Macomb County Community Mental Health

Quality Assessment and Performance Improvement Program (QAPIP) Description

Fiscal Year 2026

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/25/2026

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INTRODUCTION

Macomb County Community Mental Health (MCCMH) is the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) for Macomb County. MCCMH is the third largest Community Mental Health Services Program in the State of Michigan. MCCMH holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Care Specialty Supports and Services Waiver Programs and Substance Use Disorder (SUD) Grant Programs. In addition, MCCMH participated in the expanded Certified Community Behavioral Health Clinic (CCBHC) during its inception and has continued to participate as a CCBHC Demonstration Site. MCCMH is also a SUD Health Home and Behavioral Health Home. This places MCCMH in a unique position to offer a full array of services and support to individuals seeking services.

This document outlines requirements for the Quality Assessment and Performance Improvement Program (QAPIP) Description as described in the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement and the MDHHS Behavioral and Physical Health and Aging Services Administration for Specialty PIHPs. It also describes how these functions are accomplished and the organizational structure and responsibilities related to these functions.

Mission

MCCMH, guided by the values, strengths, and informed choices of the people we serve, provides quality services, which promote recovery, self-sufficiency, and independence.

Values

MCCMH has a phrase that drives its mission to serve its community. The phrase is "Putting People First." The way MCCMH ensures it is putting people first is by embracing the core values of being accountable, collaborative, and respectful in all interactions. MCCMH core values are incorporated into all team member functions. MCCMH's core values are best implemented into actions when the below statements are true in all interactions:

Collaborative: "I approach all situations with a teamwork and solution focused mindset."

Accountable: "I take ownership and empower others to do the same."

Respectful: "I treat people with dignity while honoring individual differences."

Quality Improvement Authority and Scope

MCCMH's Quality Improvement (QI) Program aims to provide the structure and processes necessary to improve the clinical care and quality of services for persons served. MCCMH's QI Program includes multidirectional input from its Governing Body (MCCMH's Board of Directors), Executive Leadership, Quality Improvement Committee, persons served, and providers.

The Quality Improvement Program realizes success through data and measurable outcomes to determine progress toward regulatory and accreditation requirements. The QI Program is committed to continuous quality improvement and is evaluated annually for its overall effectiveness. Based on the annual evaluation findings, the QI Program is modified to ensure opportunities are acted upon to improve the quality of care members receive.

Objectives

To achieve the overarching goals of the Quality Improvement Program, MCCMH has identified the following program objectives to work towards, herein referenced as its Quadruple Aim:

Objective	Purpose
1) Obtain National Committee for Quality Assurance (NCQA) MBHO Accreditation at full accreditation (score of >84)	Demonstrate a high-level of adherence to industry best practices, resulting in high-quality care, access and member protections, and outcomes. Quality goals focus on quality improvement, member rights and responsibilities, practitioner and facility credentialing, utilization management, and care coordination and collaboration with behavioral health and physical health providers.
2) Maintain Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation	Demonstrate MCCMH's commitment to continually enhance the quality of services and programs with a focus on the satisfaction of persons served.
3) Achieve a score of >90% on Member Satisfaction Survey	Achieving a score of > 90% on the Member Satisfaction Survey demonstrates that members are accessing high-quality provider care and are generally satisfied with the services of MCCMH and its Provider Network.
4) Achieve a score of > 90% on Provider Satisfaction Survey	Achieving a consistently high level of provider satisfaction demonstrates that providers are successfully understanding and implementing MCCMH policies and guidelines. This level of satisfaction demonstrates that MCCMH is generally supporting providers in achieving goals necessary to provide quality care to persons served.

Approach to Quality

The Quality Improvement Program is developed and evaluated in alignment with the Quadruple Aim and other regulatory and accreditation requirements. MCCMH utilizes several strategies and approaches to ensure the Program is effective in improving the health and health outcomes of MCCMH's persons served.

Quality Improvement Governance

MCCMH's organizational structure enables clear and effective administration and evaluation of the QAPIP Description. MCCMH's Chief Executive Officer provides guidance and supervision to the Chief Quality Officer. The Chief Quality Officer is responsible for the development and implementation of the QAPIP and provides quarterly reports to the Quality Committee and the Governing Board (MCCMH Board of Directors) on activities related to the QAPIP; this includes, but not limited to, Key Performance Indicators (KPI); performance improvement projects; sentinel events, critical incidents, and risk events; monitoring of over and underutilization; provider monitoring, etc., as set by MDHHS standards. This report describes current performance improvement plans, actions taken, and results of actions. Board minutes illustrate when progress reports are presented and reviewed.

