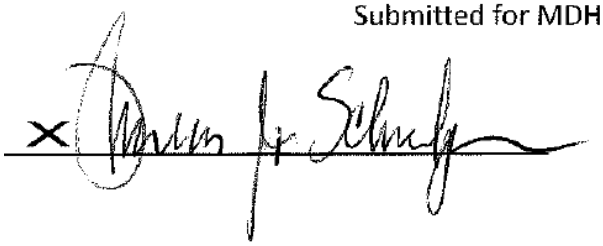
Quality Assurance and Performance Improvement Program (QAPIP) FY 2024 Plan

All SWMBH Medicaid Business Lines

October 1, 2023 - September 30, 2024

Reviewed and Approved by:
SWMBH Operations Committee on 11/29/2023
SWMBH Board of Directors on 02/09/2024
SWMBH Quality Management Committee on 02/08/2024

Submitted for MDHHS for Review by 02/28/2024



Signed by Board Chairman

Table of Contents

Descriptions and Work Plan

Attachments

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 Medicaid Managed Care rules, 42 CFR § 438, and requirements outlined in the PIHP contract.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP Plan to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the eight 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. The Board shall act as the designated authority for governance oversight of the QAPIP. More information related to the QAPIP standards can be found in SWMBH policies and procedures, the Quality Management Committee (QMC) Charter, and other departmental plans.

II. Purpose

The QAPIP Plan delineates the features of the SWMBH Quality Management program. The QAPIP serves to promote quality health care services and outcomes for members through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical and non-clinical service delivery within the network as well as the 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 SWMBH and the CMHSPs within the region include individuals and their families who experience mental illnesses, 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 the region.
- 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 provided to members.
- Promote and support best practice operations and systems that promote optimal benefits in service areas of 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 drive process improvement throughout the system.
- Promote timely identification and resolution of quality-of-care issues.
- Conduct performance monitoring and improvement activities that 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 and throughout the region.

III. Guiding Principles

The Mega Ends serve as the guiding principles for the development of annual Board Ends, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. (*See Attachment A – Value Framework, and Attachment B – SWMBH Board Roster.*)

Board 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

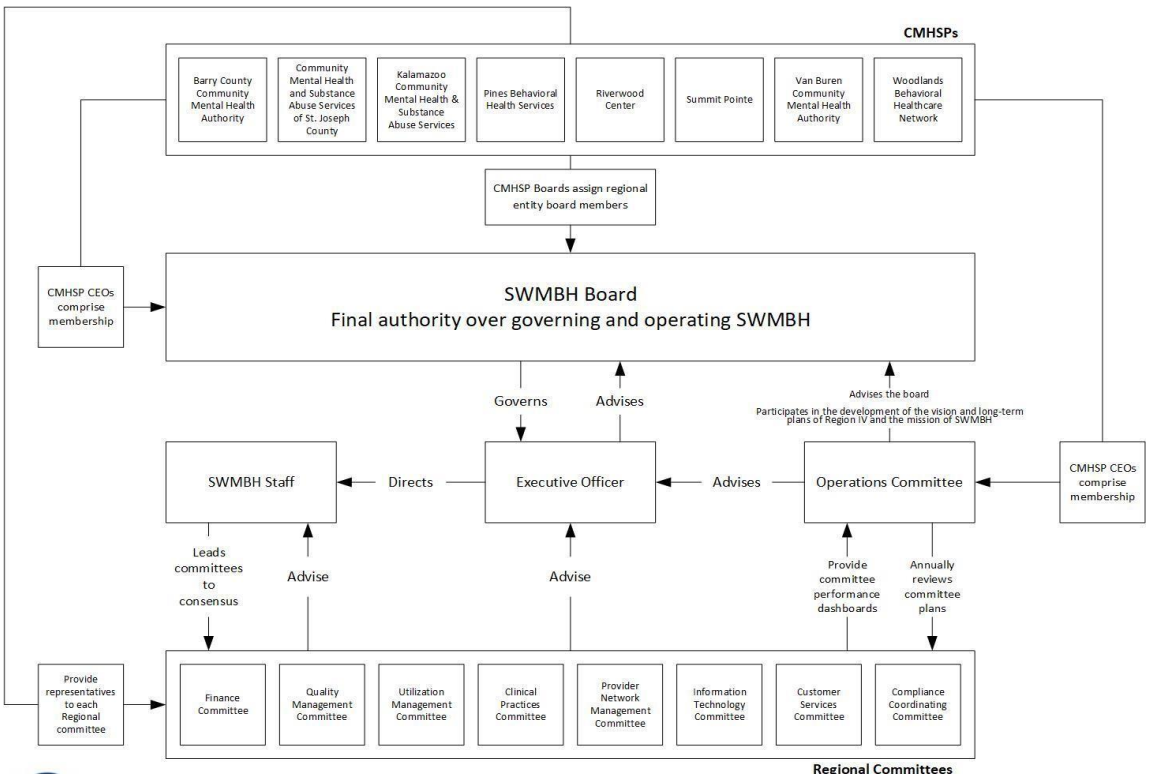
1. Quality healthcare results from a benefit management system embracing input from all stakeholders.
    - Education of all SWMBH stakeholders on continuous improvement methodologies, including providing guidance and support to other SWMBH departments, CMHSPs, and other providers as needed or requested. The involvement and inclusion of members, families, providers, and other internal and external stakeholders in the performance improvement design promotes optimal results.
    - Promoting a person-centered philosophy promotes member satisfaction with services 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 risks and benefits.
    - 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, analysis, and presentation are done with integrity.
    - Data that is consistently complete, accurate, and timely leads to consistent measurement and over time ensures data integrity.
    - Valid, accurate, complete, and timely data is vital to organizational decision-making. Making data accessible impacts value and reduces risk to SWMBH and the region.
    - Providers submitting data to SWMBH shall certify data integrity and have, available for

