9, 2024

Metric	Description	Deliverable/Goal	Date Range & Current Status
5. Achieve Compliance (based on MDHHS specified benchmarks) 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. SWMBH Metric Owner: Alena Lacey	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (J.2. PA 107 sec 105d) 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.	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 2023. 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.	Pending Data Collection Period 1/1/23 – 12/31/23 Metric Board Report Date: February 9, 2024
Strategic Imperative Category: Exceptional/Access to Care Persons and families served are highly satisfied with the services they receive.			
6. 2023 Customer Satisfaction Surveys collected by SWMBH are at or above the 2022 results identified in (a & b) and performance improvement areas/plans are identified. SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Sarah Ameter, Anne Wickham, and Mila Todd	This metric is in direct alignment with *Section V* of the 2023 MDHHS-PIHP contract *'Member Experience with Services'* a. The survey methodology must include a quantitative assessment (e.g., surveys) of member experience with services. b. The methodology must include a qualitative assessment (e.g., focus groups) of member experience with services.	a. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(<u>Improved Functioning</u> – baseline: 84.1%)* *1 point.* b. Youth Satisfaction Survey (YSS) tools. *(<u>Improved Outcomes</u> – 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. 1 point.	Pending Survey Collection Period 10/1/23 – 12/30/23 Metric Board Report Date: February 9, 2024

		d. Ensure that each CMHSP partner reviews site specific survey results and formulates Corrective Action Plans to drive identified or potential improvement areas.	
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
7. Michigan Mission Based Performance Indicator System (MMBPIS) Data, Tracking and Analysis SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Joel Smith and Alena Lacey	As directed by the 2023 MDHHS-PIHP contract *Section I 'Performance Indicators'*. The PIHP must include performance measures established by MDHHS in the areas of access, efficiency and outcomes. The PIHP must track and perform analysis to ensure each performance indicator is meeting the minimum performance benchmark/standard. Currently (7) Indicators have targeted benchmarks.	a. 24/28 indicators meet the State Benchmark, throughout all FY23 for 4 consecutive quarters 1 point. b. Indicator 3a,b,c & d achieve a 3% combined improvement (*through FY 23 all 4 Quarters*) over 2022 baseline (1/2 pt. each) 2 points.	Pending Data Collection Period 10/1/22 – 9/30/23 Metric Board Report Date: February 9, 2024
8. 2023 CCBHC Program Customer Satisfaction Surveys collected by SWMBH represent an 85% First Year *"in agreement"* Satisfaction rate average across all categories measured. SWMBH Metric Owner: Jonathan Gardner and Ella Philander	Per the 2022 CCBHC codebook section 13.B.2 and 13.B.3; the PIHP is responsible for evaluation and overall member satisfaction of the CCBHC program. The survey and assessment should consider availability and accessibility to services for eligible consumers, not just those being served. Focus groups, satisfaction surveys or advisory councils should be reviewed to determine appropriateness of service site locations.	a. SWMBH will administer an annual CCBHC consumer satisfaction survey, collecting responses from CCBHC participants using a hybrid MHSIP and YSS survey tool approved by MDHHS. ½ point b. SWMBH will complete analysis and reports for MDHHS and CCBHC locations, delivering results and identified areas/opportunities for improvement by June 2023. ½ point	Pending Data Collection Period 10/1/22 – 3/30/23 Metric Board Report Date: July 14, 2023

