Quality Assessment and Performance Improvement Program Description, Program Evaluation FY2022, and Program Work PLAN FY 2023

Approved By	Date
Compliance and Quality Committee (QOC)	June 12, 2023
Internal Operations Committee (OOC)	June 12, 2023
Board of Directors	June 28, 2023

Contents

INTRODUCTION

The Northern Michigan Regional Entity (NMRE) is the Medicaid specialty prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSPs) serving the northern lower peninsula of Michigan. The member Boards are: AuSable Valley Community Mental Health Authority (AVCMH) serving Iosco, Ogemaw, and Oscoda counties, Centra Wellness Network (CWN) serving Benzie and Manistee counties, North Country Community Mental Health Authority (NCCMH) serving Antrim, Charlevoix, Cheboygab, Emmet, Kalkaska, and Otsego counties, Northeast Michigan Community Mental Health Authority (NEMCMH) serving Alcona, Alpena, Montmorency, and Presque Isle counties, and Northern Lakes Community Mental Health Authority (NLCMH) serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties. The managed care activities are the responsibility of the NMRE.

AUTHORITY

The Quality Assessment and Performance Improvement Program (QAPIP) is reviewed and approved on an annual basis by the NMRE Governing Board. Through this process, the Governing Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

Consistent with the structure of the NMRE and the governance structure of its Board of Directors, this authority is discharged through the Chief Executive Officer (CEO) of the NMRE. In turn, the CEO discharges authority through the Compliance Director.

DEFINITIONS

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or their representative (also "Member" or "Consumer").

Community Mental Health Services Program (CMHSP): For the purposes of this document, a CMHSP member is one of the following: AuSable Velley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, or Northern Lakes Community Mental Health Authority.

Michigan Department of Health and Human Services (MDHHS): A principal department of state of Michigan, headquartered in Lansing, that provides public assistance, child and family welfare services, and oversees health policy and management.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services pursuant to the Specialty Supports and Services Contract between the State of Michigan and the NMRE, it's member CMHSPs, and/or its Substance Use Disorder (SUD) Provider Panel.

Northern Michigan Regional Entity (NMRE): One of 10 prepaid inpatient health plans (PIHPS) in the state of Michigan. The NMRE covers Region 2, the twenty-one counties at the tip of Michigan's lower peninsula (Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford).

NMRE Internal Operations Committee (IOC): An NMRE internal committee comprised of key leadership staff.

NMRE Operations Committee (Ops): An NMRE regional committee comprised of the top-level executive staff (CEO/Executive Director) of the NMRE and its five member CMHSPs.

NMRE Quality and Compliance Oversight Committee (QOC): A regional quality improvement committee, comprised of NMRE staff and quality and compliance leaders from the five member CMHSPs. Additional members may be appointed, as appropriate, including members from the NMRE SUD Provider Panel and service recipients (primary or secondary).

Prepaid Inpatient Health Plan (PIHP): The ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, intellectual/developmental disabilities, and substance use disorders.

Quality Assessment and Performance Improvement Program (QAPIP): A data driven and proactive approach to quality improvement. The QAPIP is used to ensure services are meeting quality and performance standards.

MISSION & VISION

Mission

Develop and implement sustainable, managed care structures to efficiently support, enhance, and deliver publicly funded behavioral health and substance use disorder services.

Vision

A healthier regional community living and working together.

PURPOSE

As the PIHP for the twenty-one county region, the NMRE's mission guides quality improvement activities. The QAPIP is intended to serve several functions, including but not limited to.

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one county area.
- Provide oversight of the CMHSPs' quality improvement structures and ensure coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).

- Coordinate with the regional Compliance Coordinator and Regional Compliance Committee for verification of Medicaid claims submitted.
- Describe how these functions will be executed within the NMRE's organizational structure.

This written plan describes how these functions will be accomplished. It also describes the organizational structure and responsibilities relative to these functions.

GOVERNANCE

The NMRE has a fully operational QAPIP that meets the conditions specified in its Specialty Supports and Services Contract with the State.

The NMRE Governing Board/Board of Directors reviews and approves the QAPIP on an annual basis. Through this process, the Governing Board gives authority for the implementation of the QAPIP and all its components. The Governing Board receives routine updates on the QAPIP, as well as a year-end effectiveness review.

STRUCTURE

1. Provider/Beneficiary Involvement
   The involvement of provider and beneficiary representatives is essential to the effectiveness of the QAPIP; this involvement is sought, encouraged, and supported at several levels including:

   a. The NMRE Governing Board includes beneficiaries as members.
   b. The NMRE Consumer Advisory Panel (Regional Entity Partners) provides input on various managed care activities.
   c. The regional Quality and Compliance Oversight Committee (QOC) is comprised of staff from the NMRE and its member CMHSPs.
   d. Each member CMHSP operates a Consumer Advisory Committee and includes beneficiary representatives on its Governing Board and on various committees.

2. NMRE Internal Operations Committee
   The NMRE Internal Operations Committee (IOC) has the central responsibility for the implementation of the QAPIP. Committee membership consists of key NMRE staff including but not limited to:

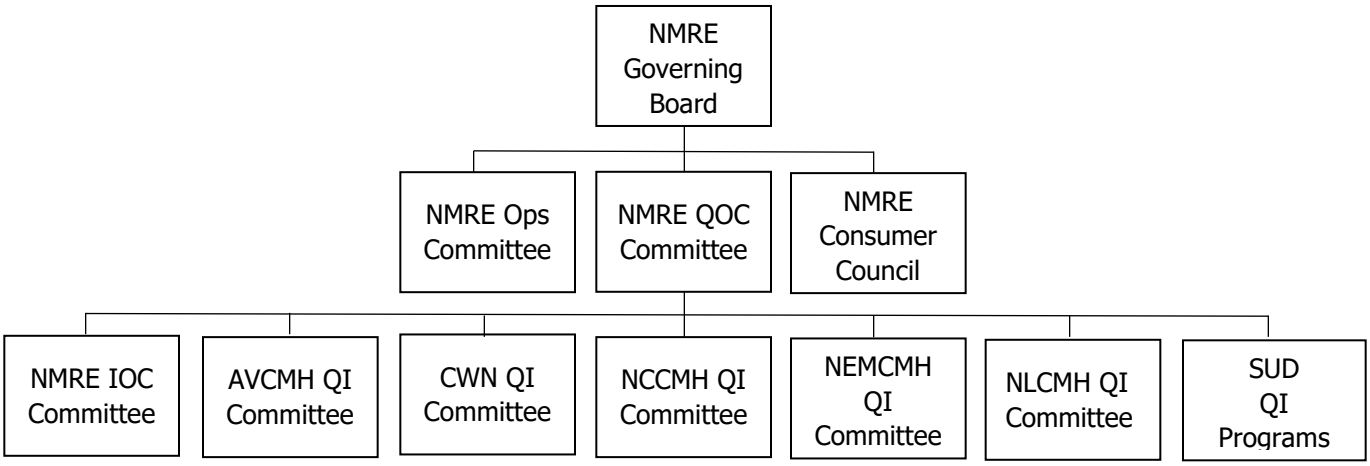
   a. Chief Executive Officer
   b. Chief Information Officer/Operations Director
   c. Chief Financial Officer
   d. Compliance Director
   e. Clinical Services Director
   f. Human Ressources Director

3. NMRE Quality and Compliance Oversight Committee
   The regional Quality and Compliance Oversight Committee (QOC) has the responsibility for ensuring that network providers have appropriate quality improvement structures and activities necessary to meet federal and state requirements. This group provides the primary link between the quality improvement structures of network providers and the NMRE. To create this link, the CEO of each member CMHSP appoints representatives to serve as members of the committee.

4. CMHSP Quality Improvement Committees
   Each member CMHSP has a Quality Improvement process to address quality issues within its operations that meets the requirements of MDHHS and the NMRE.

5. Accountability
   Because one of the tenants of quality improvement and a key element of a successful team is accountability, the success of the NMRE's QAPIP is dependent on the success of its parts. Employees and/or agents of the NMRE and its network providers will be accountable to beneficiaries, coworkers, various committees, and their primary employer for the quality and integrity of their work.

   The following table displays the reporting accountability of the various components of the quality improvement system.



RESPONSIBILITIES

Each of the components of the QAPIP structure have specific responsibilities. These various tasks, when taken in whole, ensure that the NMRE and its network providers are administering

quality services, effectively managing and protecting available resources, protecting the rights of beneficiaries, and identifying opportunities to improve.

1. NMRE Quality and Compliance Oversight Committee (QOC)
   The NMRE regional QOC acts as the NMRE's primary connection to the quality improvement activities of its network providers. This committee, the Regional Customer Services Committee, and the regional Consumer Advisory Committee (Regional Entity Partners) are the vehicles from which the NMRE receives beneficiary input.

2. NMRE Internal Operations Committee (IOC)
   The NMRE IOC has the lead role within the NMRE in implementing the QAPIP, beginning with the quality, effectiveness, and efficiency of the managed are activities.

3. Compliance Director
   The NMRE Compliance Director is a senior staff person responsible for the implementation of the NMRE's QAPIP. On an annual basis, the Compliance Director works with various committees to conduct an effectiveness review of the QAPIP and the previous fiscal year's workplan. The effectiveness review includes an analysis to determine whether members experienced any improvement in their quality of healthcare and services due to the QAPIP. The effectiveness review is shared with the NMRE Governing Board, network providers, and upon request, to members and MDHHS. The effectiveness review is used to inform the following year's QAPIP and Workplan.

4. Member CMHSP Quality Improvement Committees
   Each member CMHSP will maintain an appropriate quality improvement program that meets the requirements of federal regulations and national accreditation. Each CMHSP submits summary reports of quality improvement activities, minutes of Quality Improvement Committee meetings, and Quality Improvement Plans to the NMRE. The NMRE monitors all quality improvement program activities to ensure they are consistent with the standards and requirements of managed care, as specified in federal regulations and the NMRE's Specialty Supports and Services Contract with the State.

   Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations (SUD Provider Panel). No managed care functions are delegated to SUD providers. To ensure adequate representation of SUD service in the NMRE's quality improvement activities, the NMRE SUD Grant and Treatment Manager is an integral member of various committees.

The components of the QAPIP Structure are intended to ensure compliance with the following required activities:

1. **Claims Verification**
   The verification of Medicaid claims is required both by federal regulations and the Specialty Supports and Services Contract with the State. The primary responsibility for this activity, as specified in the NMRE Medicaid Encounter Verification Policy and Procedure is assigned to the Compliance Director.

The NMRE has established a consistent methodology for the validation of Medicaid encounters submitted within its provider network to ensure compliance with federal and state regulations in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program, the Medicaid Services Verification-Technical requirements.

Scores that fall below 95% accuracy for each quarterly review will require a plan of correction from the provider. The plan of correction template will be emailed along with the final MEV report. The provider will identify remediation strategies for the NMRE to review. Once approved, the NMRE will monitor the actions specified within the plan of correction. Services that are found to be invalid will be voided for payment with Medicaid funds; proof will be sent to the NMRE Compliance Director within 3 days of the finding or the end of review period. For SUD services, proof of retractions will be provided by a reconsideration report, sent within 2 weeks of the final report. A provider may appeal findings, in writing, to the NMRE Compliance Director, who will seek consultation and render a decision within 2 weeks from receiving the appeal.

If there is suspicion of fraud and/or abuse, the NMRE Compliance Officer will notify the NMRE Chief Executive Officer (CEO) and the Provider's CEO/Executive Director of the alleged issue. The NMRE CEO will report the suspicion to the Health Services Office of the Inspector General (HSOIG) as required by the NMRE's Specialty Supports and Services Contract with the State. No attempt to further investigate or resolve the issue(s) will be made by the NMRE or the provider once the issue has been reported to the HSOIG.

2. Practice Guidelines

The NMRE supports the use of practice guidelines that are evidence-based and widely accepted. The NMRE's practice guidelines are comprised of the American Psychiatric Association (APA) practice guidelines, other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), MDHHS practice guidelines, and region-specific practice guidelines.
The APA practice guidelines provide evidence-based recommendations for the assessment and treatment of psychiatric disorders and are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format.

a. Clinical Practice Guidelines created or made available by the American Psychiatric Associationhttps://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines

b. MDHHS Practice Guidelines (https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines)

c. Region Specific Practice Guidelines

The process of developing, reviewing, adopting, and disseminating practice guidelines as specified in the NMRE Practice Guidelines Policy and Procedure is assigned to the NMRE Provider Network Manager. The NMRE IOC has the responsibility for ensuring that the policy and procedure is implemented appropriately. Practice Guidelines are posted on the NMRE website: Northern Michigan Regional Entity - Northern Michigan Regional Entity (nmre.org).