review, the process used to collect the data for verification purposes.

V. *Authority and Structure*

The SWMBH Board of Directors 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 (including the selection of performance improvement projects and updates/results from the implementation of those), and reviews the annual evaluation of the QAPIP. The SWMBH Board ensures the annual QAPIP plan is submitted to MDHHS by the required deadline and that the plan includes a list of current Board members. 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 initiatives throughout the Region. The SWMBH Operations Committee consists of the CEO, or their designee, for each of the eight CMHSPs in the region and advises the SWMBH Board.

Regional 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 relevant information discussed during the meetings (and included in meeting minutes) back to the appropriate individuals and departments within their organization. Committee members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting minutes and other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meetings. SWMBH additionally hosts a Customer Advisory Committee (CAC) where information is shared with customers actively receiving services, with representation from all CMHSPs. CAC members are also members of various regional committees which affords SWMBH the opportunity to involve customers in quality improvement efforts. 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 relevant information discussed during the meetings (and included in meeting minutes) back to the appropriate individuals and departments within their organization. Committee members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting minutes and other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meetings. SWMBH additionally hosts a Customer Advisory Committee (CAC) where information is shared with customers actively receiving services, with representation from all CMHSPs. CAC members are also members of various regional committees which affords SWMBH the opportunity to involve customers in quality improvement efforts.



SWMBH Quality Management and Clinical Outcomes Department

The general oversight of the development and implementation of the QAPIP is given to SWMBH's Quality Management (QM) Department. The Director of Quality Management and Clinical Outcomes is the designated senior official responsible for overseeing the department and QAPIP implementation. The QM Department is staffed two Quality Assurance Specialists, three Clinical Quality Specialists, two Clinical Data Analysts, a Clinical Projects Specialist, and a Strategic Initiatives Project Manager. The QM Department may also utilize an outside contracted consultant for special projects as needed. The Director of Quality Management and Clinical Outcomes collaborates on many of the QAPIP goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the Quality Management Committee (QMC), Regional Clinical Practices (RCP) Committee, Regional Information Technology (RIT) Committee, and Regional Utilization Management (RUM) Committee.

The QM 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 includes a designated behavioral health care practitioner to support and advise the QM

Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner provides 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 also provides clinical expertise and programmatic consultation with Quality Management and Clinical Outcomes Director to ensure complete, accurate, and timely submission of clinical quality program data.

Adequacy of SWMBH Quality Management Resources

The QM Department works collaboratively with many different functional areas. SWMBH will have appropriate staff to complete QAPIP functions as defined in this plan. In addition to having adequate staff, the QM 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 QM 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 the QAPIP is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QM 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), and maintains and manages the Quality Management Committee (QMC).

The QM Department works with other functional areas within the organization and external organizations/vendors such as TBD Solutions and Health Management Associates (HMA) 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 Agency 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 C – PBIP Metrics.)

VI. Regional Quality Management Committee (QMC)

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 gathering participant communication and advice. QMC facilitates regional and

member input regarding the development and management of processes and policies related to quality management and the QAPIP. QMC is responsible for developing committee goals, maintaining contact with other committees to relay relevant information, and identifying people, organizations, or departments that can further the aims of both the QM Department and the QMC.

CMHSPs are responsible for the development and maintenance of a Quality and 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 and communication 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 QM staff. All other ad hoc members shall be identified and attend as needed, which may include provider representatives, IT support staff, Coordinating Agency staff, the SWMBH designated behavioral health care practitioner, SWMBH clinical representation, etc. Additional individuals may attend QMC meetings throughout the year to present information and/or provide insight on relevant discussions. The QMC will make efforts to maintain member representation, assist with review of reports/data, and provide suggestions for regional process improvement opportunities. Alternates are named in the charter and will have all the same responsibilities of members when participating in committee work.

QMC Roles and Responsibilities

The QMC will meet regularly (at a minimum quarterly) to inform regional quality activities, to demonstrate follow-up on all findings, and to approve required actions. Committee oversight is defined as reviewing data and identifying performance improvement 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.

