Contents

Introduction

Health Services Advisory Group (HSAG) contracts with the Michigan Department of Health and Human Services (MDHHS) to conduct an independent review of quality and outcomes, timeliness, and access to services provided by Mid-State Health Network (MSHN). The three EQR mandatory activities include the following: The Performance Measures Validation, The Compliance Review, and The Performance Improvement Project Validation. A quality improvement plan (QIP) including improvement goals and objectives in response to the external quality review should be incorporated into MSHN's Quality Assessment and Performance Improvement Program.

Validation of Performance Improvement Projects (PIP)

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

MSHN's Performance Improvement Project for 2022 through 2025 is *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.*

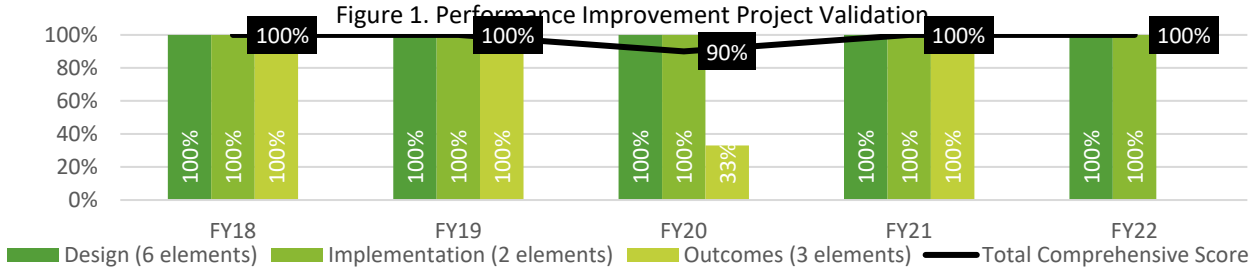
- Date Summary Submitted: 7/29/2022
- Initial Validation Report Received: 8/9/2022
- Date of Resubmission: 9/2/2022 Included clarification statements as recommended by HSAG.
- Final Validation Report Received: NA-A final validation report is not received if a status of "Met" has been achieved for the initial submission.

Validation Findings

MSHN received a status of "Met" indicating High confidence in reported PIP results.
HSAG reviewed the PIP for 9 evaluation elements. MSHN received 100% for all elements.

- Percentage Score of Evaluation Elements Met 100%
- Percentage Score of Critical Elements Met 100%

Figure 1. Performance Improvement Project Validation



FY20-Did not achieve statistically significant improvement.

Performance Measure Validation

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state and federal specifications and reporting requirements. According to CMS' *External Quality Review (EQR) Protocols, October 2019*,[1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a PIHP, or an external quality review organization (EQRO).

The PMV is conducted through an evaluation of system compliance, an overview of data integration and control procedures, and primary source verification. The following activities beginning in March, led up to the final PMV Remote Review on June 17, 2022.

- Statewide pre site webinar to overview of review process with frequently asked questions.
- PIHP completion/submission of the PIHP Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation from the PIHP and each CMHSP.
- PIHP submission of Member Level Detail File to support indicator data submitted to MDHHS.
- A submission and review of the PIHP and CMHSP Source Code that was used to calculate each performance indicators.
- Primary Source Verification of evidence and data for selected sample for the PIHP and each CMHSP. (Minimum of 310 individuals)

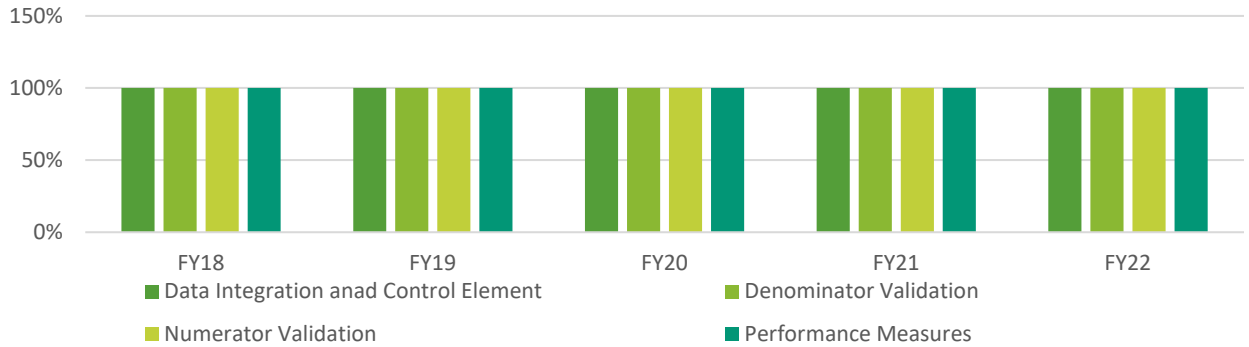
Draft Report Received 8.26.2022
Final Report Received: 9.23.2022