3. Events Reporting and Notification

The NMRE complies with its Specialty Supports and Services Contract with the State and the Event Notification/ Reporting System by providing clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE will analyze this data quarterly to identify improvement opportunities.

Quarterly, the NMRE collects, aggregates, and analyzes events data through the Quality and Compliance committee (QOC). The findings of this data are then reported to NMRE's Internal Operations Committee and the Board.

a. Sentinel Events: A sentinel event is a type of critical incident that is an "unexpected occurrence" involving death 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). A sentinel event does **not** include a death attributed to natural causes. Investigation of a sentinel event will be conducted by a staff with the appropriate credentials to review the event; for example, a sentinel event involving a death or serious medical condition will involve a physician or nurse.

To be a sentinel event, the incident must have occurred to a beneficiary in a reportable population and determined, through investigation, to be a sentinel event. Except for arrests/conviction and serious challenging behavior, each incident should be reviewed to determine if it meets sentinel event criteria.

i. Unexpected Death: The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

ii. Serious Physical Injury: Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.

iii. Emotional Harm: Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional or psychiatrist.

iv. Death by Natural Causes: The death of a beneficiary that occurred as the result of a disease process from which death is an anticipated outcome. A death by natural causes is **not** a sentinel event.

v. Physical Illness Requiring Hospital Admission: The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. A planned surgery, whether outpatient or inpatient, is **not** considered an unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for

an illness directly related to a beneficiary's chronic or underlying illness is also **not** reported as a sentinel event.

vi. Serious Challenging Behavior: A behavior that results in significant (over $100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.

vii. Medication Error: The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is **not** a medication error.

viii. Arrest/Conviction: Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction will be reported as a sentinel event [through the MDHHS Michigan Crisis and Access Line (MiCAL)] but does not require a root cause analysis.

b. Substance Use Disorder (SUD) Sentinel Event Reporting: Specific sentinel events that occurred to beneficiaries who were living in a 24-hour specialized residential substance abuse treatment settings at the time of the event are required to be reported to MDHHS. The specific categories are:

i. Death

ii. Accident that requires an emergency room visit and/or hospital admission

iii. Physical illness that required a hospital admission

iv. Arrest or conviction

v. Serious Challenging Behavior

vi. Medication error

c. Risk Events: An event that puts a beneficiary who is in a reportable population at risk of harm is categorized as a "risk event." A risk event is reported for internal analysis to determine what actions are needed to remediate the problem or situation and to prevent reoccurrence.

i. Harm to Self: An action taken by a beneficiary that causes them physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting, suicide attempt).

ii. Harm to Others: An action taken by a beneficiary that causes physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).

iii. Police Call: A call to police by a staff of a specialized residential setting, or general (AFC) residential home, or other provider agency requesting assistance with a beneficiary during a behavioral crisis, regardless of whether contacting law enforcement is addressed in a Behavior Treatment Plan.

iv. Emergency Use of Physical Management: The of physical management by a trained staff in response to a behavioral crisis.

v. Physical Management: A technique used as an emergency intervention to restrict the movement of a beneficiary by continued direct physical contact despite their resistance, to prevent them from physically harming themselves or someone else. "Physical management" does not include briefly holding a beneficiary to comfort them or demonstrate affection or holding their hand.

vi. Unscheduled Hospitalizations: Two or more unscheduled admissions of a beneficiary to a medical hospital within a 12-month period not due to planned surgery or the natural course of a chronic illness. The use of an emergency room or emergency department is **not** considered a hospital admission.

d. Critical Incidents: The NMRE requires all network providers (both CMHSPs and SUD providers) to report critical incidents to the NMRE monthly. Critical incidents include:

i. Suicide

ii. Non-suicide death

iii. Death of unknown cause

iv. MAT medication error

v. SUD medication error

vi. Seriously challenging behavior

Any unexpected death of a beneficiary who, at the time of their death, was receiving specialty supports and services will be reviewed. The review will include:

i. Confirmation of beneficiary's death (e.g., coroner's reports and/or death certificate)

ii. Involvement of medical personnel in the mortality review

iii. Documentation of the mortality review process, findings, and recommendations

iv. Use of mortality information to review quality of care

v. Aggregate mortality data to identify possible trends over time

The review will be a "formal process" and include areas of clinical risk. The review team will include individuals with appropriate credentials to review the scope of care, individuals who were not involved in the treatment of the beneficiary, and any additional individuals who may contribute to a thorough review process.

e. Root-Cause Analysis (RCA): A root cause analysis is a process for identifying the basic or causal factors that underlie variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis should result in an action plan designed to reduce or attempt to reduce future incidents. Within three (3) days of a critical incident, network provider staff will determine whether it meets sentinel event standards; if it does meet that standard network provider staff will initiate a root cause analysis within two (2) days of the determination. A request for

additional information, such as a coroner's report or death certificate, constitutes the start of a root cause analysis.

f. Unexpected Death Reporting: All unexpected deaths of Medicaid beneficiaries who, at the time of their death, were receiving specialty supports and services will be reviewed in accordance with the NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting Policy and Procedure and the NMRE's Specialty Supports and Services Contract with the State. This reporting will include suicide, non-suicide death, homicide, undiagnosed conditions, accidental death, suspicious death, or abuse/neglect.

The NMRE and/or the network provider will immediately report to MDHHS:

i. Any death of a beneficiary who was discharged from a State Facility within 12 months preceding the date of death

ii. Any death that occurs as the result of suspected NMRE or network provider staff action or inaction, or

iii. Any death that is the subject of a Recipient Rights, licensing, or police investigation.

The report will be submitted electronically within 24 hours of either the death or the responsible network provider staff's receipt of the death notification, or the responsible network provider staff's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced to the NMRE Compliance Director. The report will include:

i. Name of beneficiary

ii. Beneficiary ID Number (Medicaid or Healthy Michigan Plan)

iii. Consumer ID (CONID) if there is no beneficiary ID number

iv. Date, time, and place of death (if a licensed foster care facility, include the license #)

v. Preliminary cause of death

vi. Contact person's name and email address

In addition, the network provider will submit a written report of its review/analysis of the death to the NMRE within 45 days from the month in which the death occurred. The NMRE will notify MDHHS within 60 days after the month in which the death occurred.

The primary responsibility for the review of sentinel events, critical incidents, and risk events falls to NMRE network providers and residential treatment providers. The NMRE IOC and QOC will analyze data sent by network providers quarterly to identify trends and implement plans of correction, as appropriate, to reduce the potential for future events. These reviews will be completed in accordance with MDHHS definitions and reporting requirements and the NMRE's Critical Incident, Risk Events, Sentinel Events and Death Reporting policy.

4. Credentialing and Recredentialing

The NMRE will ensure that anyone rendering services to beneficiaries is appropriately credentialed within the state and is qualified to perform the services by having met all applicable licensing, scope of practice, contractual, and Medicaid provider requirements.

The NMRE will monitor its Network Providers so that appropriately qualified and competent staff provide covered and authorized services. Credentialing and recredentialing will be based upon specific license, education, training, experience, and competence. The provider's level of competence and professional ethics will be of the highest order, and will continuously meet or exceed the qualifications, standards, and requirements.

a. The NMRE will:

    i. Be responsible for oversight of credentialing and recredentialing decisions; and

    ii. Terminate the credentialing of a provider when appropriate.

b. The NMRE will ensure that the credentialing and recredentialing processes do not discriminate against:

    i. A behavioral health care provider, solely based on license, registration, or certification; and

    ii. A behavioral health care provider who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

c. The NMRE will ensure the following:

    i. The provision of high quality and cost-effective mental health and substance use disorder (SUD) services to consumers.

    ii. Consumer access to a timely, geographically convenient, and specialized array of mental health and substance use disorder treatment and support services.

    iii. Licensed Independent Providers (LIPs) meet and/or exceed the accreditation and regulatory standards for practicing and delivering services independently.

    iv. The decision to enter a contractual relationship with any LIP credentialed by the NMRE under this policy is left to each CMHSP based on the needs of its Board and community.

    The NMRE credentials organizational providers. Each network provider completes its own credentialing of staff. The NMRE ensures that credentialing is completed in a manner consistent with the NMRE Credentialing Policy and Procedure, MDHHS Credentialing and Recredentialing document dated May 24, 2003, and the NMRE's Specialty Supports and Services Contract with the State.

d. Provider Monitoring: The NMRE monitors its network providers at least annually, including the five member CMHSPs, the SUD Provider Panel, and other contracted providers, as needed. Monitoring includes a review of delegated functions, services and supports provisions, and compliance with administrative requirements including credentialing and staff training. As appropriate, targeted monitoring activities for people

identified as "vulnerable" are also conducted. When a network provider is found to be out of compliance with contract requirements, appropriate corrective action is required.

e. Reporting: Each of the NMRE's Network Provider's is responsible for reporting any conduct by a member of its staff or provider network that results in suspension or termination from the provider network to the NMRE; in turn, the NMRE will report the conduct to the appropriate authorities (i.e., the Michigan Department of Health and Human Services, the provider's regulatory Board or agency, the Attorney General's Office) and any other Federal and State entities as specified in the NMRE's Specialty Supports and Services Contract with the State. Additionally, NMRE will notify MDHHS regarding any disclosures of criminal offense as found in sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil monetary penalties or assessments imposed under section 1128A of the Act.

f. Coordination with Network Provider Structures: The NMRE recognizes that quality improvement is best addressed by the individuals involved in the systems to be improved. As such, those best equipped to improve the various functions of the NMRE's provider network are those within the provider organizations. The NMRE supports the existing quality improvement structures of its network providers though the NMRE retains the responsibility for ensuring that federal and state regulatory requirements and the quality improvement provisions of the NMRE's Specialty Supports and Services Contract with the State are met.

5. Utilization Management

The NMRE will ensure access to public behavioral health services in the region in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements. The NMRE supports the use of practice guidelines that are evidence-based and widely accepted to provide these services. The NMRE's practice guidelines are comprised of the American Psychiatric Association (APA) practice guidelines, other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), MDHHS practice guidelines, and region-specific practice guidelines.

Consistent with the Balanced Budget Act (BBA) and MDHHS contract requirements, the NMRE, in collaboration with the CMHSPs and contracted provider entities, will implement mechanisms to detect over- and under-utilization of services. These mechanisms will include but are not limited to:

- Develop, monitor, and track additional key performance indicators to detect patterns or trends.
- Specific studies of certain sets of services based on established factors or criteria. These may include services with high risk, high cost, ASAM levels of care, etc.
- Ares with significant variation in utilization patterns.
- Conduct data-driven analysis of regional utilization patterns
- Require corrective action when necessary.

The NMRE has a Utilization Management Plan that identifies:

a. Strategies for validating beneficiary eligibility criteria.

b. Strategies for evaluating medical necessity and service authorization decisions.

c. Mechanisms to identify the correct under- and over-utilization of services.

d. Procedures to conduct prospective, concurrent, and retrospective authorization reviews.

Collaboratively, NMRE and CMHSP designated staff are responsible to:

a. Provide oversight to ensure that each CMHSP has policies and procedures that comply with State and federal requirements related to UM.

b. Develop, monitor and track key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results across the region.

c. Engage in studies of specific populations or sets of services based on identified factors or criteria. These may include populations or services with high risk, high costs, the presence of negative outliers or outcomes, or the presence of significant variances in utilization patterns.

d. Act as the representative for the region on any Utilization Management initiatives across the state.

6. Long-Term Services and Supports

The NMRE has mechanisms in place to ensure quality and appropriate care is provided to individuals receiving Long-Term Services and Supports.

"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).

The following services are noted as LTSS services per the 1115 Pathway to Integration Waiver: Respite, Community Living Supports (CLS), Private Duty Nursing (PDN), Supported/Integrated Employment, Out of Home Non-Vocational Habilitation, Goods and Services, Environmental Modifications, Supports Coordination, Enhanced Pharmacy, Personal Emergency Response System (PERS), Community Transition Services, Enhanced Medical Equipment and Supplies, Family Training, Specialty Therapies (Music, Art, Message), Children Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services, Fiscal Intermediary Services, and Prevocational Services.

The NMRE will ensure that Long-Term Services and Supports (LTSS) are provided in accordance with 42 CFR §438.208(c)(1)(2) to persons with disabilities who need additional support due to:

a. Advancing age; or

b. Physical, cognitive, developmental, or chronic health conditions; or

c. Other functional limitations that restrict their abilities to care for themselves; and

d. Receive care in home and community-based settings or facilities such as nursing homes.

The NMRE's site review tool and consumer satisfaction survey include items monitoring the appropriateness of care for members receiving these services.

7. Performance Indicators

MDHHS has established performance indicators for CMHSPs and PIHPs. These indicators are drawn from the Michigan Mission Based Performance Indicator System (MMBPIS) in the areas of access, efficiency, timeliness, and outcomes. Each member CMHSP and the SUD Provider Panel reports relevant performance indicator data to the NMRE.