VII. 2024 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 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 D 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 2024, its eleventh 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. SWMBH measures performance using standardized indicators (where applicable) based on the systematic, ongoing collection, and analysis of valid and reliable data. 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 QM 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 QM 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.
- Validation checks are applied to incoming data from our participant CMHs and the SWMBH SmartCare system. Files that do not pass certain checks will not be put into SWMBH reporting databases or sent to the State until errors are corrected. Tableau reports are used to monitor data completeness and integrity (examples include LOCUS inter-rater reliability (IRR) reports, BH TEDS and assessment tool completeness reports, and encounter volume monitoring reports). There is a monthly data exchange workgroup with the CMHs where validation errors are reviewed, and reports are monitored to ensure data integrity. Assessment completeness and IRR reports are monitored in our regional clinical practices committee.

IX. Communication

The QM 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 QM Department works to provide guidance on project management, technical assistance, and supports data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through our Regional Committees is key. At least annually, the QM 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

X. 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 2024 Quality Assurance and Performance Improvement Program Descriptions & Work Plan

A. Michigan Mission Based Performance Indicator System (MMBPIS)

Description

SWMBH utilizes performance measures established by MDHHS in the areas of access, efficiency, and outcome measures. 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 SWMBH Commons 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 as established in the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH requests the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). SWMBH SMEs also review indicators compliance and are incorporated in approval of MMBPIS-related CAPs. 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 communicates any changes with indicator measurement or reporting to internal and external stakeholders.

SWMBH utilizes the QAPIP to assure it achieves minimum performance levels on performance indicators as established by MDHHS as defined in the contract and analyzes the causes of statistical outliers when they occur. Oversight and monitoring are conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. The 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 a site review score less than two for each indicator item.

FY24 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). Additionally, SWMBH will meet or exceed newly established State benchmarks for Indicators 2a, 2e and 3 as indicated in the current MDHHS MMBPIS Codebook version October 2023. New benchmarks for Indicators 2 and 3 are calculated by taking the total cumulative percentage (total numerator/total denominator) for each indicator for each region and are based entirely on FY22 data. Each region falls under one of the percentile columns (Below 50th percentile, 50th-75th percentile and above 75th percentile). Based on final FY22 outcomes, PIHPs are required to increase to the next column or maintain above the 75th percentile.

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. (>=62%)	Quality	QMC	Monthly
Indicator 2e - Percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorders (>=68.2%).	Quality/SUD	QMC, SUD Directors Workgroup	Monthly
Indicator 3 - Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-	Quality	QMC	Monthly

emergent biopsychosocial assessment by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (>=72.9%)			
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, SUD Directors Workgroup	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 Medicaid Managed Care rules, 42 CFR Part 438.According to the managed care rules, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. SWMBH's QAPIP includes affiliation-wide performance improvement projects that achieve thorough ongoing measurement and intervention, and demonstratable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that SWMBH serves.

Each year, one PIP is reviewed by HSAG. 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

There are currently two primary Performance Improvement Projects that SWMBH has targeted for FY2024.

1. Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). This is a high-risk service area, where improved continuity and coordination of care is needed; this project serves as our clinical PIP.
2. Increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment.

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

FY24 PIPs

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Performance Improvement Project #1 (clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Goal: "To eliminate the statistically significant disparity between African American/Black and White rates of follow up after Emergency Department (ED) visits for alcohol and other drug use, from baseline (2021) to remeasurement 1 (2023) and 2 (2024), without a corresponding decrease in White follow up rates." Monitoring: Remeasurement 1 (2023) results will be available in June 2024. We will assess our performance on the following measures to determine whether we have met the PIP goal for 2023. 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.	Quality	Regional Clinical Practices Committee and Regional Quality Management Committee	Bi-Annual

Performance Improvement Project #2 (non-clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children. Goal: In FY24, SWMBH and its provider network will increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. Monitoring: By the end of FY24 Q1, we will complete a causal barrier analysis to evaluate factors contributing to the 2023 baseline of 56.78%. By FY24 Q2, we will develop and implement interventions to address the barriers in access and timeliness of services. The interventions will be utilized to increase the 2024 percentage to 73%. Remeasurement will occur in 2025.	Quality	Regional Clinical Practices Committee and Regional Quality Management Committee	Annually and Quarterly

C. Critical Incidents – Event Reporting

Description

SWMBH's process for identifying, reporting, and following up on incidents and events that put individuals at risk of harm is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents for members are defined by MDHHS as suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrest. Hospitalization or EMT due to an injury is further classified to include whether the injury resulted from physical management. Residential treatment providers prepare and file incident reports to the contracted CMHSP when incidents occur. The CMHSPs are responsible for reviewing and classifying the incident reports and submitting the reportable incidents to SWMBH as outlined in policy. SWMBH is then 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 is also responsible for ensuring that MDHHS requests for further information, details related to the remediation of an incident, or any other requests are responded to timely.