MCCMH Governing Body - Board of Directors

1. Membership: MCCMH's Board currently includes 12 members representing the people of Macomb County.
2. **Role/Function:** The Governing Board retains the responsibility for the review and approval of the QAPIP, administrative policies, and overall governance. The Board's approval of the QAPIP will be evidenced in the meeting minutes and the QI Work Plan. The Board monitors, evaluates, and assists with the establishment of policies that support the provision of quality care in the region.
3. QAPIP Progress Reports: The Governing Board routinely reviews reports of current activities, actions taken, and the impact of those actions as presented by the Chief Quality Officer during scheduled Board Meetings. Such reviews are evidenced in meeting minutes.
4. Annual QAPIP Review: At least annually, the Governing Board formally reviews a written report on the QAPIP. The annual QAPIP review is evidenced in meeting minutes.
5. Reporting Accountability: The Governing Board reports to stakeholders via Committees and Board Meeting Minutes. Following the Board's review and approval of the QAPIP, the report is submitted to MDHHS. Each annual submission to MDHHS includes a list of members of the Governing Body. This submission must occur by February 28 of each year. MCCMH's current QAPIP is on a three-year cycle.
   5.1. February 28, 2025: First Year – Finalize QAPIP FY 2025-2027
   5.2. February 28, 2026: Second Year – Review QAPIP FY 2025-2027
   5.3. February 28, 2027: Third Year – Final Review QAPIP FY 2025-2027

Quality Improvement Monitoring and Reporting

The MCCMH Quality Improvement Program builds upon traditional quality assurance activities while simultaneously engaging in continuous quality improvement activities. The activities are directed at operationalizing the mission of MCCMH and ensuring the provision of quality care to persons served.

Quality processes include measuring MCCMH against predefined standards, utilizing formal and informal assessment activities, utilizing data to measure performance against standards, and identifying strategies with which to improve areas.

Key Performance Indicators

MCCMH has adopted the KPI for behavioral health. MCCMH is responsible for overseeing established performance measures based on Michigan's Mission-Based Performance Indicator System (MMBPIS) developed by MDHHS. Standards for performance measure compliance for FY 2025 were based on the MMBPIS Codebook. Indicators 1, 4a, and 4b have a standard of 95% or better, and Indicator 10 has a standard of 15% or less. MDHHS is in the process of revising PIHP reporting as detailed in MDHHS' CY 2027 PIHP Reporting Codebook 'Access to Care Measure.' MCCMH will continue to revise its KPIs and associated processes to comply with new requirements.

In September of 2024, the Bureau of Specialty Behavioral Health Services introduced a new set of quality measures with a three-year rollout strategy. The program will be more comprehensive with a more rigorous methodology that aligns with other state and national requirements (HEDIS measures). The first year will focus on aligning reporting requirements for PIHPs with Centers for Medicaid and Medicare Services (CMS) Core Set Reporting. By the end of the Year 1 measure roll-out, all required CMS Core Set measures will be available by PIHP. All measures in this table will possibly be stratified by race/ethnicity.

Current KPIs include indicators in the domains of Access, Efficiency, and Outcomes. MMBPIS data and provide set standards for measures based on rationale for use, population, and indicator-specific selection and exception methodology. From these set standards, MCCMH has developed internal processes and validation activities to ensure data is valid and reliable. Strategies to ensure the systematic ongoing collection and analysis of valid and reliable data through MCCMH's electronic medical record (EMR) system (FOCUS) and interactive dashboard development are a collaborative effort among key departments within MCCMH. Departmental collaboration includes Quality, Information Systems, and Data Informatics. MCCMH has used a combination of validation activities, including primary source verification, member-level detail file reviews, and ensuring that source code is up to date, to ensure reports are pulling information from the most up-to-date standards.

MCCMH also has internal reporting standards to monitor and analyze data collection. Data is reported to the Quality Committee and other internal committees for review and recommended actions to address any areas falling below the statewide threshold. When negative statistical outliers occur, MCCMH analyzes the causes and develops remediation and improvement strategies.

Performance Improvement Projects

MCCMH conducts at least two Performance Improvement Projects (PIPs) annually. PIPs address clinical and non-clinical aspects of care.

