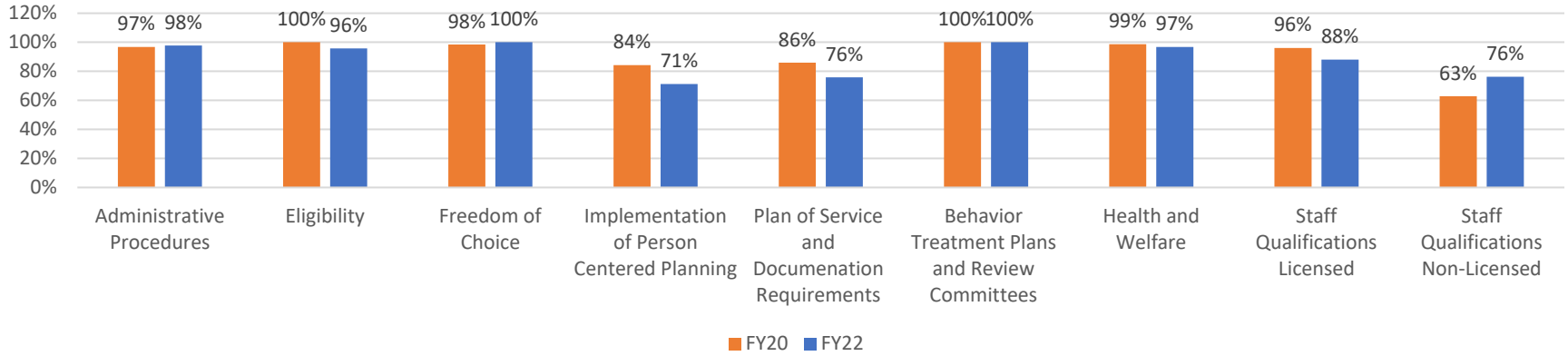
Introduction:

MDHHS conducted a site review for the 1915 (c) Waivers to ensure compliance and provide technical assistance related to the Children's Waiver Program (CWP), the Habilitation Supports Waiver(HSW), and the Serious Emotional Disturbance Waiver (SEDW) within the Mid State Health Network (MSHN) region. The review occurred June 13, 2022 through July 29, 2022. MDHHS reviewed thirteen (13) CWP records including forty (40) licensed staff, and seventy-seven (77) non-licensed staff. MDHHS reviewed forty-one (41) HSW records including one hundred and seven (107) licensed staff, and seven hundred and thirty-seven (737) non-licensed staff. MDHHS reviewed thirty (30) SED records including one hundred and thirty-six (136) licensed staff, and fifty-eight non-licensed staff. MSHN received the Final MDHHS Review Report on August 15th.

Following the receipt of the Final Report, a regional summary was developed to clearly identify those sections that decreased in performance from the prior review (2020) or demonstrated an unacceptable performance level. The results were reviewed with the MSHN internal waiver team, MSHN Waiver Review Leads, the Regional Quality Improvement Council, MSHN Clinical Leadership Committee, MSHN Compliance Committee. Each section was reviewed to identify specific standards that provided a challenge to the region. Barriers were identified with interventions to prevent recurrence, thereby improving the performance with the standard for the region. Each CMHSP participant reviewed the findings and developed a plan for individual remediation and systemic remediation. MSHN reviewed the overall findings with a focus on the repeat findings. Additionally, MSHN reviewed areas in the region could benefit from regional action to prevent reoccurrence. This report will provide an overview of the findings and actions recommended through the regional councils/committees. The action steps will be included in the Quality Assessment and Performance Improvement Work Plan for FY23.

Figure 1 Comprehensive Total for SED, CWP, and HSW Combined.



The tables below provide a comparison of the 2022 areas that require individual or systemic corrective action to the 2020 site review results. The red font indicates a repeat finding.