SWMBH delegates the responsibility of the process for the identification, review, and follow-up of immediate events, sentinel events, critical incidents, and risk events to its eight contracted CMHSPs and SUD Providers (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 CMHSPs and SUD providers have 3 business days after an incident occurs to determine if it is a sentinel event, and two subsequent business days to commence a root cause analysis of the event if it determined to be

a sentinel event. The CMHSPs work with the residential treatment provider, when applicable, to complete a root cause analysis. All unexpected deaths 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 CMHSPs and SUD Providers review all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, are reviewed and the review includes:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews. SWMBH ensures that individuals involved in the review of sentinel events have the appropriate credentials to review the scope of care (e.g. deaths or serious medical conditions involve a review by a physician or nurse).
- Documentation of the mortality review process, findings, and recommendations.
- 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.
- Use of mortality information to address quality of care.

A random sample is reviewed annually during each CMHSP Delegated Function Site Review to ensure the CMHSP is following the process as intended and is meeting all the requirements related to the review.

SWMBH requires that all CMHSPs and SUD Providers notify SWMBH within 36 hours of an immediate event that is subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). Following an immediate event notification, SWMBH will additionally submit to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within 1 year of the individual's discharge from a State-operated service.

SWMBH analyzes critical incidents, sentinel events, and risk events at least quarterly during the regional QMC meetings. The risk events reviewed minimally include those that put individuals at risk of harm including 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 (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or patterns of events are reviewed and discussed to remediate the problem or situation and prevent the occurrence of similar additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes which are saved on the SWMBH Commons and available to all QMC members. It is the expectation that members that cannot attend the meetings will review the PowerPoint presentation and the minutes, and that all members communicate information from the meetings to the appropriate people within their organizations.

SWMBH Incident and Event Flowchart

FY24 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	Quarterly

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	Quarterly
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	Quarterly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who caused harm to themselves (risk event codes B9, B10, and B11) will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who caused harm to others (risk event codes B3, B4, B5, and B6) will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly

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 (QAPI) Program Technical Requirement, attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Each CMHSP is responsible for having a Behavior Treatment Review Committee (BTRC) for the collection and evaluation of data. The purpose of the BTRC is to review, approve, or disapprove any plans that propose to use restrictive or intrusive interventions. Only the techniques that have been approved during person-centered planning by the member or his/her guardian and have been approved by the BTRC may be used with members. The CMHSP BTRCs are required to submit their BTRC data to SWMBH on a quarterly basis where intrusive and restrictive techniques have been approved for use with individuals. Data being reviewed for analysis is where physical management, 911 calls to law enforcement have been used in an emergency behavioral situation, and any intrusive/restrictive interventions are used. The analysis includes the numbers of interventions and length of time the interventions were used per person. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. 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. 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. A review and recommendation of the modification or development, if needed, of the individual's behavior treatment plan is included. 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.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete a quality review of at least 6 behavior treatment plans per CMH for FY24.	Quality	RCP and QMC	Quarterly
The region will achieve 90% or higher on the *Behavior Treatment Plan* section of the annual CMHSP audit.	Quality	RCP and QMC	Annually
SWMBH will implement a regional strategy to evaluate the BTRC's effectiveness by Q4 of FY24.	Quality	RCP and QMC	Annually

E. Member Experience - Customer Satisfaction Surveys

Description

The QM 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 (LTSS), case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY24, 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 as best practice survey tools to gauge member experience of care. The survey tools will be evaluated to ensure required data is collected from consumers and During FY24, the SWMBH Quality Department plans to collect consumer survey responses throughout the year with the goal of achieving 2100 completed surveys. Surveys can be accessed electronically 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.

SWMBH will also conduct focus groups with individuals who completed the survey and identified that they would be willing to participate. The focus groups will be aimed at gathering further information related to sources of dissatisfaction as well as strengths. The information gathered will be used to create more specific corrective actions to address areas of concern. The Consumer Advisory Committee and Quality Management Committees serve in an advisory capacity to ensure the accuracy and validity of the focus group questions, process and format. The two Committees also closely review the results/analysis of the focus groups to promote improved outcomes through enhancing programs and services.

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. This includes the SWMBH Consumer Advisory Committee, Clinical Practices Committee, Utilization Management Committee, the Regional Operations Committee, Quality Workgroups, and 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 the SWMBH website and newsletters, Annual QAPI Evaluation and other SWMBH annual publications. The results will also 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 steps will be outlined to follow up on the findings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1500 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 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Quarterly
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QAPI	QMC, RCP, and CAC Committees	Annually
Ensure CMHSPs develop improvement plans specific to their survey findings/results/analysis.	QAPI	QMC and CAC Committees	Annually
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 QM 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 year's 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 steps will be outlined to follow up on the findings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase survey participation compared to the previous year as evidenced by more participating providers and/or more completed surveys.	QAPI	QMC, SUD Directors Subgroup	Annually
Achieve 90% consumer satisfaction with SUD services as indicated by survey results.	QAPI	QMC, SUD Directors Subgroup	Annually
Ensure participating CMHSPs and SUD Providers develop improvement plans specific to their survey findings/results/analysis.	QAPI	QMC, SUD Directors Subgroup	Annually

G. 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)?

FY24 Goals

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

H. Provider Network Adequacy

Description

SWMBH completes an evaluation of the adequacy of its current fiscal year's provider network 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 throughout the fiscal year. The report is submitted to MDHHS for review and feedback.