1. Clinical areas include, but are not limited to, high-volume services, service disparity, high-risk services, and continuity and coordination of care.

2. Non-clinical areas include, but are not limited to, appeals, grievances, trends, and patterns of substantiated Recipient Rights complaints as well as access to and availability of services.

Current MCCMH PIPs include:

1. Increase percentage of adults receiving follow-up appointments and a reduction in racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization.

2. Increase the number of MCCMH persons served enrolled in the MDHHS Habilitation Supports Waiver Program.

The purpose of PIPs is to improve the performance of existing services or develop new processes to meet identified needs. MCCMH's topic selection is based on statistical disparity measures, barriers related to access of care, improving service delivery, and increasing persons served satisfaction.

Oversight of the PIPs is achieved through collaborative interdepartmental efforts within MCCMH as well as partnerships with its Provider Network, advocates, and persons served. Improvement is tracked on an ongoing basis through the development of detailed work plans, data collection, and analysis tools.

Corporate Compliance and Medicaid Services Monitoring
Medicaid program integrity activities are reported to MCCMH's Executive Staff and Board, as required, through the MCCMH Compliance Division. MCCMH's Compliance activities, which impact quality of care issues for persons served, may result in the development of additional performance indicators and/or monitoring activities.

In addition to the activities of the Compliance Division, MCCMH implements a variety of strategies to verify that services to Medicaid beneficiaries have been delivered as claimed.

Annual audits will be conducted in accordance with MDHHS Guidelines for verification of Medicaid services and MCCMH Medicaid Verification Financial Audit Process guidelines. Audits will verify the existence of appropriate clinical records for each claim in the sample selection, evaluate the reasonableness of clinical records associated with each claim, verify that services specified in the claim were part of the person's Individual Plan of Service, and verify that services provided were included in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Section, of the Michigan Medicaid Provider Manual. Final reports for each vendor, detailing findings by claim and by provider, including the dollar amount of claims that were not supported by appropriate clinical record documentation, are shared with each provider. Overall audit results are summarized and analyzed in accordance with the following:

- Total number and dollar value of claims processed during the audit period
- Total number and dollar value of the sample
- Number of claims that were found to be deficient
- Dollar value of claims that were found to be deficient

An Executive Summary Report is prepared to summarize, at the provider level, the number and dollar amount of claims not supported by appropriate clinical records and the number and dollar amount of claims for services that were not represented on the person's Individual Plan of Service. This report is submitted to MDHHS at least annually but no later than December 31 of each year.

Immediate action is taken by MCCMH to reduce the risk for overpayment of Medicaid dollars when a provider appears to have more serious documentation issues. Specific actions may include, but are not limited to, MCCMH Quality Department undertaking a more extensive audit of the provider and pre-payment reviews. Depending on the result of the findings, referrals to the MDHHS-OIG may be made.

I.   QUALITY IMPROVEMENT PROGRAM

Framework for Quality Improvement (QI)

The success of the QI Program is dependent on appropriate oversight and resources. This section outlines the framework and responsibilities of the QI Program.

1. Quality Improvement Committee Framework
   The QI Committee provides oversight into the QI Program. It focuses on performance indicator data, conducting and analyzing satisfaction surveys, overseeing performance improvement projects, monitoring quality activities to ensure quality of services, and evaluating member and provider experiences and provider performance.

   QI Committee responsibilities include, but are not limited to, the following:

   a. Managing the coordination of quality improvement efforts across the organization
   b. Establishing QI priorities
   c. Approving the Annual QAPIP Description and Workplan
   d. Overseeing QI activities and ensuring appropriate follow-up
   e. Regularly evaluating QI projects
   f. Recommending and approving QI policies and procedures
   g. Conducting an annual evaluation of the QI Program

2. Quality Improvement Committee
   The MCCMH Chief Clinical Officer and the Chief Quality Officer serve as the leads for the QI Committee. MCCMH's Chief Quality Officer is involved in the Quality Improvement Program, provides leadership to the QI Committee, advises on the development of new services and policies and procedures, and ensures that data analysis of quality improvement activities and appropriate follow-up occur.

3. Quality Sub-Committee Structure
   The QI Committee provides oversight and guidance to Quality subcommittees and is responsible for assigning quality improvement activities to the subcommittee responsible.

Quality subcommittees focus on the areas of Quality Improvement, Quality Evaluation, and Quality Monitoring. QI subcommittees are responsible for bringing information to the QI Committee for reporting, monitoring, and decision-making purposes.