A standardized PI Export/Import is used in each CMHSP system to compile the data into RECON (the NMRE's EMR/PCE system). The NMRE IOC and QOC monitor these data quarterly and over time. When a standard is not met for two consecutive quarters, the NMRE requests a corrective action plan from the provider. This information includes persons served by NMRE providers for mental health, intellectual/developmental disability, and substance use conditions. The QOC reviews and monitors the NMRE's performance in this area.

The QOC reviews the trends in service delivery and health outcomes over time. This review includes whether there have been improvements or barriers impacting the quality of care and services to members. These reports are also shared quarterly with the NMRE's Governing Board and other stakeholders.

8. Member Satisfaction

The NMRE QOC, Customer Services Committee, and SUD Providers are responsible for ensuring that surveys are administered to beneficiaries to measure their degree of satisfaction with services, including those for mental health, intellectual/developmental disabilities, and substance use disorders, including long-term supports and services. Surveys are conducted in a way that results can be measured over time. The NMRE investigates areas of dissatisfaction when the data indicates a systemic concern with a particular provider. Survey findings are shared with the NMRE Governing Board, the NMRE regional Consumer Advisory Committee (Regional Entity Partners), network providers, and the public via the NMRE website.

9. Performance Improvement Projects (PIPs)

In accordance with federal regulations and the NMRE's Specialty Supports and Services Contract with the State, the NMRE conducts at least two Performance Improvement Projects (PIPs) each year. The MDHHS mandates the topic of one of the two PIPs. The NMRE regional QOC selects the topic for the additional PIP(s). The PIP study topics include clinical and non-clinical aspects of care. Prior to selecting the PIP topics, the NMRE's Internal Operations Committee, in collaboration with the Quality Operations Committee, identified areas of concern that could be addressed through a meaningful PIP.

For the fiscal year 2023, the NMRE is conducting three PIPS:

a. Increase the percentage of individuals enrolled in the Opioid Health Home (OHH) services.
b. Increase the percentage of individuals enrolled in the Behavioral Health Home (BHH) services.
c. Impact of telehealth on no show/missed appointments.

The PIHP utilizes the plan, do, study, act model to improve the quality of services. The NMRE QOC reviews PIP data at least quarterly. The NMRE Compliance Director reports on the PIPs in accordance with the timeline established by MDHHS.

10. Analysis of Behavior Treatment Data

The NMRE believes in protecting and promoting the dignity and respect of all individuals receiving public mental health services. Therefore, the NMRE has developed a policy that provides protection for individuals receiving services, promotes the use of least restrictive optimally effective treatment, assists staff by acting as a consultative resource committee, and ensures that the BTPRCs at the CMHSPs comply with the MDHHS Technical requirement for Behavior Treatment Plans.

At least quarterly, the NMRE regional Behavior Treatment Plan Review Committee (BTPRC) reviews and analyzes data from network providers in which intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis to identify trends and any subsequent action that needs to be taken to reduce the potential for future events. Data includes the number of interventions and the length of time the interventions were used per individual. The NMRE adheres to the provisions outlined in the MDHHS Technical Requirement for Behavior Treatment Plans dated July 29, 2020, and the NMRE's Specialty Supports and Services Contract with the State.

Approval Signature

NMRE Chief Executive Officer

6/28/23

Date

FY22 QAPIP Program Evaluation

A. Performance Improvement Projects (PIPs)

1. Increase the percentage of individuals enrolled in Opioid Health Home (OHH) services.

Enrollment Process:

The Michigan OHH used a two-pronged enrollment approach where the Lead Entities (LEs) enrolled eligible members, using the MDHHS-determined, CMS-approved criteria. The LEs assigned enrolled members to one of the LEs contracted Health Home Providers (HHPs).

The OHH provides comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. For enrolled beneficiaries, the OHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model also elevates the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, a beneficiary's complete health and social needs are attended to. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

Sampling is not being used for this PIP because the entire eligible population will be used.

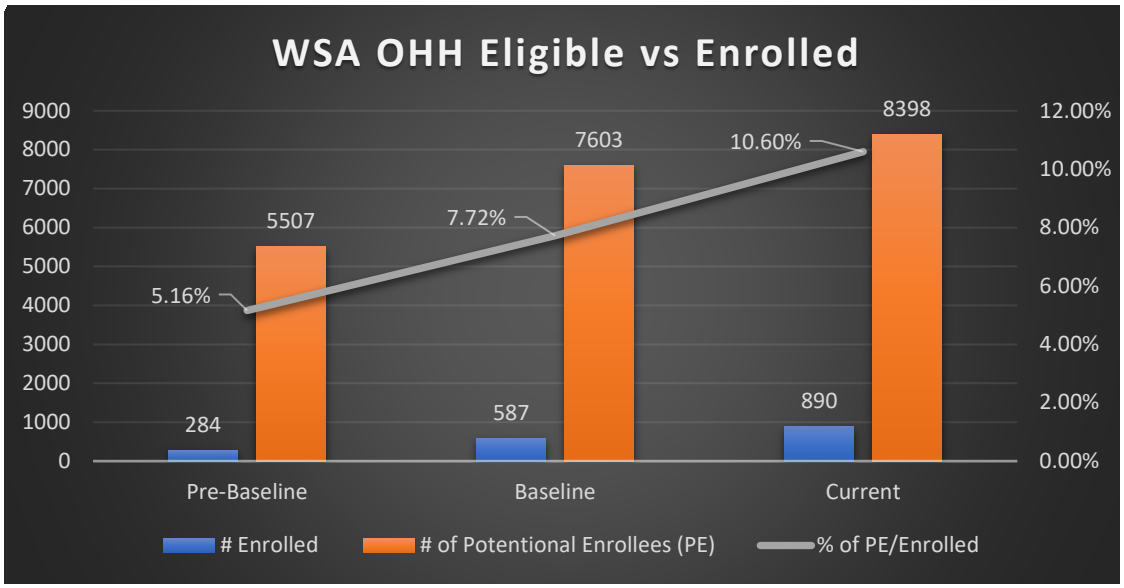
Eligible beneficiaries must reside within the NMRE's 21-county region, and must be enrolled in Medicaid, Healthy Michigan Plan (HMP), Freedom to Work, Healthy Kids Expansion, or MIChild and have a diagnosis of Opioid Use Disorder.

Goals

a. Increase access to Medication Assisted Treatment (MAT) and integrated behavioral, primary, and recovery-centered services for beneficiaries with Opioid Use Disorder
b. Decrease opioid overdose deaths.
c. Decrease opioid-related hospitalizations.
d. Increase utilization of peer recovery coaches.
e. Improve the "intangibles" of health status (e.g., the social determinants of health).

Initial Data

Time Period	Running Date	# Enrolled	# of Potential Enrollees (PE)	% of PE/Enrolled
Pre-Baseline	<= 9/30/2020	284	5,507	5.16%
Baseline	<= 9/30/2021	587	7,603	7.72%
Current	<= 9/30/2022	890	8,398	10.60%



Based on the data, the was a 0.8 percent increase in the OHH enrollment rate. The increase reflected a slight improvement in enrollment.

Positive interventions

a. Provider Network expansion: There was an increase in the provider network which led to a subsequent increase in enrollment.

b. Current providers increased participation resulting in an increase in enrollment. Some of the things that providers did differently were identified as:

   i. Hired more staff. Providers hired more staff in critical areas such as care coordinators to help maintain and expand enrollment.

   ii. Became more engaged in the process by attending meetings with the NMRE and investing more in the program.

c. The NMRE did the following to increase enrollment:

   i. Provided monthly meetings with providers. These monthly meetings helped to keep providers more engaged and motivated

   ii. Monthly meetings provided opportunities for additional education to providers.

Challenges

The major challenges were related to staffing capacity.

a. Staffing inconsistency due to high turnover
b. When providers lost critical staff, they were almost starting over because they had to either slow down or put a halt on new enrollment, hire new staff, and train new staff before they could get back on track.
c. Providers were unable to manage the overhead burden involved with this process given the ongoing staff shortage.

Systems challenges

a. Staff Stability
    i. Providers may have been doing very well then, suddenly, they lost a key staff member.
    ii. Staff were being stretched very thin and were required to cover a wide area of responsibilities.
    iii. Given the shortage in staffing, it was difficult to dedicate a staff to keep the client engaged and stay enrolled.
b. No show issues.
    i. Clients often didn't have a reliable source of transportation or didn't have transportation at all.

Other Concerns

a. Redeterminations – With the PHE coming to an end and the redetermination process starting up again, some beneficiaries will lose coverage, and this will negatively impact enrollment. The NMRE will monitor closely.
b. Some steps that the NMRE is taking to prepare:
    i. Alerting providers about the upcoming redeterminations and what that will mean for the provider and the beneficiaries.
    ii. When NMRE staff finds out that a beneficiary's address is incorrect in the WAS, they will alert the provider to make sure they have an accurate address, so communications are not going to the wrong place or person.
    iii. Encouraging providers to check beneficiary addresses to make sure they are updated in the system.
    iv. Showing providers how to run reports in the WAS to see and track redetermination due dates to be prepared for reenrollment and/or disenrollment.

v. Encouraging providers to have dedicated staff so they can have consistent enrollment.

How to measure success

Some of the ways that can be used to evaluate the success of this improvement project are:

a. Improved quality of life for individuals served.

b. Decreased Recidivism – re-hospitalization of individuals served.

c. Increased employment status for individuals served. In 2019 it was 33.9%, 2020 46.8% and 2021 52.8%

Systemic success factors

a. Fewer provider issues overall.

b. Better understanding of the OHH program by providers:

   i. Improved billing

   ii. Better care plans

Clinical Success Factors

a. Nurses at the CMHSPs saved lives because of this program; beneficiaries were referred to this program and their health outcomes improved.

b. Less use of the emergency rooms because clients were able to go to the CMHSPs for emergency services instead of going to the emergency room. Nurses at some CMHSPs were able to administer NARCAN treatments to beneficiaries in the parking lot, instead of calling 911.

c. There was improved collaboration to identify and connect beneficiaries with services.

d. Chronic conditions were kept under control by proper care coordination. This helped keep beneficiaries out of the ER because of better care management.

e. Cancer and other life-threatening illnesses were diagnosed sooner rather than later. This provided the opportunity of early intervention.

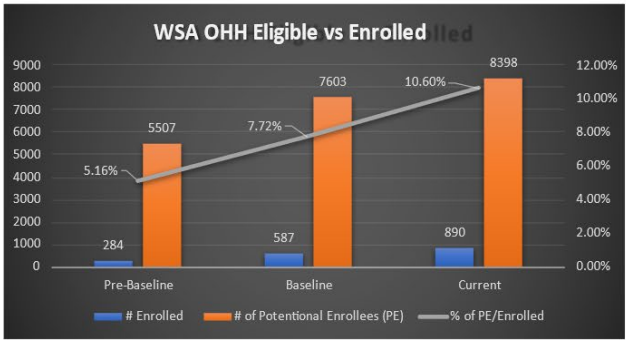
OHH PIP Data

Data as of November 17, 2022

OHH Breakout June 2, 2023

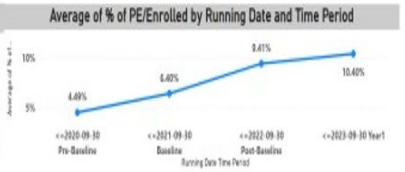
WSA OHH Eligible vs Enrolled

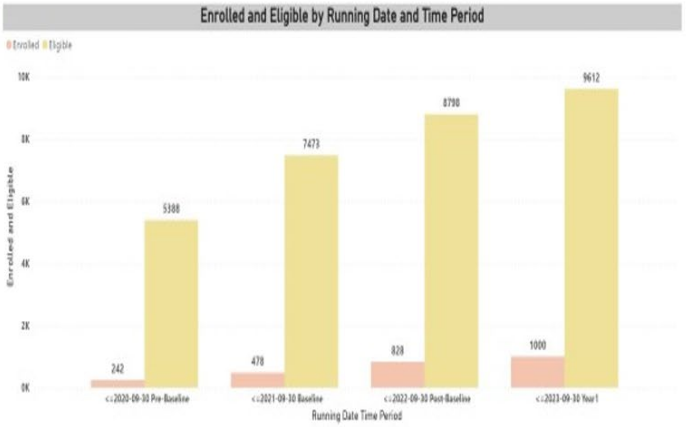
# Enrolled	# of Potentional Enrollees (PE)	% of PE/Enrolled	
284	5507	5.16%	
587	7603	7.72%	
890	8398	10.60%	



WSA OHH Breakout: Eligible versus Enrolled

Time Period	Running Date	Enrolled	Eligible	% of PE/Enrolled
Pre-Baseline	<=2020-09-30	242	5388	4.49%
Baseline	<=2021-09-30	478	7473	6.40%
Post-Baseline	<=2022-09-30	828	8798	9.41%
Year1	<=2023-09-30	1000	9612	10.40%