FY24 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 most current 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

I. Administrative and Delegated Function Site Reviews

Description

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 (performed quarterly)
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review (performed quarterly)
- Appeals File Review (performed quarterly)
- 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 Quality Management

and Clinical Outcomes 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 network 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 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.

Network 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).

FY24 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete or ensure completion of site reviews for the region (for Participant CMHSPs, SUD Providers, and Network 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, among other things, 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:

- Compliance with SWMBH or CMH organizational re-credentialing activities, including provider timely submission of credentialing applications and proofs; and
- Provider completion of 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.

Through the annual site review process SWMBH ensures, regardless of funding mechanism:

- Staff (licensed or non-licensed) possess the appropriate qualification as outlined in their job descriptions, including the qualifications for all of the following:
  - Education background
  - Relevant work experience
  - Cultural competence
  - Certification, registration, and licensure as required by law (where applicable)

FY24 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
SWMBH will develop and implement a quality performance improvement project designed to improve adherence to SWMBH and MDHHS credentialing requirements.	Provider Network & QAPI	Site Review Tools, RPNMC	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 have adopted these guidelines. SWMBH assures that information related to the guidelines is made available to members and providers.

It is policy that the employees of SWMBH, the CMHSPs, and the provider network must assure that decisions with respect to utilization management, member education, coverage of services, and other areas 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 of Quality Management and Clinical Outcomes.
- 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.
- 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.

All practice guidelines adopted for use are available on the SWMBH website. SWMBH's adopted practice guidelines include:

- Inclusion Practice Guideline
- Person-Centered planning 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 (RCP), 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 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.

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.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline and develop improvement strategies to address any deficiencies in FY24.	Quality	QMC, RCP, Site Review Tools	Quarterly

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). SWMBH 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:

- Children's Waiver Program
- Waiver for Children with Serious Emotional Disturbances (SED)
- Habilitative Supports Waiver
- 1915(i)SPA
    - 1115 Behavioral Health Demonstration

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 LTSS sections annual Member Experience Satisfaction Survey. SWMBH has incorporated survey questions 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.

The annual CMHSP site review tool that is utilized in Region 4 includes items to monitor the quality and appropriateness of care for members receiving LTSS. For reference, some of the items from the SWMBH annual CMHSP site review tool are:

- 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.
- Needs, priorities, and a professional analysis of service needs and recommendations are documented.
    - All identified needs are included and addressed in the IPOS.
- Level of Care (LOC) is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment is completed annually and when there is significant change in individual's status.
- The IPOS 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.
    - health/safety risks are identified.
    - member choice is documented.
    - natural supports that will be used to assist the customer in being able to accomplish goals and objectives are identified.
    - the 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 interventions identified in the IPOS are provided as specified –
    - goals/objectives are measurable.
    - the plan specifies the type, amount, scope, duration, frequency, and timeframe for implementing services.
    - 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 the Quality Management and Clinical Outcomes Department at both the CMHSP and PIHP levels. Results are used to inform annual provider training that is offered to the LTSS provider network. Additional quality improvement training is provided at the CMHSP-level as needed or required. Future training topics will include developing a regional approach to assess care between settings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will use the Member Experience Satisfaction Survey results and the information from the Waiver Audit Interviews to assess the quality, availability, and accessibility of care of members receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q3 of FY24.	Quality	QMC, RCP	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 (DHHS) 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 PIHP must ensure services identified in 42 CFR §438.210(a)(1) must be furnished in an amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441.

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 board-certified in addiction medicine, meet 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:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer;
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided);
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience;
5. Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential; and
6. 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

1. 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.
2. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, and/or long-term services and supports needs.
3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate.
4. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
5. 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.
6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

7. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
8. 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 percentage of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (MMBPIS #1) (Standard = 95%)
- The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (MMBPIS #2) (*Standard = >62%)
- The percentage of new persons receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD). (MMBPIS #2e) (*Standard = 68.2%)
- The percentage of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MMBPIS #3) (*Standard = 72.9%)
- The percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (MMBPIS #4a) (Standard = 95%)
- The percentage of discharges from a substance abuse withdrawal management (detox) unit who are seen for follow-up care within seven days. (MMBPIS #4b) (Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less.