4. Partnered Committees

The Utilization Management (UM) Committee is chaired by the Director of Managed Care Operations. This Committee conducts ongoing reviews of under- and overutilization of services, reviews consistency of utilization management criteria application, reviews and approves the UM Program Description, and compiles an annual UM Evaluation report. The UM Committee reviews established data dashboards to assess timeliness of intake assessments, hospitalization rates, usage of services by service category, and other datasets to identify utilization rates and propose improvement strategies, as needed. As improvement strategies are operationalized, ongoing reports are presented to and discussed at the Quality Committee. Although the UM Committee is not an official sub-committee of the Quality Committee, their reviews and findings are incorporated into Quality activities and formal UM reports are presented to the Quality Committee at least annually.

The Credentialing Committee is chaired by the Chief Medical Officer. Although the Credentialing Committee is not an official subcommittee of the Quality Committee, credentialing processes are highly influenced by Quality activities. The Credentialing Committee reports to the QI Committee on its processes, at least annually, to ensure ongoing collaboration between the Committees' scopes of work.

5. PIHP CCBHC Oversight

The PIHP is responsible for developing, implementing, and maintaining an effective oversight program for the CCBHC. This includes the CCBHC data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The goals are selected based on population needs as revealed through the Needs Assessment and based on past performance of CCBHC.

MCCMH's reporting structure for these committees is as follows:
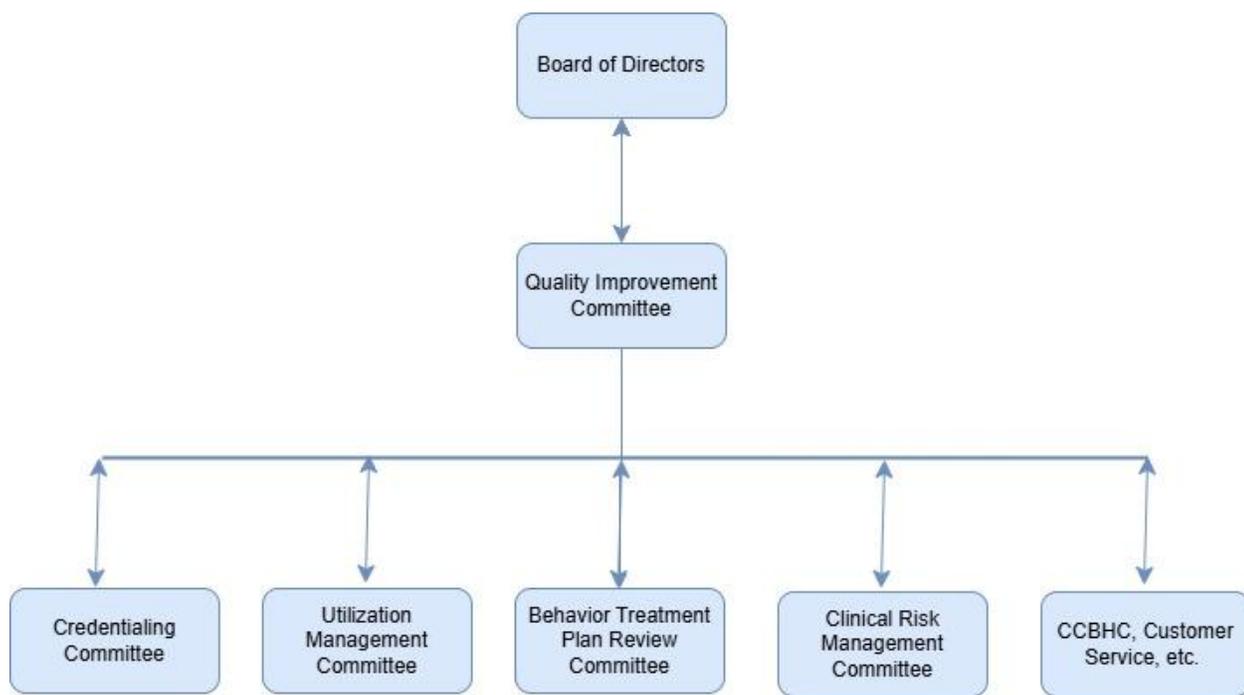
6. Stakeholders and Persons Served
    The involvement of persons served and advocates in MCCMH's QI Program is actively sought through the two advisory bodies to the Board; The Citizens Advisory Council (CAC) and the Oversight Policy Board (OPB) Input is sought from CAC and OPB during the development of the QAPIP Description and throughout the year. Person-served input is also sought through the Member Satisfaction Survey.