Administrative Procedures

A. 1. All Waivers Administrative Procedures	FY20	FY22
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents.	100%	100%
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents.	100%	100%
A.1.3 Review and verify that the process is being implemented according to policy.	100%	100%
A.1.4 PIHP/CMHSP is implementing the Quality Improvement Project as approved by MDHHS. • PIHPs/CMHSPs document evidence of training on the revised IPOS policy/procedures. • PIHPs/CMHSPs incorporate ongoing monitoring tools for IPOS training into the internal review process. • PIHPs/CMHSPs incorporate ongoing monitoring tools for SEDW to ensure service and supports are provided as specified in the plan.	NA	NA
A.1.5 The PIHP/CMHSP has a policy that guides the contracting process with new providers or providers who are expanding their service array. These policies ensure new providers are assessed to ensure they do not require heightened scrutiny based upon isolating of institutional elements. • PIHP/CMHSP provides evidence of the policy • Review of PIHP/CMHSP provisional approval documents	100%	100%
A.3 SEDW Administrative Procedures	FY20	FY22
A.3.2 CMHSP has a process to prior authorize all services. (PM A-3)		100%
A.3.3 Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)		90%
A.3.HSW Administrative Procedures	FY20	FY22
A.3.1. If a Waiver enrollee receives Environmental Modifications or Equipment, the PIHP has implemented prior authorizations in accordance with their process. (HSW PM A-4) (NA=38)	80%	100%
A.2.CWP Administrative Procedures	FY20	FY22
A.2.2. Claims are coded in accordance with MDHHS policies and procedures. /Prior Auths (PM I-1)	100%	92.31%

Implementation of Person-Centered Planning

P.2 HSW Implementation of Person-Centered Planning	FY20	FY22
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	98%	85%
P.2.3. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.	98%	100%
P.2.4. The individual plan of service is modified in response to changes in the individual's needs.(HSW PM D-6)	91%	93%
P.2.5. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life.MCL 330.1701(g)	98%	90%
P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	77%	68%
P.2.7: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence:1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	93%	68%
P.2.8: Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed). (NA=29)	67%	58%
P.1. CWP Implementation of Person-Centered Planning	**FY20**	**FY22**
P.1.1: The IPOS is developed through a person- centered process that is consistent with Family- Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. (PM-D-3)	92%	77%
P.1.2: The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	85%	92%
P.1.3: The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers. (PM-D-2)	78%	85%
P.1.4: The IPOS is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. plan contains measurable goals/objectives and time frames; 2. Category of Care/Intensity of Care determination was completed by staff certified or trained by MDHHS in Category of Care/Intensity of Care determination. (PM D-4)	85%	8%

P.3 SEDW Implementation of Person-Centered Planning	FY20	FY22
P.3.1. The IPOS is developed through a person- centered process that is consistent with Family-Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. (PM-D-3)	75%	67%
P.3.2: The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	89%	90%
P.3.3: The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care provider. (PM-D-2)	79%	67%
P.3.4 IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. IPOS contains meaningful and measurable goals and objectives. 2. Prior authorization of services corresponds to services identified in the IPOS. (PM-D-4)2020: Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or “up to” language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements.	61%	20%

Plan of Service Documentation

P.5 HSW PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS	FY20	FY22
P.5.1. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)NOTATION: Technical Assistance provided around the use of ranges/range language in recommending/authorizing supports and services. Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or "up to" language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements.	65%	22%
P.5.2. Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing. (HSW PM D-7)	77%	51%
P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. (HSW PM D-5)	93%	100%
P.4.CWP Plan of Service and Documentation Requirements	**FY20**	**FY22**
P.4.1: A current narrative supports the identified Category of Care/Intensity of Care determination and services are authorized and provided accordingly. (PM-D-4)	77%	92%
P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM-D-7)provided around the use of ranges/range language in recommending/authorizing supports and services. Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or "up to" language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements.	69%	23%
P.4.4: Physician-signed prescriptions for OT, PT, and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed. (PM-D-4) NA=12	100%	100%
P.4.5: Physician-signed and dated prescriptions for locally authorized waiver durable medical equipment and supplies are in the file. (PM-D-4) NA=11	NA	100%
P.4.6: The IPOS was updated at least annually. (PM-D-5)	100%	100%
P.4.7: The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs (evidence: IPOS is updated if assessments/quarterly reviews/progress notes indicate there are changes in the child's condition). (PM-D-6)	100%	85%
P.6. SEDW (PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS)	**FY20**	**FY22**
P.6.1 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM D-7)	68%	53%
P.6.3 Physician-signed prescriptions for OT, PT, services in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed. (PM D-4) NA=29	NA	100%
P.6.4 The IPOS was updated at least annually NA=6	100%	92%
P.6.5: The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs (evidence: IPOS is updated if assessments/quarterly reviews/progress notes indicate there are changes in the child's condition). (PM D-6)	96%	67%