2. Behavioral Health Home (BHH) – Improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by the end of FY2023.

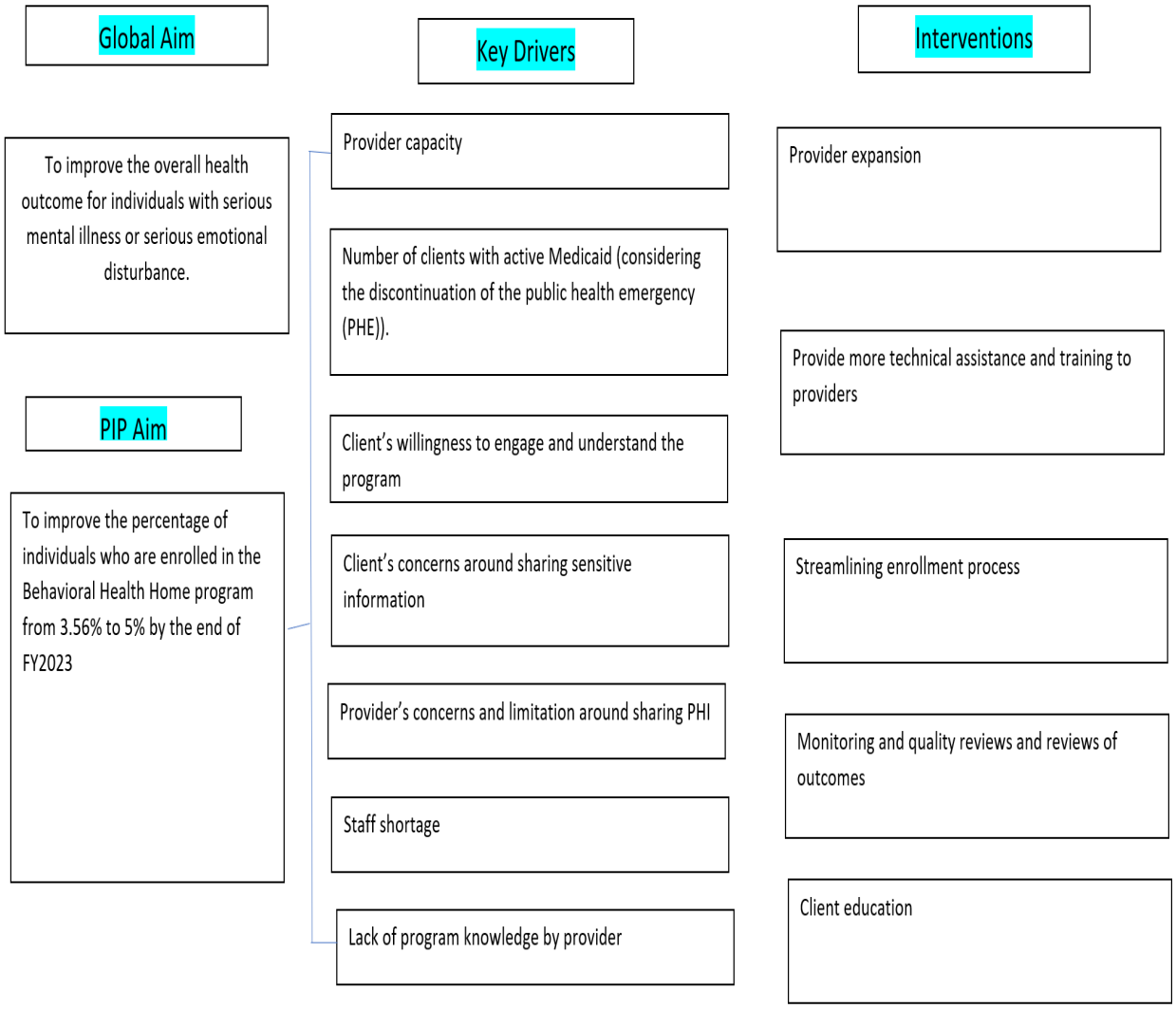
Goals

a. Improve care management for beneficiaries with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).

b. Improve care coordination between physical and behavioral services.

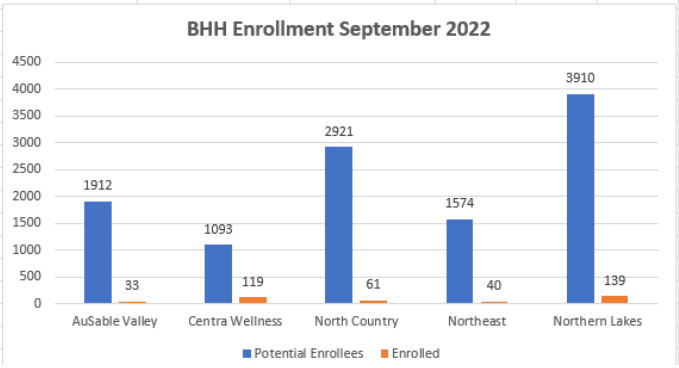
c. Improve care transitions between primary care, specialty services and inpatient settings.

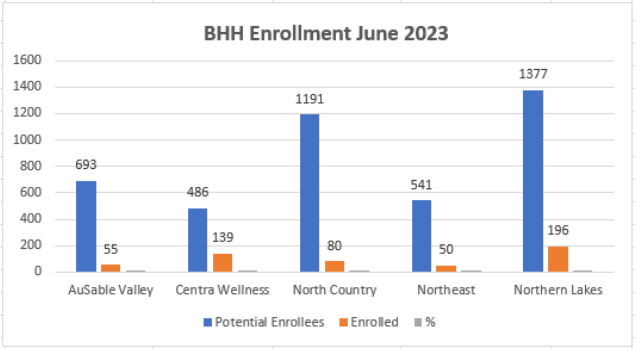
Key Driver Diagram for Behavior Health Home



BHH Enrollment September 2022			
	Potential Enrollees	Enrolled	%
AuSable Valley	1912	33	1.73%
Centra Wellness	1093	119	10.89%
North Country	2921	61	2.09%
Northeast	1574	40	2.54%
Northern Lakes	3910	139	3.55%
	11410	**392**	**3.44%**

BHH Enrollment June 2023			
	Potential Enrollee	Enrolled	%
AuSable Valley	693	55	7.94%
Centra Wellness	486	139	28.60%
North Country	1191	80	6.72%
Northeast	541	50	9.24%
Northern Lakes	1377	196	14.23%
	4288	**520**	**12.13%**



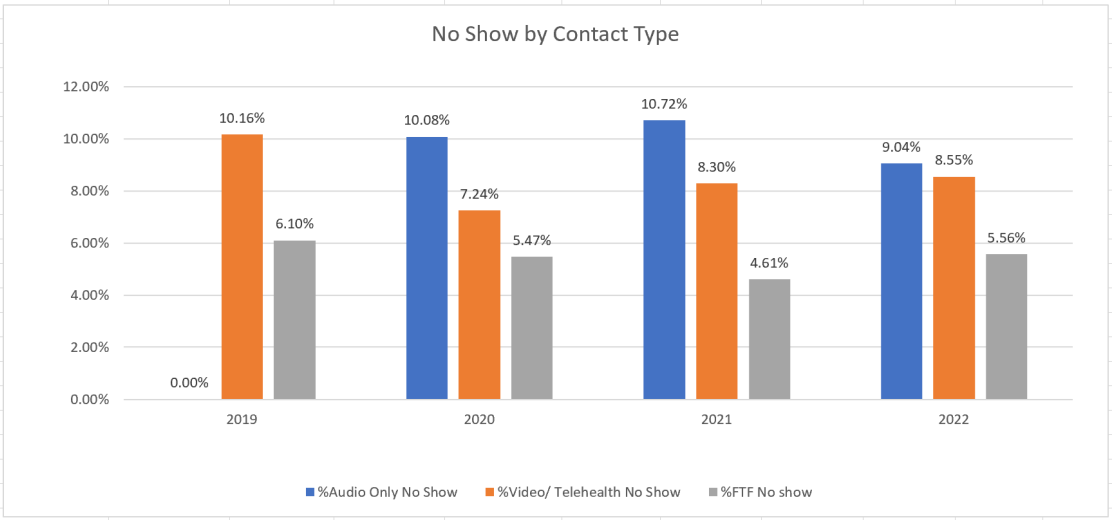


*** It should be noted that in 2022 the data was pulled for all eligible beneficiaries in the region. However, it was determined that the data would be more meaningful if it only reflected eligible beneficiaries served by each CMHSP. This explains the drop in potential enrollees from September 2022 to June 2023.

3. Decrease no-show/missed appointment rate for psychiatric services.

Region Wide No-Show Data

	Total Appointments Scheduled	Total No Show	%Total No Show	Audio Only Scheduled	Audio Only No Show	%Audio Only No Show	Video/ Telehealth Scheduled	Video/ Telehealth No Show	%Video/ Telehealth No Show	FTF Scheduled	FTF No Show	%FTF No show
2019	225018	12562	**5.58%**	1	0	**0.00%**	9544	970	**10.16%**	189718	11570	**6.10%**
2020	229678	17083	**7.44%**	90485	9120	**10.08%**	22052	1597	**7.24%**	116071	6351	**5.47%**
2021	235344	17050	**7.24%**	82605	8854	**10.72%**	32134	2666	**8.30%**	119595	5519	**4.61%**
2022	194798	12533	**6.43%**	26889	2432	**9.04%**	23456	2005	**8.55%**	145362	8081	**5.56%**



Next Steps

a. Discussion on challenges from various Boards.

b. Boards sharing successes.

c. Review common goals.

B. Site Reviews

1. HSAG Compliance Review

The FY 2022 compliance review was the second year of the three-year cycle of compliance reviews that commenced in FY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance review for Michigan PIHPs consists of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (FY 2021), and a review of the remaining seven standards in Year

Two (FY 2022). In Year Three (FY 2023), a comprehensive review was conducted on each element scored as *Not Met* during the FY 2021 and FY 2022 compliance reviews. The standards that were reviewed in FY22 are comparable to the standards reviewed in 2019. Although the FY22 standards were much more elaborate, there was still an 8% increase in 2022 compared to the outcomes from 2019. The practice guidelines had the lowest score, and some process changes were put in place to mitigate this situation. There was significant improvement in the Confidentiality standard and additional processes were implemented to maintain this standard.

The FY 2021 compliance review CAP was approved, and the CAP implementation is in progress. The FY 2022 CAP was submitted and accepted.

2019 HSAG Compliance Review

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	6	4	0	60%
Total	82	57	25	0	70%

2022 HSAG Compliance Review

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	84%
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	80%
Standard XI—Practice Guidelines	7	7	4	3	0	57%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	21	9	0	70%
Total	119	118	92	26	1	78%

2. NMRE Site Review

The NMRE conducts regional CMH site reviews biannually; year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. Fiscal year 2022 was a full review year for the NMRE's site review. The NMRE requested random sample of evidence from the CMHSPs. It was a Hybrid review where part was a deck review and NMRE staff went on site for separate piece.

Results Summary					
TOOL	OVERALL SCORE				
	AVCMHA	CWN	NCCMHA	NEMCMHA	NLCMHA
DMC	100%	99.4%	99.7%	97.9%	97.6%
Program Specific	97.37%	97.9%	97.4%	92.6%	95.8
Clinical Records	97.85%	98.2%	97.4%	96.6%	95.0%
Training			88.5%	85.4%	92.0%

Site Review Observations:

a. Most of the missing documentation; trainings were from 2020.

b. Most of the missing documents; trainings were from AFC Homes.

c. Unable to see a clear or separate training between the various specialties such as customer service, cultural competency, etc.

d. Some Boards did not have a training grid which would have made it easier to identify the various roles and trainings.

e. National Practitioner Databank (NPDB) checks were not incorporated in the initial verifications of clinical staff.

f. The CMHSPs are currently working on the CAPs for the FY2022 site review.

3. MDHHS Review

The NMRE team worked with the CMHSPs and MDHHS to complete the initial 2022 (c) Waiver (HSW, CWP, SEDW) review; this review occurs every other year. There were no outstanding trends among the five CMHSPs reviewed; however, there was a need for a technical assistance call with the five CMHSPs to clarify certain areas.

4. SUD Program Review

The NMRE conducts SUD Providers site reviews biannually; year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. The 2022 compliance review for SUD providers was a CAP review of the 2021 full review. This year the NMRE requested evidence of CAPs that were activated as a result of the 2021 NMRE site review. The SUD providers in the region were found to be substantially compliant with the CAPs.