7. Committee Councils and Workgroup Structures
    MCCMH has additional committees that collaborate with the QI Program on various quality improvement activities and initiatives. These include:

    a. Behavior Treatment Plan Review Committee (BTPRC): Reviews behavior treatment plans with restrictive or intrusive techniques and provides approval or denial of plans with these techniques.
    b. Clinical Risk Management Committee (CRMC): Reviews areas of clinical risk within the MCCMH Provider Network. These include incident reports, findings of mortality reviews and root cause analyses. Key findings and recommendations are provided to the Quality Committee or Executive Staff for action, as necessary.
    c. CCBHC: Ensures integration of medical and behavioral health, along with SUD.
    d. Process Improvement Committee (PIC): Engages in the development of new data warehouses, dashboards, and reports.

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e. CAC: Comprised of primary and secondary persons served, service and advocacy representatives, and interested members of the community.

f. MCCMH Prescribing Practices Peer Review Group-Lead: Evaluate prescribing patterns for MCCMH's direct and network providers and offer recommendations as applicable to licensed prescribers. This group meets once every other month for one hour.

g. Credentialing and Privileging Committee: Grants credentials and privileges to MCCMH direct providers.

h. SUD OPD: The OPB provides advice and consultation to the MCCMH Board on matters relating to planning, funding, and implementation of a comprehensive SUD network. Appointed members represent individuals in recovery from SUD and/or family members, the local health department, schools, law enforcement, the Provider Network, and other community stakeholders. Comprised of individuals representing public health, the Macomb County Department of Human Service, intermediate/local school district, individual in recovery from SUD or a family member impacted by addiction, public and private SUD prevention, treatment or recovery providers, and the community at large, including civic organizations, the corporate community, representatives from the medical community, law enforcement, faith-based organizations, military veterans, and interested citizens who are willing to advocate for prevention, treatment, and recovery services for persons with or who are at risk for SUD.

Clinical Practice Guidelines

MCCMH has adopted Clinical Practice Guidelines to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. MCCMH's Clinical Practice Guidelines are updated at least every two years and are based on scientific evidence and/or professional standards from recognized sources and approved by the QI Committee. MCCMH distributes the guidelines in a bulletin and email to all providers and practitioners upon initial adoption and at least every two years. Practitioners and providers are notified of the availability of the guidelines on the MCCMH website and may request a copy of the Clinical Practice Guidelines to be mailed to them as needed. Annually, each guideline will be measured for effectiveness on two important aspects of the clinical process of care as outlined in the Clinical Practice Guideline and QI Workplan.

Clinical Practice Guidelines developed by MCCMH are presented to the Quality Committee as they are developed. MCCMH has expanded the development of clinical protocols to support the integration of physical and behavioral healthcare. The Substance Use Division continues to focus on expanding treatment services for opioid and other substance use disorders through the expansion of the crisis continuum.

Credentialing and Re-Credentialing

MCCMH maintains written policies and procedures that delineate standards and processes to credential and re-credential its practitioners. MCCMH's policies adhere to MDHHS' Credentialing and Re-Credentialing requirements and federal regulations. MCCMH, through its Credentialing Committee, reviews and credentials licensed behavioral healthcare practitioners/professionals employed directly by MCCMH. The Substance Use Department monitors the substance use Provider Network for compliance with state and federal requirements. MCCMH Quality Department monitors the rest of the Provider Network to make sure they comply with state and federal requirements.

MCCMH contracted providers have the responsibility of credentialing individual practitioners employed directly by the provider. All MCCMH network providers will adhere to MCCMH's credentialing policy. During re-credentialing, MCCMH reviews any sanctions, complaints, and quality issues pertaining to the practitioner. This must include, at minimum, a review of Medicare/Medicaid sanctions; state sanctions or limitations on licensure, registration, or certification; enrollment in the Community Health Automated Medicaid Processing System (CHAMPS); and specific internal quality concerns or issues, including but not limited to, grievances and appeals.

MDHHS standards and MCCMH contracts with providers require that providers provide training for all new staff and ongoing training and development activities for existing staff. MCCMH's Training Department ensures that staff possess the appropriate qualifications as outlined in their job descriptions, including qualifications for educational background, relevant work experience, cultural competence, and certification/registration/licensure as required by law. Team members participate in training required for their job responsibilities and MCCMH's policies and standard operating procedures.