Strategic Imperative Category: Quality and Efficiency The SWMBH region is a learning region where quality and cost are measured, improved, and reported.			
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
9. 2023 Health Service Advisory Group (HSAG) External Quality Compliance Review (EQR) Results and Improvement Strategies SWMBH Metric Owner: All SLs with contributors dependent on Standards selected for review	As directed by the 2023 MDHHS PIHP contract Attachment P 7.7.1.1 – Amendment 1 – Medicaid Managed Specialty Supports Services/Programs, the PIHP must adhere to annual audits of the following categories: Member Rights, Emergency Services, Availability of Services, Assurances and Capacity of Services, Coordination of Care, Provider Selection, Confidentiality, Grievance and Appeals System, Sub contractual Delegation, Practice Guidelines, Health Information Systems and Quality Assessment and Performance Improvement Programs.	a. All standards or corrective action plans reviewed, will receive a score of 90% compliance, or designation that the standard has been "Met" or "Accepted" or SWMBH will be within the *top 2* scoring Michigan PIHP's. 1 Point.	Pending Data Collection Period 10/1/22 – 9/30/23 Metric Board Report Date: November 10, 2023
10. 2023 HSAG Performance Measure Validation (PMV) Audit Results and Improvement Strategies SWMBH Metric Owner: Natalie Spivak SL Contributors: Jonathan G and other contributors dependent on Standards selected for review during specified Fiscal Year	As directed by the 2023 MDHHS PIHP contract Attachment P 7.7.1.1 – Amendment 1 – Medicaid Managed Specialty Supports Services/Programs, the PIHP must adhere to annual audits of the following categories: Data Integration, Data Control, Data Accuracy and Performance Indicator Validation.	a. All standards or corrective action plans reviewed, will receive a score of 90% compliance, or designation that the standard has been "Met" or "Accepted" or SWMBH will be within the *top 2* scoring Michigan PIHP's 1 Point.	Pending Data Collection Period 1/1/23 – 6/30/23 Metric Board Report Date: November 10, 2023

Strategic Imperative Category: Improved Health Individual mental health, physical health and functionality are measured and improved			
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
11. SWMBH will achieve CCBHC Demonstration Year 1 Quality Bonus Payment Metrics (QBP's), against the States FY23 indicated Benchmarks. SWMBH Metric Owner: Ella Philander and Jonathan Gardner CMHSP Contributions/Owners: Kalamazoo and St. Joseph	As directed by the 2023 CCBHC Handbook under Table 1.A.1 – QBP Metrics and Benchmarks. The Regional PIHP will work with CMSHP-CCBHC participant programs to define processes and strategies for collection and reporting data. The PIHP will be the primary liaison for the submission of all required reports and follow-ups as directed by MDHHS. SWMBH will submit reports based on the identified metrics to MDHHS within 6 months of *DY 1 or by 3/31/2023.*	1. Child and Adolescent Major Depressive Disorder; Suicide Risk Assessment *(SRA-BHC - 23.9%) ½ pt.* 2. Major Depressive Disorder, Suicide Risk Assessment *(SRA-A - 12.5%) ½ pt.* 3. Adherence to Antipsychotic Meds for Individuals with Schizophrenia *(SAA-AD – 58.5%) ½ pt.* 4. Follow-up after Hosp. for mental illness, ages 18+ *(FUH-AD – 58%) ½ pt.* 5. Follow-up after Hospitalization for Children *(FUH-CH – 70%) ½ pt.* 6. initiation and Engagement of Alcohol and other drugs *(IET-14 – 42.5% & IET-34- 18.5%) ½ pt.*	Pending *.5 bonus point for each metric (1-6) successfully achieved. Data Collection Period 10/1/22 – 3/30/24 Metric Board Report Date: November 10, 2023
12. SWMBH will retain 60% of (OHH) enrollees, enrolled after 9/30/22. Program Enrollees must maintain 'enrolled' status for at least 6 months. SWMBH Metric Owner: Joel Smith	The retention metric is defined within the OHH handbook for Performance Year 2 goals (10/1/22 through 9/30/23). Further guidance on the metric can be found by clicking on the resource below. www.michigan.gov/OHH.	a. 334 Enrollees in the OHH Program as of 9/30/22. b. OHH retention Metric: 60% of enrollees enrolled after 9/30/22 will remain in "enrolled" status for at least 6 months. (*200 enrolled members by March 31, 2023*) 1 point	Pending Data Collection Period 10/1/22 – 3/31/23 Metric Board Report Date: May 12, 2023
13. SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY23. SWMBH Metric Owner: Natalie Spivak	As directed by the 2023 MDHHS-SWMBH contract, performance metrics table, SWMBH shall maintain a 95% compliance rate within the applicable Mental Health, Substance Use Disorder and Crisis BH TEDs fields. Each element (MH, SUD and Crisis) must have a matching and accepted BH TEDs record, as confirmed by the MDHHS quarterly status report.	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. 1 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. 1 point	Pending Data Collection Period 1/1/23 – 12/31/23 Metric Board Report Date: January 12, 2024