C. Satisfaction Surveys

The NMRE will ensure that Network Providers have established policies and procedures that comply with regulations regarding member experience. Providers must conduct, at least annually, the regional consumer satisfaction survey in a way that is representative of all the individuals served including those receiving long term care (LTSS) such as case management, support coordination, etc.

The MI and I/DD survey was updated to include areas specific to individuals receiving LTSS. The NMRE Customer Services Specialist followed up on all negative comments or responses that were less than favorable.

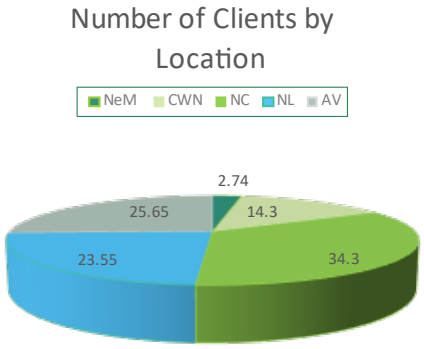
The NMRE used survey monkey to collect these data, and later aggregate and analyze the data. The results were reviewed with the Internal Operations Committee, QOC, and the NMRE Board. The results were also shared with the provider network and REP committees and placed on the NMRE.org website.

1. The following satisfaction surveys were completed:
    a. SUD Residential
    b. MH Outpatient
    c. Detox
    d. Methadone
2. The NMRE Customer Services Specialist and Compliance Director:
    a. Reviewed the surveys for trends and identified areas for improvement.
    b. Identified underperforming providers and reached out to them to implement a CAP and provide technical assistance.
    c. Followed up with the CAP through to completion.
3. Survey results were disseminated/communicated as follows:
    a. Shared with the individual providers.
    b. Shared and discussed during the SUD Director's meeting.
    c. Shared and discussed during the Compliance and Quality Committee meeting.
    d. Shared with the Board of Directors.
4. The following challenges to the survey process were identified:
    a. Low participation
    b. Lack of communication between staff and administration resulting in low participation.
    c. Not all clients returned to inpatient services.
    d. Completed surveys were not returned timely.

A few highlights from the survey as follows:

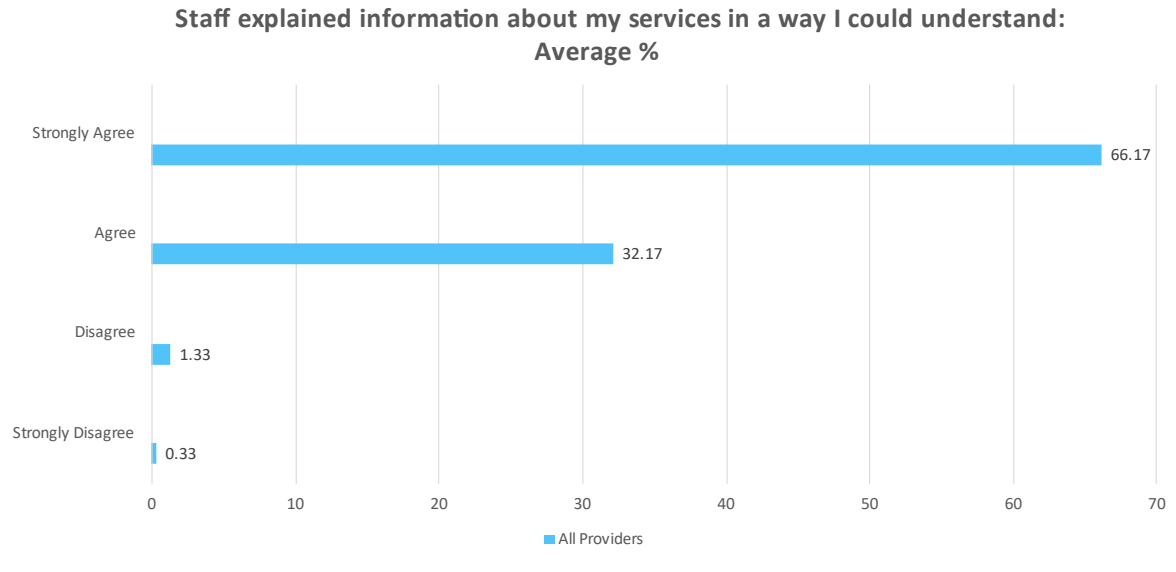
Mental Health Outpatient

- Total Responses: 620



Location # of Clients Completing Survey

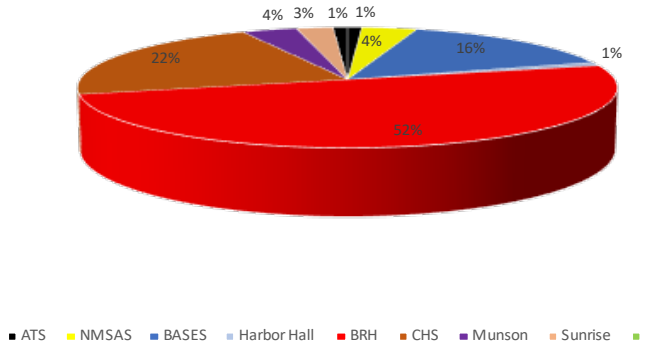
Northeast Michigan CMH	17
Centra Wellness Network	87
North Country CMH	211
Northern Lakes CMH	146
AuSable Valley CMH	159



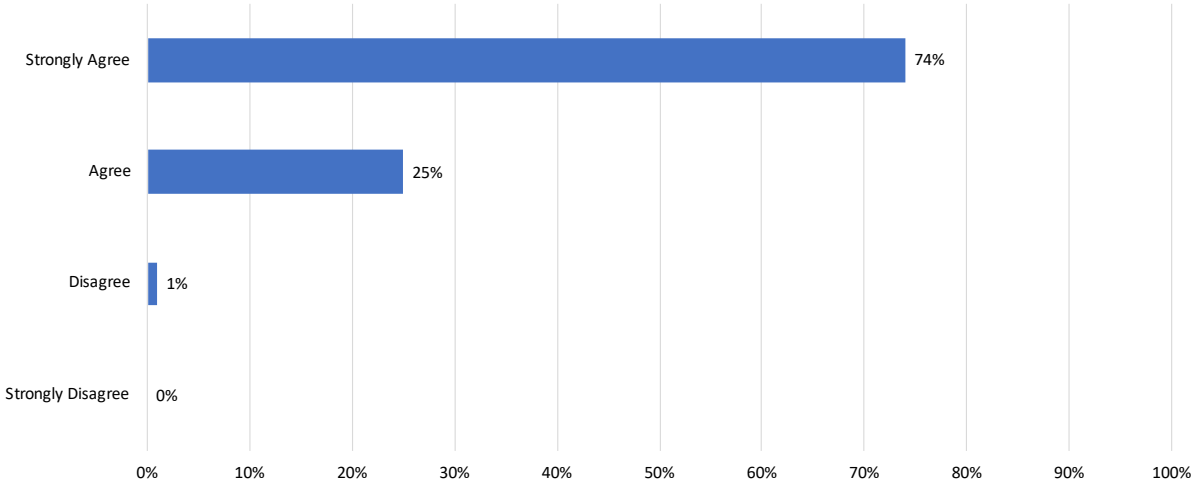
SUD Outpatient Survey

Responses : 238

Location	# of Clients
Addiction Treatment Service	3
Bear River Health	120
Sunrise Center	6
Catholic Human Services	52
Munson	9
Harbor Hall	1
BASES	37
NMSAS	9
GRACE Center	1



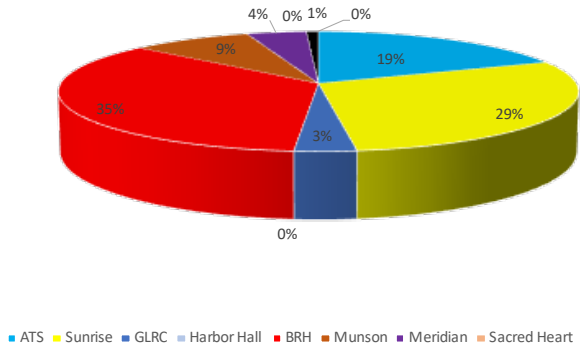
Services were provided quickly after I contacted the program.



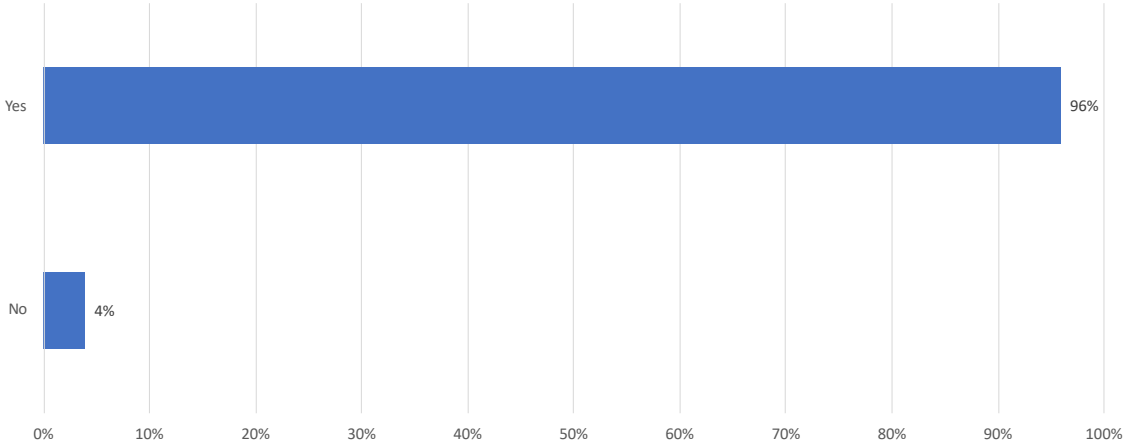
SUD Residential Survey

Residential Responses: 117

Location	# of Clients
Addiction Treatment Service	22
Bear River Health	41
Sunrise Center	34
Great Lakes Recovery Center	4
Munson	10
Harbor Hall	0
Meridian	5
Sacred Heart	0
Ten Sixteen	1
Dot Caring	0



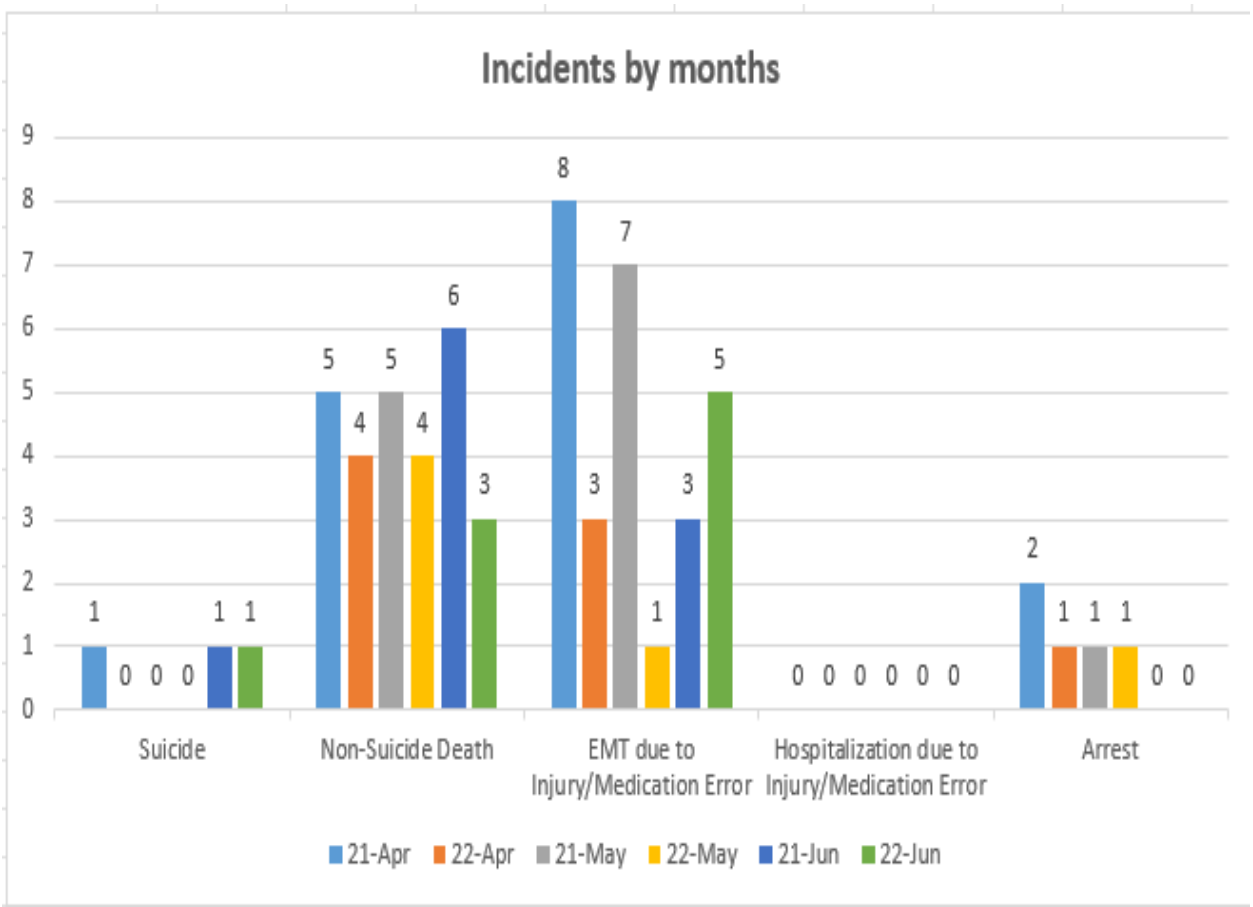
I am involved in my treatment planning.