Member Safety

MCCMH is committed to the safety of the members. Member Safety activities align with the Quadruple Aim of achieving quality care for our members. This is accomplished through the following mechanisms:

Coordination of Care
The Chief Clinical Officer and Chief Quality Officer are responsible for coordinating and participating in quality activities to improve coordination of care among providers in the network. These activities include:

1. Ongoing coordination of care monitoring:

    1.1. Coordination of care between care settings among behavioral health practitioners and providers.

    1.2. Coordination of care between medical and behavioral health practitioners.

2. Partnerships with physical health managed care organizations in joint quality activities and initiatives related to best practices in clinical care.

Use of Appropriate Treatment Guidelines

MCCMH has adopted Clinical Practice Guidelines for disorders that are commonly identified. MCCMH's goal for the Clinical Practice Guidelines is to provide both clinicians and the community with reference to the standards of care used by MCCMH. Standards are based on the most current resources available in the field of behavioral healthcare. MCCMH uses the 25th edition of the MCG Behavioral Health Care Guidelines, which houses thousands of research-supported standards for clinical care, as the reference source for Clinical Practice Guidelines.

For Adults:
Clinical Practice Guideline – Major Depressive Disorder
Clinical Practice Guideline – Schizophrenia
Clinical Practice Guideline – Bipolar

For Children:
Clinical Practice Guideline – ADHD And Disruptive Behaviors
Clinical Practice Guideline – PTSD

Evidence-Based Practices:
Evidence-Based Practice List – Adults and Children

Practitioner/Facility Office Review
On-site office reviews may occur as part of the complaint investigation process when a quality-of-care concern warrants a site review, when physical concerns have been identified, when a need for chart review presents itself, and/or during provider meetings. Processes for complaints, grievances, critical incidents, and quality of care concerns to investigate and address member safety issues may also lead to the need for onsite review.

Chart Audits
To ensure quality of care and member safety, provider medical records are reviewed through multiple mechanisms:
1. The facility site review process conducts chart reviews of different levels of care. This process is incorporated into the credentialing (initial and recredentialing) process.

2. Charts are reviewed for compliance with billing rules for fraud, waste, and abuse.

3. The effectiveness of behavioral health interventions is monitored for selected Quality metrics.

4. Effective discharge management planning and follow-up care are monitored.

Member Health and Safety
MCCMH Policy 8-003, "Reporting and Responding to Critical Incidents, Sentinel Events, and Risk Events," establishes definitions and guidelines, based on criteria specified by MDHHS' technical and reporting requirements, for reporting and reviewing potential sentinel events and critical incidents. MCCMH Policy 8-003 delineates standards requiring all MCCMH providers, including but not limited to primary, ancillary, and residential providers, to report critical incidents and risk events within the required timeframes and according to MCCMH incident reporting requirements. Such reports are submitted by providers through the MCCMH incident report module in its EMR system or through the Office of Recipient Rights (ORR) fax line.

MCCMH uses the Critical Incident Reporting System to report information on suicides, non-suicide deaths, emergency medical treatment due to injury or medication error, type of injury will include a subcategory for reporting injuries that resulted from the use of physical management, hospitalization due to injury or medication error, hospitalization due to injury related to the use of physical management, and arrest of the individual. MCCMH analyzes additional risk events that may include actions taken by persons served that cause harm to themselves or others and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when a person has a terminal illness) within a 12-month period.

MCCMH's CRMC reviews sentinel events and other critical incidents and acts upon them as appropriate. CRMC is composed of individuals with the appropriate credentials to review the scope of care and includes individuals not involved in the treatment or care of the person served. The CRMC's review process results in the understanding of causes of the event, and if necessary, a root cause analysis (RCA) with subsequent corrective action plans is implemented to avoid similar events from occurring in the future. An RCA is required when there has been a risk to an individual in which there is the potential to redesign and reduce these types of incidents. MCCMH continuously monitors critical incidents to evaluate the quality and performance of the Provider Network. CRMC reports sentinel event findings and documents follow-up and system improvements as required by MDHHS.

MCCMH creates quarterly summary reports on issues or trends pertaining to quality of care based on information received from the mortality review process, sentinel event investigations and action plans, critical incident reports, and risk event reports. MCCMH's Quality Department provides these quarterly summary reports to the Quality Committee for further review, discussion, and recommendations when necessary.