		c. 97% of applicable Crisis served clients (with accepted encounter) will have a matching BH TEDS record, as confirmed by MDHHS quarterly status report. 1 point	
Strategic Imperative Category: Mission and Value Driven CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.			
Metric	**Description**	**Deliverable/Goal**	**Date Range & Current Status**
14. SWMBH will meet or exceed FY23 contractual Critical Incident Reporting timeliness and efficiency benchmarks utilizing the new DHHS Customer Management System (CRM) SWMBH Metric Owner: Jonathan Gardner SL Contributors: Alena Lacey and SWMBH Chiefs	As of 10/1/2022, DHHS is requiring PIHP's to report through its new CRM system. The PIHP must meet the timeliness reporting standards to DHHS of: Immediate Events – 48 hours after becoming aware of the incident, Sentinel Events and Critical Incidents – 30 days after the end of the month in which the event occurred. The new CRM system requires that the PIHP provides timely updates as requested/assigned by DHHS.	a. SWMBH will submit all required incidents, meeting the identified benchmarks for Immediate, Sentinel and Critical Events. Final status will be provided through DHHS annual review results. 1 point b. SWMBH will provide annual CI site review audits on CMHSP's to ensure; timely reporting of Critical Incidents, appropriate documentation, involving the appropriate personnel, and using the information to address quality of care at their sites. 1/2 Point c. SWMBH will convene the internal Immediate/Sentinel Event review task force, as needed; to ensure root cause analysis and other required elements were in compliance with contractual policy standards.	Pending Data Collection Period 10/1/22 – 9/30/23 Metric Board Report Date: November 10, 2023

Metric	Description	Deliverable/Goal	Date Range & Current Status
15. SWMBH will meet or exceed MDHHS FY23 Autism Benefit Waiver Access to Care and Timeliness Standards SWMBH Metric Owner: Alena Lacey	SWMBH and MDHHS have placed emphasis on the underserved Autism population during 2023 and providing increased access and timeliness of services for those who have been waiting longer than 90 days for IPOS development and over 48 hours from referral to first scheduled appointment. The following metrics are State sponsored and targeted towards improving access and timeliness of service for consumers with an autism diagnosis.	a. Targeting Underserved Population: 30% improvement completing IPOS for consumers with Autism diagnosis who do not currently have an active IPOS in managed care system, or valid reason for inactivity listed in their record . (*baseline 125 – 37 completed IPOS by 9.30.23).* ½ point b. Decrease rate of overdue (over 90 days) autism 're-evaluations' within the SWMBH region by 10% by (9.30.23). Current rate of overdue evaluations is 20% d. (86/859)=10%. ½ point	Pending Data Collection Period 10/1/22 – 9/30/23 Metric Board Report Date: November 10, 2023

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 time table/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:

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

ATTACHMENT C – SWMBH BOARD ROSTER

Southwest Michigan BEHAVIORAL HEALTH

2023 Board Member Roster

Barry County

- Ruth Perino
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Chair
- Nancy Johnson (Alternate)

Branch County

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

Calhoun County

- Sherii Sherban
- Kathy-Sue Vette (Alternate)

Cass County

- Louie Csokasy
- Jeanne Jourdan (Alternate)

Kalamazoo County

- Erik Krogh
- Karen Longanecker (Alternate)