Validation Findings

MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- The Data Integration and Control- Thirteen Standards 100%
- Denominator Validation -Seven Standards (2 NA) 100%
- Numerator Validation – Five Standards 100%
- Performance Measures-Fourteen Measures Fully Validated 100%

Figure 3. External Quality Review Performance Measure Validation



Strengths:

- MSHN works closely with the regional CMHSPs to implement multiple interventions to improve access to services (e.g., same-day access, appointment reminders, psychiatric urgent care centers, utilizing paraprofessionals such as family support assistants, and developing a support program for inpatient high utilizers). [Quality, Timeliness, and Access]
- MSHN has been increasingly leveraging CAPs with delegated CMHSPs and reports that through the process of working closely with the CMHSPs and monitoring performance improvement efforts, it is collectively finding many systemic issues that are being addressed through process improvements. [Quality]

Growth Areas:

- MSHN should ensure all CMHSPs are using correct programming code consistent with MDHHS specifications and include enhancements to the validation process for the elimination or reduction of discrepant data for the BH-TEDS.

Recommendations:

- HSAG recommends that Mid-State Health Network ensure that programming code for all delegated CMHSPs does not identify no-show appointments as a compliant record for the performance indicator. Additionally, HSAG recommends that the PIHP continue using the Encounters-to-BH-TEDS report as an additional check of any records that show as compliant in the BH-TEDS record but do not have a corresponding encounter for the same date.
  Potential Remediation: Requires additional discussion with CMHSPs and MSHN Internal. If this process can be completed at the PIHP level with a high reliability it would potentially result in significant efficiencies for both the CMHSP and the PIHP.
- The MDHHS Codebook specifications state that the date of assessment must fall within 14 days following the service request. HSAG recommends that Mid-State Health Network ensure that programming code used for data extraction from source systems is not using service dates prior to the qualifying event to identify numerator compliance.
  Remediation: Add a validation step in REMI to flag those records that occurred on the same day and/or before the service request date.
- HSAG recommends that Mid-State Health Network ensure that all delegated CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator. HSAG also recommends that the PIHP include unusual case scenarios during QIC meetings with the CMHSPs in the region to ensure that all delegates are interpreting the scenarios consistently and in accordance with the specifications.
  Remediation: Execute a targeted remediation (as discussed in QIC) to include an increase in the sample size for primary source verification for those CMHSPs that used correct exception methodology.
- HSAG recommends that Mid-State Health Network and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.
  Remediation: The records included were old records previous to the implementation of the validations that would prevent illogical combinations. MSHN will review the validations and the outcome of the CMHSP monitoring during the DMC reviews, to verify no issues currently exist, and review options for efficiently closing old records.

Compliance Review

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid prepaid inpatient health plan (PIHP), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post stabilization services requirements described in §438.114 and the quality assessment and performance improvement requirements described in §438.330.

The Compliance Review is conducted over a period of 3 years. HSAG conducted a review of the first 6 standards for year one (2021). The remaining 7 standards were reviewed in year 2 (2022). The third year is used for a focused review on those standards that received a "not met" the previous two years resulting in a corrective action plan. The third year (2023) score is the score of all standards after the CAP has been completed.

The following activities beginning in March led up to the final Compliance Review on July 22, 2022.

- HSAG conducted a pre-site review preparation session to provide an overview of review process with frequently asked questions.
- Submission of primary source documentation for selected sample files.
- Submission of completed compliance review tools with supporting evidence.

Changes in 2021

Health Services Advisory Group modified the tools to align with the Federal Managed Care Final Rule.
The compliance review standards in Michigan were reduced from 17 standards to 13 standards.
The standards for Staff Qualifications and Training; and Disclosure of Ownership, Control and Criminal Convictions were removed. Standards related to the validation of the Network Adequacy were included.