  * Effective FY24, Standards are based on the FY22 final percentages. PIHPs that fell below the 50th percentile will be expected to reach or exceed the FY22 50th percentile. PIHPs that fell in the 50th -75th percentile the benchmark will be expected to reach or exceed the FY22 75th Percentile. The PIHPs that are above the FY22 75th percentile would be expected to maintain their level of performance.

Level of Intensity of Service Determination

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; 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 request; prior authorization required; if services are denied/ appealed and deemed urgent, Expedited Appeal 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; Prior authorization required
Retrospective	Accessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided	Within 30 calendar days of 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 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, and the ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the SIS (Supports Intensity Scale) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. 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.

1. 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.
2. 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).
3. 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.
4. 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. Management of identified high cost, high risk service outliers or those with under- utilized 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 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, EQRO, 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 focus 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).

1) 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.

2) Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3) Outlier Management Procedures

1. 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.

2. 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 ensure understanding of the utilization trends or patterns.
3. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion.

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 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.

FY24 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
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques.	UM, Clinical Quality, SUD	RUM, RCP	Monthly
SWMBH will identify the levels of care and subsequent reports to manage utilization and uniform benefit.	UM, Clinical Quality	RCP	Quarterly

SWMBH will ensure regional inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	UM	RUM	Annually
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 Customer Services	RUM, Regional Customer Service Committee	Quarterly, Annually
Emergent and non-emergent access to treatment will be periodically monitored to ensure compliance with timeliness standards.	UM, Customer Service	RUM, Regional Customer Service Committee	Quarterly
SWMBH will achieve a call abandonment rate of 5% or less.	UM	Data submission to MDHHS	Quarterly
SWMBH will achieve an average call answer time 30 seconds or less	UM	Data submission to MDHHS	Quarterly
SWMBH will ensure a call center monitoring plan is in place and provide routine quality assurance audits.	UM	QMC	Monthly
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	UM	Site Review Tools	Annually

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.

SWMBH delegates some Customer Service functions, Due Processes, and Grievances and Appeals to the CMHSPs. As such, a Memorandum of Understanding (MOU) between SMWBH and each CMHSP is implemented to specify the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all members have access to customer services that meet federal and state requirements, and to ensure the services are provided in a uniform manner throughout the SWMBH Region to ensure continuity of care for members.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Committee will review current Memorandum of Understanding (MOU) between SWMBH and CMHSPs and the application of the MOU delegated functions to the areas listed below by the end of FY24. (CCBHC, iSPA, CFAP, Managed Care Regulations/Contract, New MOU).	Customer Services	Regional Customer Service Committee	Annually
SWMBH will provide quarterly monitoring and feedback regarding Grievance and Appeal files to ensure contractual and delegated functions are met at each CMHSP at least 3 quarters by the end of FY24.	Customer Services	Regional Customer Service Committee	Quarterly
Committee will review Grievance and Appeal data for trends, ongoing.	Customer Services	Regional Customer Service Committee	Quarterly

O. Certified Community Behavioral Health Clinics (CCBHC)

Description

CCBHC Demonstration was created under Section 223 of the federal Protecting Access to Medicare Act. On June 25, 2022, the Bipartisan Safer Communities Act approved expansion of the CCBHC Demonstration extending the duration of the demonstration to six years. The act also allowed current Demonstration agencies to expand with new locations, and additional agencies to be brought into the demonstration. October 2023 Michigan expanded the demonstration agencies bringing on additional CMHSPs.

In October 2020, SWMBH had two participating CCBHCs (Pivotal, previously knowns as Community Mental Health and Substance Abuse Services of St. Joseph County, and Integrated Services of Kalamazoo). In October 2023 four additional CMHSPs joined from SWMBH's region: Barry County Community Mental Health Authority; Berrien County Mental Health Authority, DBA Riverwood Center; Branch County Mental Health Authority, DBA Pines Behavioral Health; and Calhoun County Mental Health Authority, DBA Summit Pointe. While Van Buren County Mental Health has a CCBHC Expansion Grants, SWMBH is not responsible for monitoring these requirements.

The CMS CCBHC Demonstration requires certified sites to provide nine core services and Michigan CCBHCs have twelve required and seven recommended evidence-based practices they must use.

Core Services: Screening, assessment, and diagnosis, including risk assessment; Patient-centered treatment planning or similar processes, including risk assessment and crisis planning; Outpatient mental health and substance use services; Outpatient clinic primary care screening and monitoring of key health indicators and health risk; Targeted case management; Psychiatric rehabilitation services; Peer support and counselor services and family supports; and Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

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. Below is a sampling of the specific requirements:

PIHPs must have the capacity to evaluate, select, and support providers who meet the certification standards for CCBHC, including:

Identifying providers and DCOs who meet the CCBHC standards,

Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services,

Collecting and sharing member-level information regarding health care utilization and medications with CCBHCs,

Providing implementation and outcome protocols to assess CCBHC effectiveness,

Developing training and technical assistance activities that will support CCBHCs in effective delivery of CCBHC services.