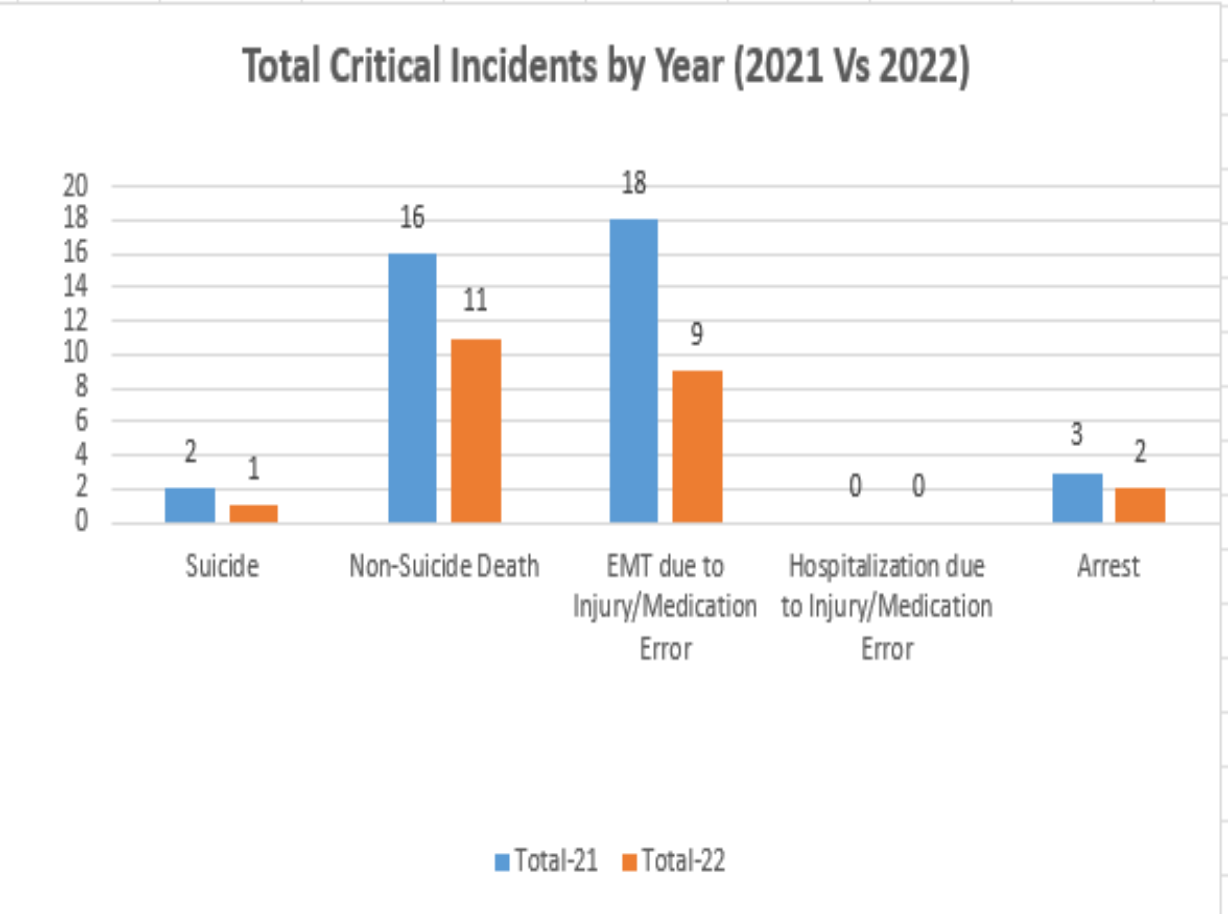


D. Events Data

1. Critical Incidents

Critical Incidents data were broken down by months and by year. March of 2022 had the highest number of incidents reported, however, there were no trends identified around this occurrence. Non—suicide death was the highest category in 2022. It was determined that the impact of COVID was the major cause of the increase in reported deaths. EMT due to injury/Medication error came second. This came as no surprise because Region 2 continues to experience a significant level of staff shortage and high turnover. Overall, there was a total of 106 critical incidents reported in 2022, a 29% decrease from 2021.

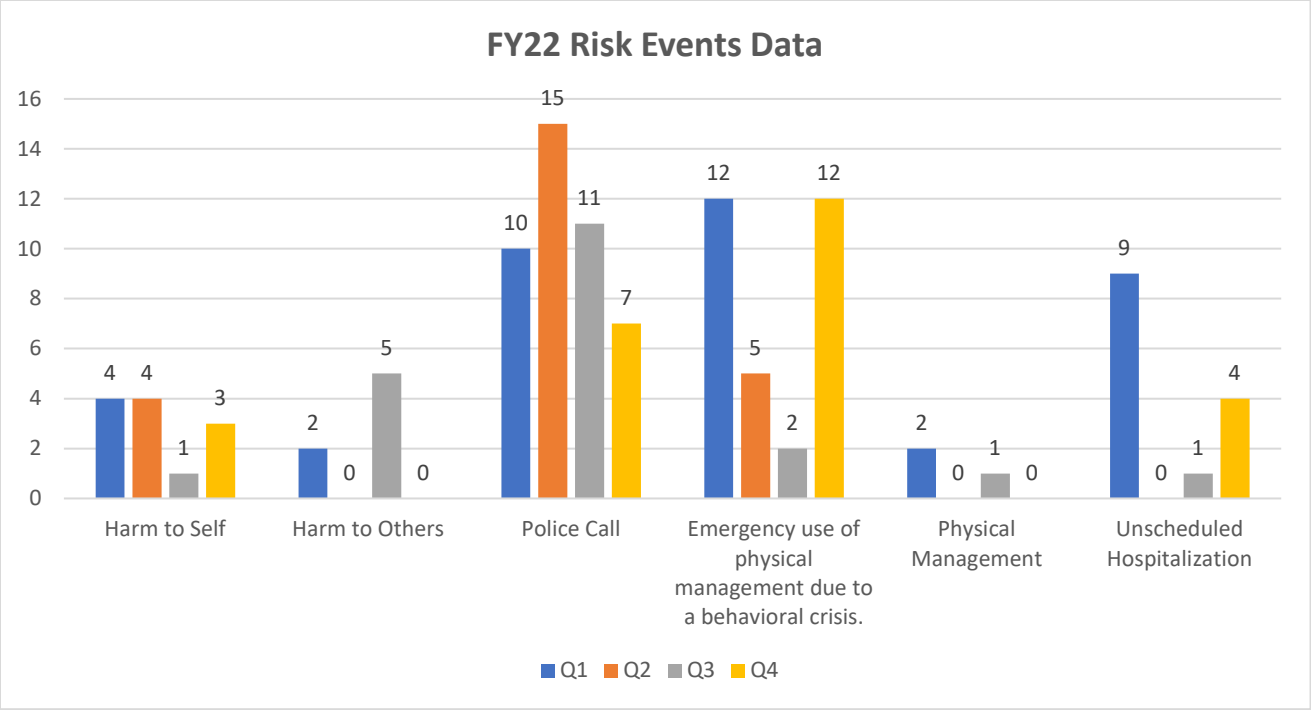




2. Risk Events Data

Risk events data were reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Police calls remained consistently high due to increasing cases with chronic behavioral issues with either less staffing or insufficiently trained staff due to the staff shortage and staff turnover in the region. Emergency use of physical management due to behavioral crisis came in second. This was again attributed to the high staff turnover and staff shortage which didn't allow staff to be properly trained before they fully assumed their duties.

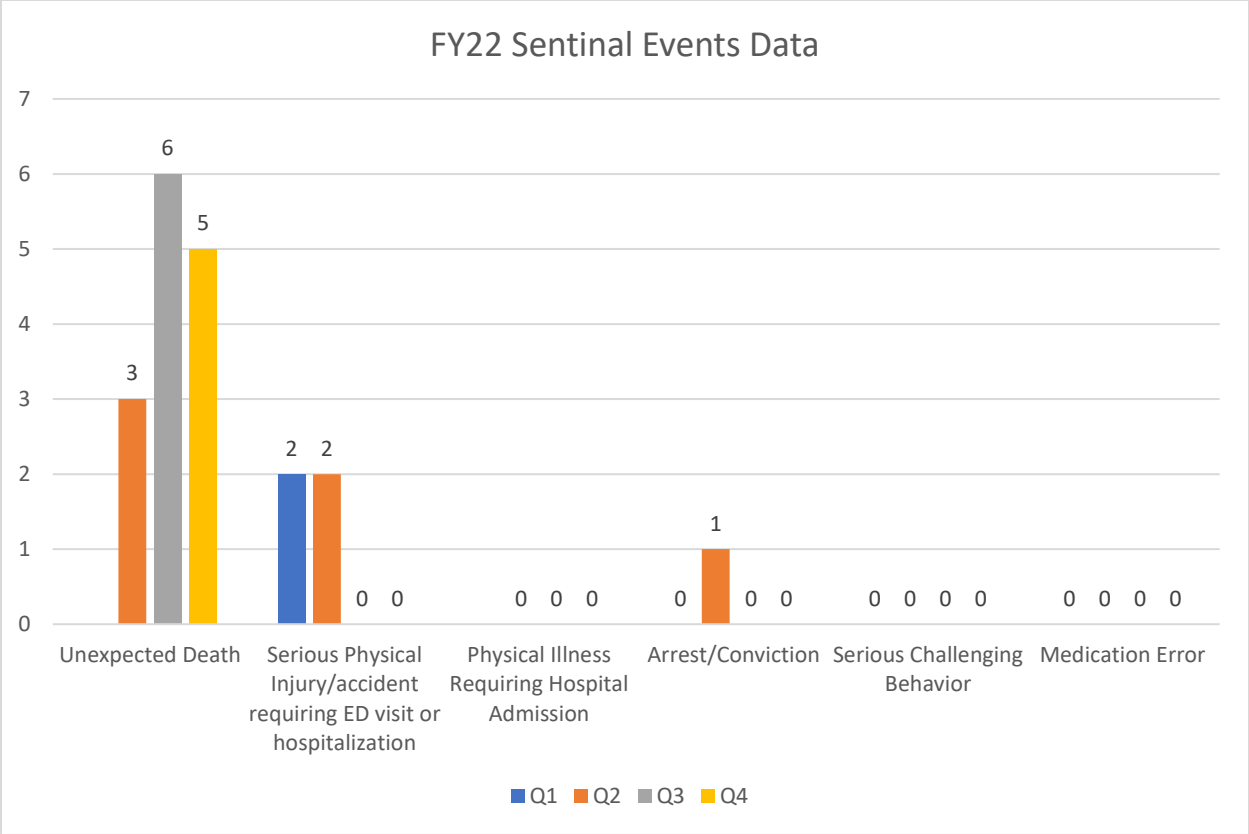
Event Type	Q1	Q2	Q3	Q4
Harm to Self	4	4	1	3
Harm to Others	2	0	5	0
Police Call	10	15	11	7
Emergency Use of Physical Management Due to a Behavioral Crisis	12	5	2	12
Physical management	2	0	1	0
Unscheduled Hospitalization	9	0	1	4



3. Sentinel Events Data

Sentinel events data were reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Suicidal death was the highest sentinel event reported; unfortunately, there was no identified trend. The cause of death and location varied; however, a need for enhanced crisis planning and the ongoing use of crisis plans was detected. It was also observed that there was an increase in substance use disorders and lack of training to properly identify SUD and high-risk individuals. Some of the CMHSPs created an SUD committee to address this need. Motivational Interviewing training was also being pursued.

Event Type	Q1	Q2	Q3	Q4
Unexpected Death		3	6	5
Serious Physical Injury/Accident Requiring ED Visit or Hospitalization	2	2	0	0
Physical Illness Requiring Hospital Admission		0	0	0
Arrest/Conviction	0	1	0	0
Serious Challenging Behavior	0	0	0	0
Medication Error	0	0	0	0



For critical incidents that were classified as a sentinel events, the NMRE had two business days to commence root cause analyses of the events. This was a challenge, however, because the information was not usually being passed on from the provider to the NMRE.