MCCMH's CRMC reviews sentinel events reported by network providers and annually submits to the Board of Directors a summary report for review. The Quality Department tracks and trends patterns related to critical incidents and risk events.

Behavioral Treatment Review:
MCCMH's Behavioral Treatment Plan Review Committee (BTPRC) standards and expectations are included in MCCMH Policy 8-008, "Behavior Treatment Reviews." MCCMH's Quality Committee reviews data from the BTPRC 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. The data tracks and analyzes the length of time interventions are used per individual.

Quality Efforts:
Quality Improvement activities are implemented and monitored through a combination of various groups and committees, network providers, members, advocates, and additional stakeholders working in collaboration with one another to ensure the delivery of quality supports and services.

This is not an exhaustive list and does not cite all daily and ongoing efforts made in collaboration with MCCMH's community partners. This list is specific to activities that are the responsibility of the MCCMH Quality Department. MCCMH's QI activities include efforts to:

1. Provide an outline of MCCMH's QI structure for its region.

2. Evaluate QI processes and outcomes on an ongoing basis to ensure that they are effective and have a positive impact on the quality of care and services provided to MCCMH's stakeholders.

3. Evaluate MCCMH systems and processes on an ongoing basis related to clinical and non-clinical services that can be expected to impact the quality of life and satisfaction for persons served.

4. Review and identify, on an ongoing basis, opportunities for priority performance improvement based upon information obtained from data and stakeholders.

5. Ensure that input from stakeholders is received and considered in the development of QI activities for the Quality Department.

6. Ensure the focus of QI activity development is on prevention instead of remediation. The ability to have a positive impact on the service delivery system by engaging in administrative simplification while simultaneously ensuring a high-quality service delivery system decreases the strains placed upon all stakeholders.

7. Seek continuous feedback from stakeholders on the quality of services being provided and incorporate feedback into future QI initiatives.

8. Meet standards set forth within MCCMH's various regulatory agencies.

Member Satisfaction

MCCMH annually conducts quantitative and qualitative reviews of member satisfaction through member surveys, focus groups, and complaints and appeal information.

Member Experience Survey:

1. MCCMH conducts an annual member experience survey and identifies improvement opportunities and actions designed to improve member experience. Survey data is collected over a defined period to capture the level of satisfaction based on experience from individuals actively receiving MCCMH services.

2. Surveys are distributed throughout the survey period via paper or electronically. Individuals can complete the survey electronically by scanning a QR code or navigating to MCCMH's website. Paper surveys are made available at each service site, and once completed, are securely uploaded and aggregated with the survey responses collected electronically.

3. To collect quantitative data, MCCMH utilizes standardized assessment tools to conduct satisfaction surveys for its adult and children's populations. The MHSIP survey is used to assess adults, and the YSS-F is used for children/caregivers to collect data for customer satisfaction. To collect qualitative data, MCCMH provides space within the survey for narrative responses and encourages individuals who may want to share additional feedback

to provide their contact information to receive direct communication and follow-up from an MCCMH representative.

4. The survey presents statements about services within eight domains. The eight domains include Access, Participation in Treatment Planning, Person-Centered Care Planning, Quality and Appropriateness (or Cultural Sensitivity), Social Connectedness, Functioning, Outcomes, and General Satisfaction.

5. The assessment addresses issues of quality, availability, and accessibility of care. The member experience survey includes questions about the experience members have with language services when communicating with MCCMH and during experiences with providers. Quality improvement opportunities are identified for areas not meeting the threshold of 90%.

6. As a result of the assessments, MCCMH:
   6.1. Takes specific action on cases as appropriate;
   6.2. Identifies and investigates sources of dissatisfaction;
   6.3. Outlines systemic action steps to follow-up on the findings;
   6.4. Informs practitioners, providers, recipients of service, and the governing body of assessment results.

7. MCCMH monitors and identifies opportunities for improvement, implements interventions, and measures the effectiveness of the interventions for the following categories of complaints:
   7.1. Quality of Care
   7.2. Access
   7.3. Availability
   7.4. Attitude and Service
   7.5. Billing and Financial Issues
   7.6. Quality of Practitioner Office Site

8. Input may be sought from persons served and the community using focus groups and ongoing community-wide forums. The Citizens' Advisory Council (CAC) may be asked to participate in the development of new questions for focus groups and locally developed surveys. The CAC is part of the MCCMH committee structure and provides reports related to the QAPIP. MCCMH conducts annual satisfaction surveys for continuous identification of improvement opportunities. Happy or Not terminals are located at each clinic location and on the website to provide real-time customer service feedback.