PIHPs must use CareConnect360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.

PIHPs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC.

SWMBH has a regional implementation governance structure for CCBHC with a steering committee of senior executives from SWMBH and CMHSPs. SWMBH restructured the sub-committees in 2023 from three (clinical/client flow, data/reporting, and finance) to two, finance/ IT and clinical/data quality. Each is led by a SWMBH director and CCBHC/CMHA representative, populated by current Medicaid CCBHC Demonstration CMHSPs with an open door to SAMSHA CCBHC CMHSPs.

CCBHC Monitoring & Evaluation Requirements

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

The specific Core Measures and other federal requirements are laid out below:

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- n/a**	**State**

**DY3 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. If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s). CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the reported Medicaid daily visits x demonstration year PPS rate). If a CCBHC does not meet all benchmarks for QBP measures, the potential

distribution amount will be added to a QBP Redistribution pool for CCBHCs who either hit or exceeded benchmarks.

Reporting Requirements

During the DY, CCBHCs should complete their SAMHSA 2016 Data 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 the DY for purposes of monitoring and evaluation planning.

FY24 Goals

Goal	Responsible Department/Person	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will track QBP measures and CCBHC-Reported Measures monthly and report to Clinical/Data Quality subgroup and Steering Committee each time they meet.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Bi-monthly, at minimum
Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBP measures.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
PIHPS will collect, validate clinic-reported data and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly Annually by 3/31/2024 (DY2) 3/31/2025 (DY3)
Develop written guidelines and process maps to support new regional CCBHC sites.	CCBHC Coordinator	All CCBHC Subgroup Meetings	Annually

P. External Monitoring and Audits

Description

The SWMBH Quality Management (QM) Department is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from Michigan Department of Health and Human Services (MDHHS), Health Service Advisory Group (HSAG), Centers for Medicaid Services (CMS), and other organizations as identified by the SWMBH Board. Audit results are reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board. Regional and internal corrective action plans are established for reviews/audits that do not achieve specified benchmarks or established targets. The QM Department is responsible for working with all SWMBH functional areas to ensure corrective action plans are developed, reviewed, submitted and followed up on in a complete and timely manner.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH achieve an overall compliance score of >90% or top 2 scoring PIHPs during the 2024 HSAG External Quality Review (EQR).	Quality	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >95% on the annual HSAG Performance Measure Validation Review (PMV).	Quality	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
During FY24, SWMBH will follow up on all recommendations from the FY23 Waiver Audit in preparation for improved scores in FY25. Systemic issues from the FY23 MDHHS Waiver Audit will be addressed during regional committees for systemic remediation and to prevent the likelihood of a repeat citation.	Quality	QMC, CPC and other Regional Committees as necessary	Annually
SWMBH will achieve an overall compliance score of >95% on the MDHHS Substance Use Disorder Administrative Protocols/Review.	Quality /SUD	QMC, SUD workgroup and Board	Annually

Q. Cultural Competency

Description

SWMBH is dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all Members. 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.

To effectively demonstrate such commitment to cultural competence and demonstrate compliance with the MDHHS/PIHP contract, SWMBH has the following five components in place:

1. community assessment
2. policy and procedure
3. service assessment and monitoring
4. ongoing training
5. culturally contextual services/supports.

Community Assessment:

SWMBH uses the annual regional Network Adequacy Assessment and a variety of consumer satisfaction surveys to assess for a culturally competent provider network and consumer involvement throughout the region. Languages spoken throughout the provider network are gathered through the Region's credentialing process.

At the county level, Michigan DHHS requires each CMHSP to conduct a nominal Needs Assessment at least every

two years. Michigan also launched as a CCBHC Demonstration state in 2021, and Michigan DHHS will require all local CCBHC sites to have a Needs Assessment. These community health needs assessments provide current demographic data and involve extensive stakeholder surveys spanning both provider agencies and persons served. The CMHSPs analyze stakeholder survey responses alongside data points for a combined qualitative and quantitative view of cultural competence and needs in each county. These data points are discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments are used to create a foundational equity framework that is specific to the county level, complete with root cause analysis and subsequent strategic planning.

Policy and Procedure:
SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network.

Service Assessment and Monitoring:
SWMBH is fully dedicated to improving health equity within Region 4, as evidence by adding the Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. This is a grant funded position that will continue to plan and develop region wide programming to increase the access and participation of minority populations in behavioral health services. From this position, a Regional Health Equity Focus Group was formed, consisting of representation from all 8 counties in region 4. The workgroup helped to identify regional and county barriers, frontline partners for further coordination and support, provide feedback to training and campaign efforts.