Reminders were provided during various regional committee meetings to make sure that information is being passed on to the NMRE appropriately. The initial sentinel event reporting form requires the CMHSPs and other providers to report sentinel events to the NMRE within 24 hours. The NMRE also implemented a Root Cause Analysis (RCA) form. The RCA must commence within two days of confirming that a sentinel event occurred and must be completed and submitted to the NMRE within 45 days unless an extension is requested. Extensions requests must be properly documented. The NMRE continued to provide reminders to the CMHSPs and the SUD providers. The NMRE will monitor the CMHSPs to make sure they are also providing similar trainings to their provides.

E. Performance Indicators

The Michigan Department of Health and Human Services (MDHHS) requires that the NMRE complies with certain quality measures as they relate to access to care, efficiency, and outcomes. The MDHHS established measures known as the Michigan Mission Based Performance Indicator System (MMBPIS).

The NMRE is required to share this data with MDHHS quarterly. This data is usually referred to as performance indicators and it is broken down by the various indicators in tables. The NMRE's goal for 2023 was to meet and exceed the MMBPIS measures.

Performance indicator data was shared with all the PIHPs and the Substance Use Disorder (SUD) Directors for review and feedback. During QOC and at the SUD Directors meetings, this data was presented and the opportunity for meaningful discussions was provided. During these meetings, the NMRE highlighted areas of success and areas with deficiencies were discussed.

It was discovered that there were certain situations when a client went back into the hospital prior to 7 days after discharge, the system did not pick up the exception consistently. This required a manual adjustment which was not usually completed consistently by all the Boards. It was also revealed that hospitals sometimes do not schedule the follow-up visit before a client leaves that hospital. Once the client leaves the hospital, it is sometimes difficult to reach them prior to the 7-day window. The CMHSPs worked with the hospitals to mitigate this situation.

For SUD access to care, due to the staffing shortage, it was sometimes not possible to have schedule an intake appointment within seven days. SUD providers continued to explore other options, such as telehealth to be able to bridge this gap.

The NMRE did not have the capability to obtain the value for table 2b – Timeliness/first request. As a result, the NMRE looked at expired requests and focused on ways to reduce that number.

Prior to the exceptions being removed from table2 2 and 3, the NMRE consistently scored values over 95%. With the exceptions in place, the percentages dropped. The NMRE routinely monitors statewide data on these indicators.

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# < 3 Hours	% < 3 Hours
Children	180	179	99.44%
Adults	770	761	98.83%
Total	**950**	**940**	**98.95%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	# In 14 Days	% In 14 Days
MIC	353	195	55.24%
MIA	910	498	54.73%
DDC	77	59	76.62%
DDA	33	20	60.61%
Total	**1,373**	**772**	**56.23%**

Table 2b – Access – Timeliness/First Request - Substance Use Disorder

Population	Admissions	Expired	# In 14 Days	% In 14 Days
SA	Calculated	217	Calculated	%

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	# In 14 Days	% In 14 Days
MIC	229	162	70.74%
MIA	515	330	64.08%
DDC	70	52	75.71%
DDA	22	14	63.64%
Total	**836**	**559**	**66.87%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
Children	59	14	45	45	100%
Adults	228	80	148	145	97.97%
Total	**287**	**94**	**193**	**190**	**98.45%**

Table 4b – Access – Continuity of Care - Substance Use Disorder

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
SA	255	102	153	145	94.77%

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	# Readmit in 30 Days	% Readmit in 30 Days
Children	59	0	59	4	6.78%
Adults	228	1	227	26	14.45%
Total	**287**	**1**	**286**	**30**	**10.49%**

F. Medicaid Encounter Verification

1. Medicaid Encounter Verification (MEV)

MEV audits of providers were conducted quarterly. This process allowed the NMRE to ensure that all claims for services were properly documented and that services were provided prior to payment. This audit was completed quarterly, and the results were shared with the providers. If an audited sample yielded less than 95% accuracy, a Plan of Correction was

required. If an audited population fell below 90% accuracy during a 12-month period, a stratified sample was pulled, and a plan of correction was required.

- CMHSP Direct Provided Services Population (5 Providers Total)
  40 Services per year, 10 per Quarter
- CMHSP Subcontractors Provided Services Population (5 Providers Total)
  40 Services per year, 10 per Quarter
- SUD Provider Population (1 Provider Total)
  60 Services per year, 15 per Quarter
- Financially Significant Population (3 SUD, 0 CMHSP)
  40 Services per year, 10 per Quarter

Any single provider that accounted for more than 10% of the total MH or SUD budgets accordingly.

- Stratified Population-if review yielded less than 90% accuracy

The MEV audit of the five (5) CMHSP yielded the following findings. For details on the population of providers, see sampling methodology above.

a. Five providers were audited (CMH Contracted Services and CMH Direct Services).

b. $146,890.56 dollars were audited, with $146,509.64 dollars validated.

c. 400 encounters were audited and 398 were valid.

d. $380.92 dollars were invalid.

e. 99.5% of encounters were compliant.

The MEV audit of ten (10) Substance Use Disorder Providers yielded the following findings. For details on the population of providers, see sampling methodology above.

a. A total of ten providers were audited.

b. $58,837.10 dollars were audited, with $55,890.72 dollars validated.

c. 180 encounters were audited and 153 were valid.

d. $2,946.38 dollars were invalid.

e. 85% of encounters were compliant.

The Medicaid Encounter Verification Audit for FY 2022 resulted in a few plans of correction which were due to the NMRE 30 days after the final MEV report was received by the providers. It was noted that several providers struggled with the following issues:

- Staffing shortage, especially with the SUD providers. As a result of this, staff were stretched too thin which caused them to miss certain aspects of the job.

- High turnover also played a major factor. When staff left, they took the knowledge they had gained with them; new staff needed to be trained all over again. During the training period, certain processes were missed as new staff getting on board.

Grand totals for the NMRE's FY 2022 MEV audit yielded the following findings. For details on the population of providers, see sampling methodology above.

a. 15 Providers in total were audited.
b. $205,727.66 dollars were audited, with $202,400.36 dollars validated resulting in a compliance rate of 95%.
c. 580 encounters were audited, with 551 encounters validated.
d. $3,327.03 dollars and 29 encounters were found to be invalid.

Persistent challenges such as the pandemic, high staff turnover, and staff shortage, caused a 1% decrease in MEV results in 2022 compared to 2021.

2. Prevention Program.

The NMRE contracted with four prevention providers to deliver evidence-based programs with fidelity standards as well as other services to prevent youth drinking, marijuana misuse, drug misuse, and youth tobacco sales within the 21-county region. The annual audit involveed a random sample method that included program monitoring, staff verifications, and Michigan Prevention Data System (MPDS) verifications and was conducted through site visits (if applicable), desk review, and concluded with an exit interview. The Prevention Monitoring tool broke down each section in detail to compile the results, as shown below.

Provider	Program Monitoring	Staff	MPDS	Synar Complete	Total	Records Audited
Catholic Human Services	90%	100%	73%		81%	19
Centra Wellness	59%	100%	86%		82%	13
District Health Dept #10	100%	100%	100%		100%	10
Health Dept of NW MI	98%	100%	100%		99%	14
District Health Dept #2						
NMRE Grand Total	**87%**	**100%**	**90%**		**91%**	**56**

Definitions/Explanations*

Program Monitoring- Review assessments, meeting minutes, publication samples/approvals, Prevention Plans, Cultural Competency, and reporting

Staff Verification- Credentials, background checks, and trainings

MPDS- Direct services are entered into this state system within 30 days of service. Contracted providers deliver supporting documentation that this activity occurred as billed.

Synar checks- In accordance with the Federal Youth Tobacco Act, the NMRE Contracts with Designated Youth Tobacco Use Representative (DYTUR) to ensure retailers do not sell tobacco or Electronic Nicotine Delivery Systems (ENDS) to underage persons.

G. Utilization Management (UM) Committee

A Regional Utilization Management (UM) Committee was formed in 2022. The purpose of this committee was to provide oversight and perform utilization management functions to control costs and minimize risk while assuring quality care. The NMRE UM Plan established a framework for oversight and guidance of the Medicaid program by ensuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services. Individuals and or entities that conduct utilization management activities must sign an attestation stating that compensation cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

The committee accomplished the following:

1. Reviewed the current UM processes for all the CMHSPs and SUD services providers.
2. Discussed authorization decision making processes to make sure that services are not being denied unnecessarily.
3. Other areas reviewed included:
    a. Service denials
    b. Telehealth
    c. Out-of-state placements
    d. Respite program
    e. 14-day compliance
    f. Intake and first services

H. Behavior Treatment Plan Review Committee (BTRC)

A regional Behavior Treatment Plan Review (BTPR) Committee was formed in 2022. The committee quarterly reviewed and analyzed data from the CMHSPs' Behavior Treatment Review Committees where intrusive or restrictive techniques were approved for use with beneficiaries and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that were approved during person-centered planning by the beneficiary or his/her guardian, were permitted to be used with beneficiaries. Data included the number of interventions and length of time the interventions were used per person.

In FY22, the committee accomplished the following:

1. Developed and approved the Behavior Treatment Review Committee (BTRC) Policy.

2. Reviewed and approved the BTRC data collection template.
3. Reviewed BTRC data from all five CMHSPs.

Once the data was reviewed, it was evident that more training was required. Some reports missed important details such as the length of time of the interventions. Additional training was provided to improve this process.

I. Credentialing and recredentialing

Exclusion/sanctions verifications

a. The NMRE completed exclusion checks for all NMRE employees, contractors, contracted entities/providers, and Board Members upon hire,prior extending a contract, and monthly thereafter.

b. The NMRE completed monthly checks for SUD Providers.

The databases that were searched included:

- MI_SPL – Michigan Medicaid List of Sanctioned Providers
- OIG – Office of Inspector General – List of Excluded Individuals/Entities
- OIG_Most_Wanted – Office of Inspector General – Most Wanted Fugitives
- SAM System for Award Management: Excluded Parties
- SDN – Office of Foreign Assets Control – Specially Designated Nationals
- NPDB – National Practioner Data Bank

J. Network Adequacy

The NMRE's anticipated monthly enrollment of Medicaid beneficiaries was approximately 180,444. Of the total Medicaid beneficiaries, children made up 31.9%, or 57,737 enrollees (Table 1: Enrollment).

Table 1. Enrollment

Funding	Age Group	Eligible Recipients (2020)	Eligible Recipients (2021)	Eligible Recipients (2022)
MC (excluding HMP)	At or Over 18	40,345	48,066	63,575
MC (excluding HMP)	Under	40,911	42,146	57,737
MC (excluding HMP)	Total	81,256	90,212	121,312
HMP	At or Over 18	36,896	50,301	59,132
HMP	Under	0	86	0

HMP	Total	36,896	50,387	59,132
Combined At or Over 18	At or Over 18	77,241	98,367	122,707
Combined Under 18	Under	40,911	42,232	57,737
Combined Total	Total	118,152	140,599	180,444

Based on the latest network adequacy report, the decline in ACT services ended in 2020; an increase of 7.3% wad observed in 2021, though 2023 again saw a decrease of 3% to 362 enrollees. (Table 2: ACT)

Table 2: ACT

Fiscal Year	Service Received	# of Enrolled Individuals
2018	ACT	362
2019	ACT	344
2020	ACT	328
2021	ACT	352
2022	ACT	342

Psychosocial Rehabilitation (Clubhouse) decreased slightly for the second year in a row. (Table 3: Clubhouse)

Table 3: Clubhouse

Fiscal Year	Service Received	# of Enrolled Individuals
2018	Clubhouse	380
2019	Clubhouse	372
2020	Clubhouse	369
2021	Clubhouse	333
2022	Clubhouse	314

Home-Based services increased steadily from FY 2018 – 2021, then saw a decrease of 31% in FY 2022. (Table 4: Home-Based)

Table 4: Home-Based

Fiscal Year	Service Received	# of Enrolled Individuals
2018	Home-Based Services	316
2019	Home-Based Services	358
2020	Home-Based Services	395
2021	Home-Based Services	434
2022	Home-Based Services	317

Wraparound services have remained relatively unchanged from FY 2018 through FY 2022. (Table 5: Wraparound)

Table 5: Wraparound

Fiscal Year	Service Received	People
2018	Wraparound	107
2019	Wraparound	124
2020	Wraparound	123
2021	Wraparound	127
2022	Wraparound	126

The NMRE region maintained 23 Children's Home-based full-time equivalents (FTEs) and 8.5 Children's Wraparound FTEs. CMHSP-specific data was reported as follows:

- AuSable Valley Community Mental Health: 2 Home-based FTEs, 3 Wraparound FTEs
- Centra Wellness Network: 2 Home-based FTEs, 1 Wraparound FTEs
- Northeast Michigan Community Mental Health: 3.5 Home-based FTEs, 1 Wraparound FTE
- North Country Community Mental Health: 6 Home-based FTEs, 1.5 Wraparound FTEs
- Northern Lakes Community Mental Health: 10 Home-based FTEs, 3 Wraparound FTEs

The NMRE met all the state identified standards of network adequacy for adult and child populations with the exception of Opioid Treatment Programs (OTP), which is very close to being met. The NMRE added a fourth OTP setting on April 1, 2022, in St. Ignace, Michigan to assist regional enrollees in obtaining this service in the northern portion of the region.