Figure 4. Crosswalk of new standards

Previous Standards	New Standards
Standard I—QAPIP Plan and Structure (8)	**Standard XIII**—Quality Assessment and Performance Improvement Program
Standard II—Quality Measurement and Improvement (8)	
Standard III—Practice Guidelines (4)	**Standard XI**—Practice Guidelines
Standard IV—Staff Qualifications and Training (3)	n/a
Standard V—Utilization Management (16)	**Standard VI**—Coverage and Authorization of Services (11)
	Standard II—Emergency and Post stabilization Services (10)
Standard VI—Customer Service (39)	**Standard I**—Member Rights and Member Information
Standard VII—Grievance Process (26)	**Standard IX**—Grievance and Appeal Systems
Standard VIII—Members' Rights and Protections (13)	**Standard I**—Member Rights and Member Information (19)
Standard IX—Subcontracts and Delegation (11)	**Standard X**—Subcontractual Relationships and Delegation
Standard X—Provider Network (12)	**Standard VII**—Provider Selection
Standard XI—Credentialing (9)	

Previous Standards	New Standards
Standard XII—Access and Availability (19)	**Standard III**—Availability of Services (7)
	Standard IV—Assurances of Adequate Capacity and Services (4)
Standard XIII—Coordination of Care (11)	**Standard V**—Coordination and Continuity of Care (14)
Standard XIV—Appeals (54)	**Standard IX**—Grievance and Appeal Systems
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions (14)	n/a
Standard XVI—Confidentiality of Health Information (10)	**Standard VIII**—Confidentiality
Standard XVII—Management Information Systems (14)	**Standard XII**—Health Information Systems

Final Report 2021 Received: 11/1/2021
Draft Report 2022 Received 10/14/2022
Final Report 2022 Received: 11/7/2022
Corrective Action Plan Due: 12/5/2022

Review Findings

Total Comprehensive Score 88% (105/119 Elements)

Standard VII-Provider Selection 75% (12/16 Elements)

Required Actions

Elements 14-16. The PIHP must comply with, and ensure delegates performing recredentialing, credentialing, activities comply with all initial credentialing, credentialing, organizational credentialing requirements as outlined in its contract with MDHHS.

Standard VIII-Confidentiality 91% (10/11 Elements)

Required Actions

Element 11. The PIHP must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3).

Standard IX- Grievance and Appeal System 84% (32/38 Elements)

Required Action

Elements 4, 16. The PIHP must acknowledge receipt of each appeal.

Elements 6, 21, 27. The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PIHP receives the appeal. For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice.

Element 25. For untimely appeal resolutions, the PIHP must ensure that the appeal is deemed exhausted, and members are provided immediate access to their State Fair Hearing (SFH) rights.

Standard X-Sub contractual Relationships and Delegation 100% (5 Elements)

No required action

Standard XI- Practice Guidelines 100% (7 Elements)

No required action

Standard XII-Health Information 92% (11/12 Elements)

Required Action

Element 7. The PIHP must implement a Patient Access API that meets all requirements under 42 CFR §431.60 (member access to and exchange of data) and complies with the implementation guidelines required by CMS.

Standard XIII-Quality Assessment and Performance Improvement Program (93% 28/30 Elements)

Required Action

Element 25. As a result of the member satisfaction assessments, the PIHP must evaluate the effects of activities implemented to improve satisfaction.

Element 27. The QAPIP evaluation must include the results of any efforts to support community integration for members using Long Term Supports and Services (LTSS).

Health Services Advisory (HSAG) 2021-2022 Recommendations-Appendix A

Health Services Advisory Group (HSAG) 2022 Recommendations-Appendix B

HSAG Michigan Performance and Recommendations

The External Quality Review Technical Report for Prepaid Inpatient Health Plans, published annually, includes the performance for each PIHP for the Performance Improvement Project Validation, The Compliance Review, and The Performance Measure Validation. Each PIHP provides a status of actions that have been established to improve organizational performance. HSAG includes statewide strengths, growth areas and recommendations to enhance the current goals within the MDHHS Quality Strategy. The HSAG Technical Report has not been published yet for 2022.

State FY 2021 External Quality Review Technical Report for Prepaid Inpatient Health Plans

MSHN Next Steps/Recommendations

- Communication of results to MSHN internal staff and assign responsibility for follow up.
- Identify action steps to address citations that cross standard sections.
    - Board/Committee/Council Meeting minutes:
        - Name and title of attendees
        - Name of organization in which each attendee represents
        - Include documentation of feedback provided by organization and committee/council to ensure follow up.
        - Include action such as approval and adoption on the meeting minutes.
- Develop summary of recommendations with interventions for submission to HSAG.
- Develop a corrective action plan based on the Final Compliance Review Report to be submitted for review by November 30th, with submission to HSAG by December 5th.
- Goals and objectives developed by responsible department to address the External Quality Review findings and relevant recommendations will be added to the QAPIP Work Plan for FY23.
- Review MI2022 PIHP EQR TR Report, when published for statewide recommendations.