Behavior Treatment Plan

B. BTPRC	FY20	FY22
B.1.The BTPRC process includes all the following elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR. 2. Evaluation of committees' effectiveness occurs as specified in the TR. 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of intrusive/restrictive techniques by each individual receiving the intervention. 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques. 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis. 6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or hospitalization and death are reported to the Department via the event reporting system. 7. Documentation that there is a mechanism for expedited review of proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.	100%	100%
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved or disapproved by the committee. 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly. 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan. 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year). 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.	38%	78%

Health and Welfare

HSW Health and Welfare G.1-G.2 (New Section 2020) (2 elements)	FY20	FY22
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.	95%	100%
G.2 Individual served received health care appraisal.	100%	98%
CWP Health and Welfare G.1-G.2 (New Section 2020) (2 elements)	**FY20**	**FY22**
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.	100%	92%
G.2 Individual served received health care appraisal.	100%	100%
SEDW Health and Welfare G.1-G.2 (New Section 2020) (2 elements)	**FY20**	**FY22**
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.	100%	97%
G.2 Individual served received health care appraisal. (Date/document confirming	96%	93%

Staff Qualifications

Q.2. HSW Staff Qualifications	FY20	FY22
Q.2.1. The PIHP ensures that Waiver service providers meet credentialing standards prior to providing HSW services. (HSW PM C-1) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	96%	88%
Q.2.2. The PIHP ensures that Waiver service providers continue to meet credentialing standards on an ongoing basis. (HSW PM C-2) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	93%	88%
Q.2.3. The PIHP ensures that non-licensed Waiver service providers meet the provider qualifications identified in the Medicaid Provider Manual. (HSW PM C-3) Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.	88%	88%
Q.2.4 All HSW providers meet staff training requirements. (HSW PM C-4) Not limited to group home staff. All HSW providers for the samples should meet staff training requirements (includes own home and family home). evidence: Training records: • Has received training in the beneficiary's IPOS.	60%	89%
Q.1. CWP Staff Qualifications	**FY20**	**FY22**
Q.1.1 Clinical service providers and case managers are credentialed by the CMHSP prior to providing services. (evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP). (PM C-1)	95%	82%
Q.1.2. Clinical service providers and case managers are credentialed by the CMHSP ongoing. (evidence: personnel records and credentialing documents-including licensure and certification and required experience for QIDP) (PM C-2)	100%	87%
Q.1.3 Non-licensed/non-certified providers meet provider qualifications. Personnel records contain documentation that staff is: 1. At least 18 years of age, 2. In good standing with the law 3. Able to practice prevention techniques to reduce transmission of any communicable diseases. Documentation staff has completed all core training requirements – e.g. recipient rights, prevention of transmission of communicable diseases, first aid, emergency procedures, and that staff is employed by or on contract with the CMHSP or hired through Choice Voucher arrangements.) (PM C-3)	58%	71%
Q.1.4 All CWP providers meet training requirements including training of CLS/Respite staff on the implementation of the IPOS by the appropriate professional. (evidence: case file notes identifying the who, what and when of training, personnel files with documentation of training). (PM C-4)	54%	69%

Q.3 SEDW Staff Qualifications	FY20	FY22
Q.3.1 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP prior to providing services. (evidence: personnel records and credentialing documents – including licensure and certification and required experience for child mental health professionals). (PM C-1)	99%	94%
Q.3.2 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP ongoing. (evidence: personnel records and credentialing documents-including licensure and certification and required experience for child mental health professionals). (C-2)	94%	89%
Q.3.3 Non-licensed/non-certified providers meet provider qualifications. Evidence: personnel records contain documentation that staff is: 1. At least 18 years of age, 2. Is in good standing with the law 3. Is free from communicable disease. Documentation staff has completed all core training requirements – e.g. recipient rights, prevention of transmission of communicable diseases, first aid, emergency procedures, and that staff is employed by or on contract with the CMHSP.) (PM C-3)	67%	93%
Q.3.4 All SEDW providers meet training requirements including training of CLS/Respite staff on the implementation of the IPOS by the appropriate professional. (evidence: case file notes identifying the who, what and when of training, personnel files with documentation of training). (PM C-4)	50%	47%

Next Steps:

- MSHN in collaboration with the CMHSP participants will develop an individual and systemic remediation plan to address the areas that were not in full compliance.
- MDHHS will approve the corrective action plan.
- A Follow Up review will occur 90 days from the date MDHHS approved the CAP.

References:

MSHN R5 2022 Exit Webinar
MSHN_R5_FY22 CWP Report Final
MSHN_R5_FY22 SEDW Report Final
MSHN_R5_FY22 HSW Report Final