Cultural competency is further assessed and monitored according to current PBIP, CCBHC, MMBPIS and other metrics geared toward ensuring cultural competence and fairness in service delivery. Metrics that center around underserved populations are reviewed by SWMBH's internal Health Equity Performance Improvement Project (PIP) work group monthly, to ensure up to date monitoring. This group will continue to expand on its work in FY23, which included creating a pathway for encounter data to reflect interventions for the FUA metric, hosting education opportunities for hospitals, and quarterly meetings with Medicaid Health Plans (MHPs) to collaboratively monitor fluctuations in performance measures and identify interventions pertaining to disparities.

Training:
SWMBH requires ongoing training to assure that staff are aware of, and able to effectively implement cultural competency policies and procedures. SWMBH requires all provider's staff that are in-network to have cultural competency training and reviews this item as part of the Staff Training File Review in the annual site review process. SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan are trained annually during a Quality Management Committee meeting. Through the SWMBH Health Disparities Grant, representatives from each CMH in the region attended Advancing Health Equity in Public Health Training hosted by Michigan Public Health Institute (MPHI). SWMBH has likewise begun offering the following trainings free of charge to all provider agencies in Region 4: Ableism 101 and 102, Disability and Healthcare Equity Training, Disability and Intersectionality Training, Implicit Bias Training. In 2024, a health equity lecture series and symposium will be offered.

Culturally Contextual services/supports:

SWMBH strives to ensure that supports and services are provided within the cultural contexts of our recipients. SWMBH's community-sponsored events are selected by the Community Outreach Committee, which is dedicated to finding opportunities to better reach underserved and minority populations. Van Buren Project Connect.

FY24 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Further develop trainings in 2024 by adding a health equity lecture series and symposium will be offered.	Quality		
Promote continued education throughout the organization and 8-county region by participating in or contributing to local organizations and public events. Continue to seek culturally relevant, visible opportunities that attract minorities and their allies.	Customer Services	Customer Services, Provider Network and Clinical Practices Committees	Annually
SWMBH will evaluate language spoken by network providers vs. enrollees for FY24. SWMBH believes capturing more Provider data regarding languages spoken, cultural competency and physical accessibility of office space will assist the Provider Network Departments at each CMHSP in ensuring the Region's Member's needs are being met in this capacity.	Provider Network	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 – SWMBH BOARD ROSTER

2024 Board of Directors Roster

Barry County

- Mark Doster
- Robert Becker (Alternate)

Berrien County (Riverwood)

- Edward Meny - Chair
- Nancy Johnson (Alternate)

Branch County (Pines)

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

Calhoun County (Summit Pointe)

- Sherii Sherban
- Kathy-Sue Vette (Alternate)

Cass County (Woodlands)

- Louie Csokasy
- Jeanne Jourdan (Alternate)

Kalamazoo County (ISK)

- Erik Krogh
- Karen Longanecker (Alternate)

St. Joseph County (Pivotal)

- Carole Naccarato - Secretary
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes
- Angie Dickerson (Alternate)

ATTACHMENT C – 2024 Performance Bonus Incentive Program (PBIP) Measures

FY24 PIHP Performance Bonus Incentive Program

1. Contractor-only Pay for Performance (P4P) Measures (45% of total withhold)

Measure	Description	Deliverables
P.1. Implement data driven outcomes measurement to address social determinants of health (40 points)	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record. MDHHS specifications published at Reporting Requirements (michigan.gov)	Contractor will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31. Narrative (based on guidance provided by MDHHS during FY24) must address beneficiary changes in employment and housing and actions taken to improve housing and employment outcomes. 20 points awarded for Employment and 20 points awarded for Housing.
P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) (10 points)	Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period	The Contractor must participate in DHHS-planned and DHHS provided data validation activities and mtgs. PIHPs will be provided SAA-AD data and validation template by January 31, and within 120 calendar days, return the data validation templated, completed, to DHHS.
P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (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: 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.	Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with Calendar year 2023. The points will be awarded based on Contractor performance measure rates. Points will be divided evenly between Initiation and Engagement measures.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (25% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

2. MHP/Contractor Joint Metrics (30% of total withhold)

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

For J.2.2 and J.3.2 listed below, the PIHP metric scoring will be aggregate of/for all their MHPs combined, not each individual MHP-PIHP dyad.

Category	Description	Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the PIHP/MHP Collaboration Work Group in consultation with the State. Plans will submit an unscored narrative (no more than three pages) describing the process in place for identifying minors with appropriate severity/risk and providing care coordination of the population. Due August 1, 2024.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be calendar year 2023. The points will be awarded based on MHP/Contractor combination performance measure rates. (20 points) 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023. The points will be awarded based on Contractor performance measure rates. (20 points) The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given PIHP. See MDHHS reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at MDHHS - Reporting Requirements (michigan.gov)
J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with Calendar year 2023. The points will be awarded based on Contractor performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given PIHP. See MDHHS reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at MDHHS - Reporting Requirements (michigan.gov)

ATTACHMENT D – 2023-2024 STRATEGIC IMPERATIVES

ATTACHMENT E – 2023 REGIONAL STRATEGIC IMPERATIVE DECISION/PRIORITY MAP