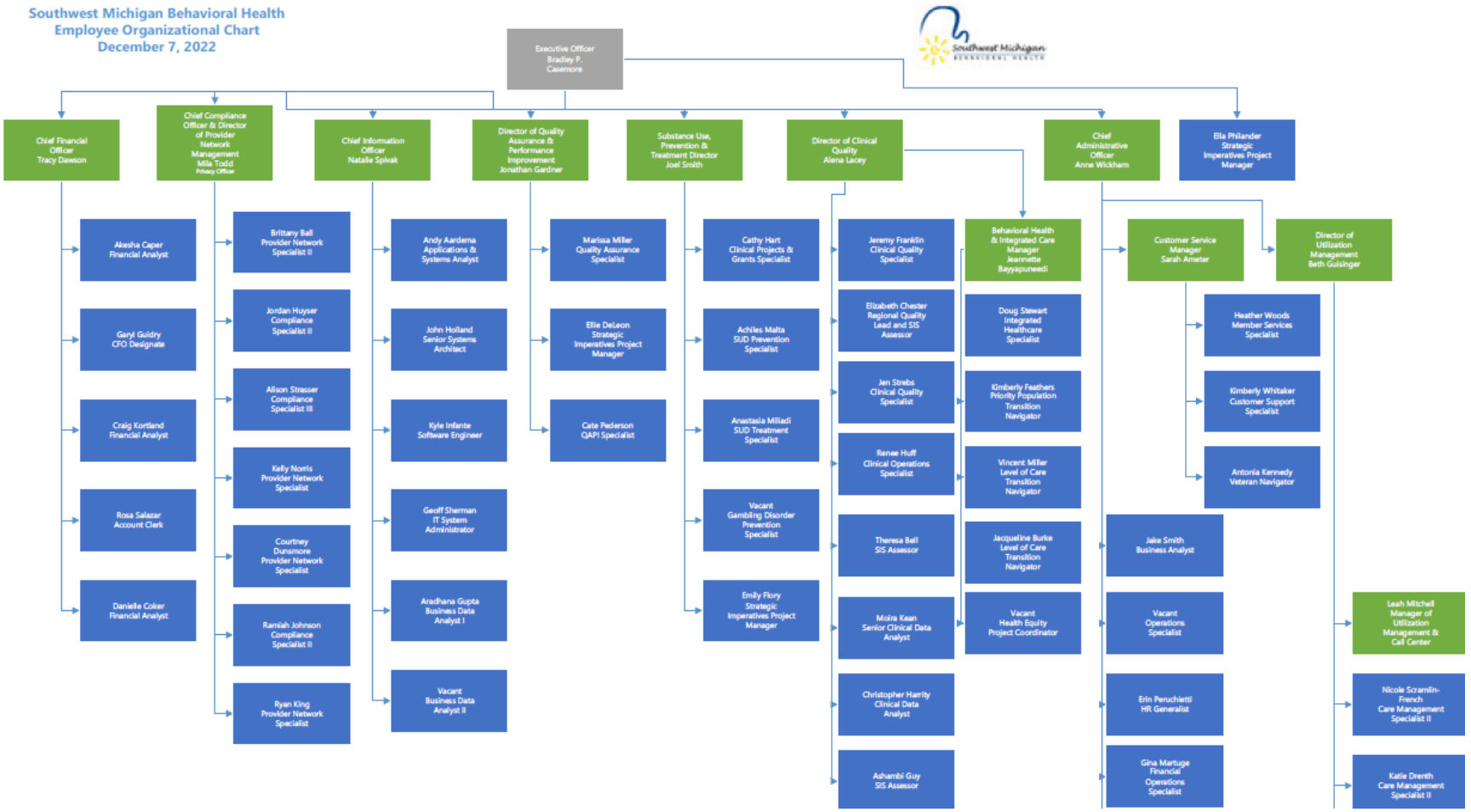
St. Joseph County

- Carole Naccarato
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

ATTACHMENT D – SWMBH ORGANIZATIONAL CHART



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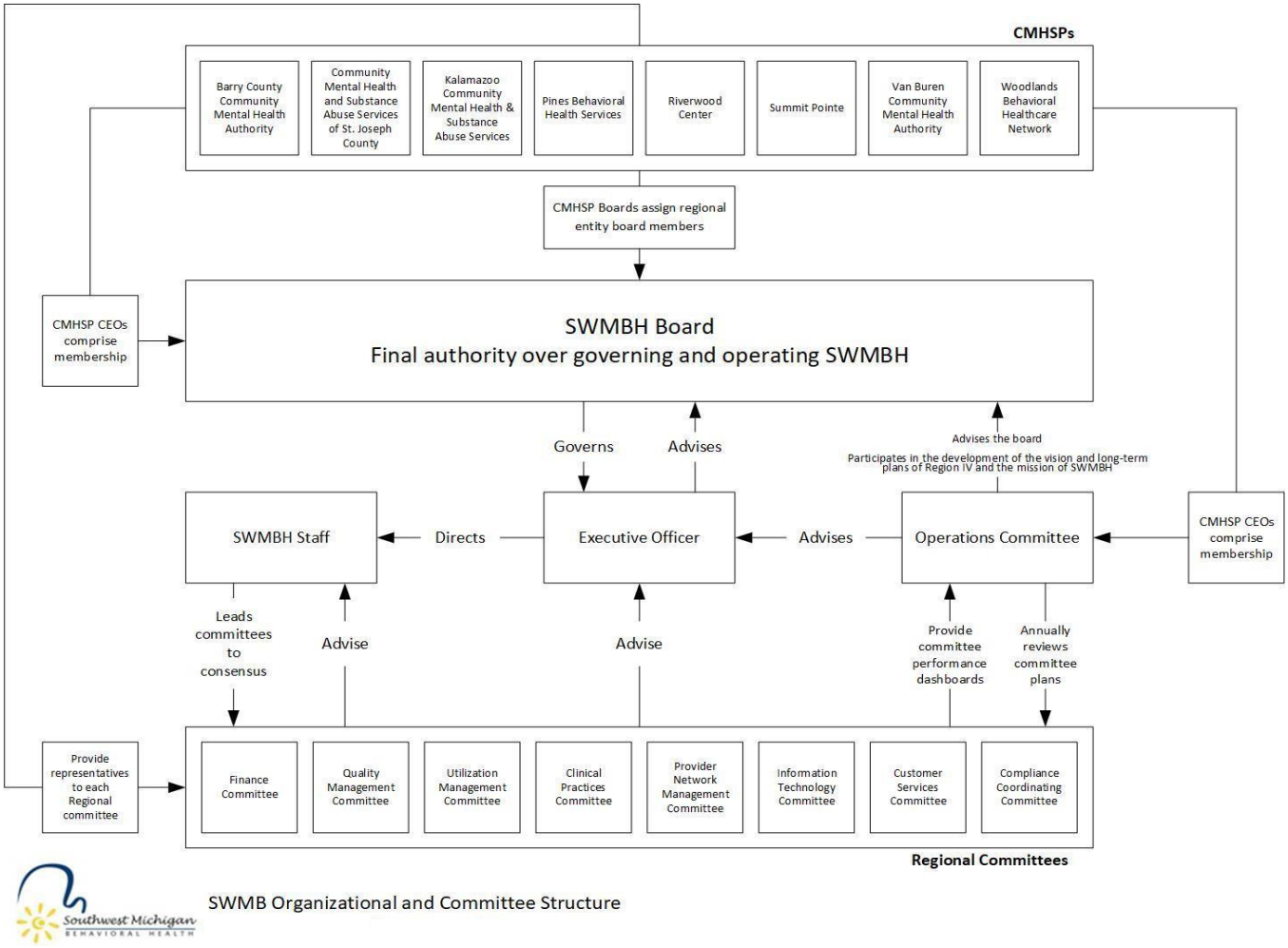
Megan O'Dea
Operations
Specialist
Amy Mrazek
Care Management
Specialist II
Ann Stokes
Care Management
Specialist II
Tracy Quintanilla
Care Management
Specialist III
Lynda Seume
Care Management
Specialist I
Jane Yang
Care Management
Specialist II
Karen Farwell
Care Management
Specialist II
Sara Damon
Triage & Support
Specialist
Samantha
Fulkerson
Care Management
Specialist II
Angela Stapert
Care Management
Specialist II
Carolyn Gabriel
Care Management
Specialist II
Erin Hetrick
Care Management
Specialist II

ATTACHMENT E – SWMBH ORGANIZATIONAL AND COMMITTEE STRUCTURE



SWMB Organizational and Committee Structure

ATTACHMENT F – 2023 Performance Bonus Incentive Program (PBIP) METRICS

(30% of Total Withhold)

Category	Description	Deliverables	Responsibility
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Payor 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.	Payor
J.2. Follow Up after Hospitalization (FUH) for Mental Illness within 30 days using HEDIS descriptions. (40 points)	The percentage of discharges for members 6 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.	Adult (ages 18 and older) minimum standard: 58% Child (ages 6-17) minimum standard: 70% Measurement Period: Calendar Year 2022 **(20 points)** Data will be stratified by race/ethnicity and provided to plans. The Payor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement Period: Comparison of Calendar Year 2021 with Calendar Year 2022 **(20 points)**	Provider and Payor
J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence using HEDIS descriptions. (25 points)	Beneficiaries 13 years of age and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to plans. The Payor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement Period: Comparison of Calendar Year 2021 with Calendar Year 2022	Payor

(45% of total Withhold)