The NMRE and the member CMHSPs utilized single case agreements for enrollees in need of services that were not be available at the network adequacy standards; the NMRE utilized single case agreements when necessary for OPTs to ensure that services were conducted in accordance with PIHP and MDHHS policies and state, federal, and Medicaid regulations.

The NMRE's five CMHSPs contracted with a total of 44 adult crisis residential beds and 24 pediatric crisis residential beds (Note: COFR agreements completed as necessary). CMHSP-specific data was reported as follows:

- AuSable Valley Community Mental Health: 14 adult CRU beds, 24 pediatric CRU beds
- Centra Wellness Network: 24 adult CRU beds
- Northeast Michigan Community Mental Health: 14 adult CRU beds, 18 pediatric CRU beds
- North Country Community Mental Health: 12 adult CRU beds, 24 pediatric CRU beds
- Northern Lakes Community Mental Health: 44 adult CRU beds, 24 pediatric CRU beds

The NMRE used Power BI to build reporting structures to measure mileage and drive time from its CMSHPs to contracted inpatient psychiatric locations and Substance Use Disorder Providers by ASAM level, and continued this methodology for the CMHSPs' full array of service locations in FY 2023. The NMRE used the data reported in Power BI to project the time/distance requirements stated in its Specialty Supports and Services Contract with the State by rural distance standards. In addition, the NMRE used the data to provide adequacy reporting for the following enrollee-to-provider ratios:

Adult Services

- Assertive Community Treatment teams
- Psychosocial rehabilitation (Clubhouses)
- Opioid Treatment Programs (OTP)
- Crisis residential beds

Pediatric Services

- Home-Based regional FTEs
- Wraparound regional FTEs
- Crisis residential beds

CONCLUSION

The NMRE's QAPIP Report was reviewed and updated with input from various stakeholders and approved by the Governing Board. The NMRE's Board of Directors, the Operations Committee, the Internal Operations Committee (IOC) and the Compliance and Quality Oversight Committee (QOC) were responsible for the evaluation of the effectiveness of the QAPIP. The Annual Effectiveness Review included analyses of whether there have been improvements in the quality of healthcare and services for recipients due to quality assessment and improvement activities and interventions carried out by the NMRE. The analysis considered trends in service delivery and health outcomes over time and included the monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP was provided to network providers and to recipients upon request. The annual analysis was provided to the MDHHS no later than February 28, 2023.

The NMRE's QAPIP Report provided a summary of the accomplishments and highlights from the previous Fiscal Year as well as key information to determine whether current systems and processes provided desired outcomes. This report was shared with the NMRE Board of Directors, Provider Network, Regional Consumer Council, and other interested stakeholders.

The NMRE posted this document on its website at https://www.nmre.org. Copies of this document were made available to stakeholders upon request.

FY23 QAPIP Program WORKPLAN

Goal #1

The NMRE will conduct Performance Improvement Projects (PIPs) that achieve ongoing measurement and intervention, demonstrable 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 member satisfaction.

Objective #1

The NMRE Quality and Compliance Oversight Committee (QOC) will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program through September 30, 2023. The NMRE will collect data and conduct analysis in preparation for Measurement 1 to show evidence of enrollment improvement from the baseline by September 30, 2024.

Objective #2

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by September 30, 2024.

Objective #3

The NMRE QOC will collect data and conduct analysis for no-show/missed psychiatric appointments with a goal of decreasing the regional no-show/missed appointment rate for psychiatric services by the end of FY2024.

Goal #2

The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC will also work on improving the data quality and timeliness in reporting events.

Objective #1

The NMRE will provide training to providers on the type of data to collect, the population involved in this data collection, and timeliness in reporting. The expectation is that these providers will continue to train and remind their staff about this process.

Objective #2

The NMRE will update the incident reporting policy and will review the changes with network providers so they can also review the changes with their staff; this is intended to reduce underreporting.

Objective #3

The NMRE will continue to collect events data quarterly, analyze trends, and implement necessary interventions.

Objective #4
The NMRE will ensure that a root cause analysis (RCA) is completed and reviewed by the quality team to ensure that proper corrective action plans were implemented.

Objective #5
Annually, the NMRE will check to see if interventions are improving patient safety. This will be done by reviewing the data submitted which will include the number of events.

Goal #3
The NMRE will conduct quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract whit the State. Assessment results will be used to improve services, processes, and communication.

Objective #1
The NMRE will incorporate consumers receiving long-term supports or services (LTSS) (e.g., persons receiving case management, respite services or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

Objective #2
The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction.

Objective #3
The NMRE will conduct separate Substance Use Disorder (SUD) surveys, including Withdrawal Management/Detox and Methadone surveys, to identify specific member experiences.

Objective #4
The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Objective #5
The NMRE will outline systemic action steps to follow-up on the findings from survey results on an ongoing basis.

Objective #6
The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, the Regional Consumer Council (Regional Entity Partners), and post copy to the NMRE.org website.

Goal #4

The NMRE will monitor its network providers at least annually.

Objective #1

The NMRE will conduct site review annually for all contracted service providers by 9/30/2023.

Objective #2

The NMRE will monitor and follow-up on corrective action plans to ensure Corrective Action Plans (CAPs) are being implemented as stated by network providers.

Objective #3

The NMRE QOC will receive regular updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

Objective #4

The NMRE will perform quarterly audits to verify Medicaid claims/encounters submitted within the provider network. This will include verifying data elements from individual claims/encounters to ensure proper codes are used and proper documentation is in place.

Goal #5

The reginal Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.

Objective #1

The NMRE will monitor that only techniques permitted by the MSHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used with members through its annual site reviews by 9/30/2023.

Objective #2

The NMRE regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used.

Objective #3

The NMRE regional BTRC will monitor behavior treatment data quarterly, including the numbers of interventions and length of time the interventions were used per person.

Objective #4

The NMRE regional BTRC will review analyses of data from each CMHSP behavior treatment committee review process quarterly.

Objective #5
The NMRE QOC will review meeting minutes from the BTRC quarterly to assure that its reviews of data are accurate and complete.

Goal #6

The NMRE will establish regional HEDIS measures to demonstrate the effectiveness of improvements in the quality of health care and services for members as a result of the NMRE quality assessment and improvement activities and interventions carried out by the NMRE provider network. In addition, the NMRE will include other performance measures as established by MDHHS in areas of access to care, efficacy, and outcome.

Objective #1
The NMRE will provide HEDIS measure reports to the NMRE QOC on a regular basis.

Objective #2
The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment.

- Follow-up after hospitalization (FUH) for mental illness within 30 days.
- Follow-up after (FUA) emergency department visit for Alcohol and Other Drug Dependence.

Objective #3
The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment with the CMHSPs and identify interventions to improve these outcomes.

Objective #4
The NMRE OOC will continue to monitor the impact of the changes with FUH and FUA data. FUH and FUH are being calculated using the unaltered HEDIS specifications; this means that certain service coded that applied to these measures will no longer qualify.

Objective #5
The NMRE QOC will work provider network to maintain the performance measures that are already at 95% and above. This will also work at improving the measures that are under-performing especially with tables two (2) and three (3) where the exceptions were removed.

Objective #6
The NMRE and QOC will review performance measure data at least quarterly to identify areas for improvement and implement measures to improve.

Goal #7

The NMRE will meet and maintain the performance standards as set by the MDHHS and the PIHP contract with the state.

Objective #1
The NMRE will continue to meet all MDHHS MMPBIS and a 95% rate or higher for indicators 1, 4a, and 4b. The PIHP will also find ways to capture percentage for indicator 10 and be sure to maintain less than 15% for that standard.

Objective #2
The NMRE will continue to monitor the CMHSPs to ensure they are maintaining at least 95% for indicators 1, 4a, and 4b and als ensure they are staying below 15% for indicator 10.

Objective #3
The NMRE will require a corrective action from CMHSPs and providers for each indicator not met to quarters in a roll.

Goal #8

The NMRE will identify an external vendor to conduct Medicaid Encounter Verifications. (MEV) for the region. However, the NMRE will continue to pull the sample data.

Objective #1
The NMRE will identify a vendor that is suitable for this task, possibly a vendor that is already conducting similar tasks for other PIHPS.

Objective #2
The NMRE will inform the providers including the CMHSPs about the change in this process and the new vendor.

Objective #3
The NMRE will develop and implement timelines as to how and when this transition will occur.

Objective #4
The NMRE will invite the vendor to the SUD provider meeting and to QOC to introduce them and also have them explain their process and allow for questions and clarifications.

Objective #4
The NMRE will collaborate with providers and CMHSPs to make data available for the audit.

Goal #9

The Compliance Director will continue to provide quarterly updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities.

Objective #1
QAPIP activities will be reviewed and evaluated by QOC.

Objective #2

The QAPIP update report will be shared with the Governing Board quarterly.

Objective #3
QAPIP activities will be shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees and posting to the NMRE.org website.

Goal #10
The NMRE and its network providers will implement a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS). The NMRE will also develop and adopt additional regional practice guidelines.

Objective #1
The NMRE, in collaboration with its network providers, will review and adopt practice guidelines established by APA and MDHHS.

Objective #2
The NMRE, in collaboration with its network providers and stakeholders, will develop and adopt additional regional practice guidelines as they relate to the services provided pursuant to the NMRE's Specialty Supports and Services Contract with the State.

Objective #3
The NMRE will disseminate adopted practice guidelines to all affected providers, members, and potential members as needed.

Objective #4
The NMRE will publish adopted practice guidelines on the NMRE.org website to be accessible to all interested stakeholders.

Goal #11
The NMRE will update Sub-contractual Relationships and Delegation Agreements to include the recommendation from HSAG during the compliance review.

Objective #1
The NMRE will ensure that in future agreements there is specific language around "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".

Goal #12
The NMRE will update its credentialing and recredentialing standards to align with its Specialty Supports and Services Contract with the State and federal regulations.

Objective #1
The NMRE will update its annual monitoring tools, as applicable, to ensure evidence is collected in policy, procedure, and practice regarding its delegation review of member

concerns, grievances, appeal information, or quality issues during periods of individual practitioner recredentialing.

Objective #2
Because the CMHSPs have recently taken over running all staff in a monthly third-party exclusion check, the NMRE will annually and periodically ensure that the CMHSPs processes for exclusions checks are maintained each month and verify their processes for validation of the reports.

Objective #3
The NMRE will create a new monitoring tool specific to organizational credentialing and recredentialing using the HSAG tool as an example. The NMRE will ensure all standards in the MDHHS Credentialing and Recredentialing Guidelines are reviewed. The NMRE will further ensure that evidence of credentialing decision and accreditation or ongoing quality assessment, and timeframes, are reviewed.

Objective #4
The NMRE will host a series of Credentialing Roundtables for the region with the intention of educating staff that do the actual individual credentialing. This will allow the NMRE to drive a series of interactive meetings that allow the CMHSPs to discuss their processes as a group and review the following in an organized manner:

a. The NMRE's Specialty Supports and Services contract with the State's credentialing and recredentialing standards (including timeline and all credentialing application requirements),

b. HSAG's monitoring tool requirements,

c. NMRE's monitoring tool requirements,

d. CAP document and noted deficiencies,

e. MDHHS credentialing report requirements, and

f. Localized CMHSP practices that are responsible for deficiencies and recommended changes for "best practice."

Goal #13
The NMRE will transition substance use disorder (SUD) exclusion check activities from the NMRE to the SUD Providers. (The NMRE will continue to run exclusion checks for the SUD providers until the transition is complete.)

Objective #1
Review Exclusion Check policy with SUD providers and update, if necessary.

Objective #2
Share the Exclusion Checks Policy with providers and receive feedback to make sure everyone is on the same page.

Objective #3
Provide necessary information and assistance to ensure a smooth transition.

Goal #14

The NMRE will continue to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements.

Objective # 1
Develop, monitor, and track additional key performance indicators to detect patterns or trends.

Objective # 2
Research and engage in specific studies of various services based on established factors or criteria as it applies to the region.

Objective # 3
Conduct additional analysis on areas with significant variation in utilization patterns to identify root causes and opportunities for improvement.

Objective # 4
Incorporate LTSS into the UM plan.