Measure	Description	Deliverables	Responsibility
P.1. PA 107 of 2013 Sec. 105d(18): Identification of enrollees who may be eligible for services through the Veteran's Administration (25 points)	1) Improve and maintain data quality on BH-TEDS military and veteran fields. 2) Monitor and analyze data discrepancies between VSN and BH-TEDS data.	Due in January 2023: 1) Resubmission of October 1 through March 31 of FY2022 comparison of the total number of individual veterans reported on BH-TEDS and the VSN form. 2) Submission of April 1 through September 30 of FY2022 comparison of the total number of individual veterans reported on BH-TEDS and the VSN form. The Payor must compare the total number of individual veterans reported on BH-TEDS and the VSN between October 1 through March 31 of FY2023 and conduct a comparison. By July 1, the Payor must submit a 1-2 page narrative report on findings and	Payor

		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.	Two or more CMHSPs within Payor's service area, or the Payor and one CMHSP, 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, 2023, Payor must submit to the State, a report no longer than 2 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 Payor's ADT submissions this will not constitute a failure on Payor's part.	Payor
P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence using HEDIS descriptions. (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 enrollees who initiate treatment within 14 calendar days of the diagnosis. - Engagement of AOD Treatment: The percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit. Points awarded based on PIHP participation in data validation activities and meetings.	Payor must participate in MDHHS-planned and MDHHS-approved data validation activities and meetings. PIHPs will be provide IET data files by January 31 each year, and within 120 calendar days, return their data validation template, completed, to MDHHS. Points are awarded based on Payor participation.	Payor

(25% of Total Withhold)

Measure	Description	Deliverables	Responsibility
P.4. PA 107 of 2013 Sec 105d (18): Increased participation in patient-centered medical homes	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). The State will provide consultation draft review response to the Payor by January 15th. The Payor will have until January 31st to reply to the State with information.	Submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements to increase participation in patient-centered medical homes. The specific information to be addressed int eh narrative is as follows: 1. Comprehensive Care 2. Patient-centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety	Payor and Provider

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: 1/28/22

Next Scheduled Review Date: 1/26/23

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 annual survey processes, results and make recommendations for Regional Performance Improvement efforts. ▪ 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. ▪ Work with the other Regional Committee's to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.
Relationship to Other Committees	As needed, 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 Advisory 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 QMC Chairperson by the SWMBH Executive Officer 2. Appointed participant CMH representation 3. Member of the SWMBH Customer Advisory Committee with lived experience 4. SWMBH staff representation as appropriate 5. 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 making a determination 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/ Goals:	The Committee will support SWMBH Staff in the following Regional Objectives: ▪ Annual Quality Work Plan development and review ▪ Annual QAPI Evaluation Report development and review ▪ Michigan Mission-Based Performance Indicator System (MMBPIS) regional report ▪ Event Reporting Dashboard Review and action related to identified trends ▪ Regional Survey Development, Analysis and improvement strategies (*including: The annual consumer satisfaction survey, RSA-r survey, Provider Communications survey and the Provider UM Access survey*) ▪ Completion of Regional Strategic Imperatives or goals, assigned to the committee ▪ Completion, feedback and analysis on any Performance Improvement o Projects assigned to, or relevant to the committee ▪ Assist in the review and formulation of the Annual Board Ends Metrics ▪ Assist in the review of annual Regional Audit/Review results and make recommendations for corrective action plans as needed ▪ Assist in the review and completion of the annual Performance Bonus Incentive Program (PBIP) Narrative Report

	FY 2023 Quality Management Committee Goals (Measurement Period: Oct 1, 2022 – Sept 30, 2023) 1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By 6/30/23) ▪ Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project. ▪ Identify common denominators and classify into strategic categories. ▪ Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category). ▪ Develop and target interventions to improve identify problem areas. ▪ Determine tracking mechanisms and targets goals for each identified area. ▪ Share results with Operations Committee and other relevant committees. ▪ Identify alternative electronic methods of gathering consumer responses, other than telephonic. ▪ Establish and maintain 'new' process to keep the survey open for consumer participation all year, opposed to isolated dates. ▪ Identify tools/resources, which determine how many surveys have been completed and current scores (real time). ▪ Each CMHSP should review their individual survey results and submit to the PIHP, a plan of action for improving identified areas of improvement. This should be well documented within CMHSP internal quality review, or other CMHSP workgroup meeting minutes/notes. ▪ Review individual Performance improvement projects for each CMHSP, during the Regional Quality Management Committee meetings. 2. Review current survey tool for the 2023 Consumer Satisfaction Survey Project, to ensure that it meets CCBHC and Best Practice Methodology for Measurement and Analysis (By 3/30/23) ▪ Identify NCQA approved consumer satisfaction survey tools, to ensure we are using the best option. ▪ Review tools, questions and scoring methodology with relevant regional committees for feedback. ▪ Identify survey distribution methods and possible process changes. ▪ Communicate project logistics to CMHSP survey point persons and regional committees. ▪ Complete analysis of results and distribute to internal and external stakeholders. ▪ Evaluate selected tools effectiveness and make modifications, as necessary. 3. Redesign structure/format of the annual QAPI-UM Plan and Evaluation report. (By 6/30/2023) ▪ Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.

	▪ Utilize the MDHHS suggested template. ▪ Identify program weaknesses and strengths for each category evaluated. ▪ Identify detailed plans/timeline to remediate identified weaknesses. ▪ Ensure all elements/standards/MDHHS recommendations are included in the redesigned report. 4. Create a flow chart for each quality related MDHHS contractually obligated reporting requirement. (By 12/30/2023) ▪ Each chart should provide processes and steps for collecting data, reporting data, timelines, project point persons and additional resources available. ▪ Identified areas to include such as MMBPIS, Grievance and Appeals, etc. 5. Work with the Quality Management Committee and other Regional Committees to improve Health Service Advisory Group (HSAG) External Quality Review (EQR) results and corrective action plans. (By 10/30/2023) ▪ Establish a schedule of review for each section not receiving a score of "Met" within the relevant Regional Committees. ▪ Identify action plans for improvement and assign functional area leaders. ▪ Ensure CMHSP's and SWMBH are compliant with any standards/elements indicated as '*Not Met*' within the 3-year audit cycle. ▪ Ensure that all sections identified during each of the 3 year audit cycle meet compliance at a minimum of 90% or SWMBH is one of the top 2 performing PIHPs in Michigan.

Current Committee Roster

Member Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Jonathan Gardner *Director of QAPI*	*SWMBH*	*Voting - Committee Chair*
Ellie DeLeon *Strategic Initiatives Project Manager*	*SWMBH*	*Voting*
Cate Pederson *Quality Assurance Specialist*	*SWMBH*	*Voting*
Marissa Miller *Quality Assurance Specialist*	*SWMBH*	*Voting*
Chris Harrity *Clinical Data Analyst*	*SWMBH*	*Voting*
Alena Lacey *Clinical Director*	*SWMBH*	*Voting*
Jannette Bayyapuneedi *Behavioral Health & Integrated Care Manager*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Ad Hoc*

Dr. Ramesh *Psychiatrist*	*SWMBH – Contract – As needed*	*Ad Hoc*
Natalie Spivak *CIO*	*SWMBH*	*Ad Hoc*
Sandra Bell *Consumer Representative*	*Member*	*Voting*
Amy Gallick *Analytics Manager*	*ISK*	*Voting*
Sheila Hibbs *Quality Director*	*ISK*	*Voting*
Teresa Lewis *Customer Services Manager*	*ISK*	*Voting*
Emily Whisner *Chief Clinical Officer/CIO*	*Barry*	*Voting*
Brenna Ellison *Compliance Officer/QI Manager*	*Barry*	*Voting*
Pete Murphy *CIO*	*Cass*	*Voting*
Beth Miller *Corporate Compliance Officer*	*Cass*	*Voting*
Kyle Kenny *Quality Improvement Specialist*	*Branch*	*Voting*
Grae Miller *Director of UM and Access*	*St. Joe*	*Voting*
Joe Reed *IT Director*	*St. Joe*	*Voting*
Jarrett Cupp *Compliance/Quality Director*	*St. Joe*	*Ad Hoc*
Mandi Quigley *Corporate Compliance Director*	*Calhoun*	*Voting*
Bridget Avery *Director of Revenue Cycle*	*Calhoun*	*Ad Hoc*
Kyleen Gray *Quality Director*	*Van Buren*	*Voting*
Caleb Richardson *Business Intelligence Manager*	*Berrien*	*Voting*
Doris Glowacki *Continuous QI Coordinator*	*Berrien*	*Voting*

ATTACHMENT H – 2023-2024 STRATEGIC IMPERATIVES

ATTACHMENT I – 2023 REGIONAL STRATEGIC IMPERATIVE DECISION/PRIORITY MAP