Access to Services
MCCMH ensures member access to services by reviewing the answer and abandonment rates of telephone calls to the MCCMH Customer Services line, monitoring the provision of interpretation and translation services, evaluating penetration rates, and other means.

On a quarterly basis, MCCMH monitors telephone access and responsive rates, including the rate of answering telephones and abandonment rates.

Cultural and Linguistic Diversity:

MCCMH is committed to serving a culturally and linguistically diverse membership in a manner to prioritize members accessibility to services and care and identify potential health care disparities. MCCMH requires that Cultural Competency trainings be completed by contracted providers and their workforce members as well as all MCCMH workforce members. Such trainings remind the network that cultural values affect behavior and provide the basics for team members to begin or continue their work toward cultural competency. Through continuous monitoring and evaluation of its network, MCCMH equips itself to identify and pursue opportunities to improve its service delivery system's cultural and linguistic diversity.

Member Needs Assessment:

The cultural and linguistic needs of MCCMH's members are assessed annually through the Member Needs Assessment in the following:

1. Conducting ongoing member needs assessment in service utilization through areas such as penetration rates and identifying service access rates by race/ethnic groups.

2. Annual analysis of primary language by service needs.

3. Conducting data analysis that focus on several variables including race, gender, age, eligibility category, and language to gain insight into the long-standing disparities in the health status of people of diverse backgrounds.

4. Monitoring the provision of interpretation and translation services to ensure effective communication with non-English-speaking populations.

5. Monitoring the provision of alternative communication for individuals who are deaf or hard of hearing, including American Sign Language, and providing alternative methods of phone communication, including Text Telephone Typewriter (TTY).

6. Ensuring that member materials are culturally competent and available for members in a preferred language or communication method on MCCMH's website and mailed when requested.

Results of the Member Needs Assessment will be used to improve services offered to members and make Provider Network capacity changes.

Long-Term Services and Supports (LTSS):

CMS requires that states monitor the quality of LTSS provided through managed care as part of their state quality strategies, regular external quality reviews (EQR), and reporting of quality and performance measures. These activities are described in detail on Medicaid.gov. There are a few standardized measures of access and quality that are specific to LTSS. Medicaid measures include standardized measures of access and quality, some of which may be relevant to assessing access to care for LTSS enrollees. MCCMH's HCBS programs serve a variety of targeted population groups— such as older adults and people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders (MH/SUDs) and provide opportunities for Medicaid beneficiaries to receive services in their own homes and communities rather than in

institutions. These Medicaid benefits help enrollees manage their basic needs and live independently in the community.

MCCMH has mechanisms in place to assess the quality and appropriateness of care furnished to individuals using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the person's treatment/service plan. Mechanisms comprehensively assess each Medicaid person served identified as needing LTSS to identify any ongoing special conditions of the person that require treatment or regular care monitoring. Some of the activities conducted by MCCMH include, but are not limited to, timely and appropriate service authorization, adequate Provider Network, encounter data verification, and review of appeals and grievances.

Assessment mechanisms use appropriate providers or individuals meeting MDHHS' LTSS service coordination requirements. This may include, but is not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care, such as the Level of Care Utilization System (LOCUS)

MCCMH ensures individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) are incorporated in the review and analysis of information obtained from both quantitative and qualitative methods. MCCMH continuously reviews care between settings and compares services and supports received based on the individual's plan of service.

LTSS members are included as survey participants, and members of the CAC and LTSS cases are tracked and reported on the MDHHS OBRA dashboard.

Reducing Healthcare Disparities
MCCMH assesses various performance measures for healthcare disparities related to language, cultural competence, and physical accessibility. Identified disparities are addressed with specific interventions to reduce healthcare disparities. MCCMH's network adequacy is assessed annually to ensure the network is culturally competent.

Education and Prevention Programs:
MCCMH has established routine guidelines to ensure the promotion of educational information to persons served and identifies members monthly to participate in the screening program. Members are informed annually of self-management tools available on its website.

Provider Satisfaction

Provider Participation
MCCMH regularly includes practitioners and provider representatives in decision-making committees to ensure provider input is incorporated into MCCMH practices and initiatives. Practitioner and provider representatives participate in at least the following committees:
- Quality Improvement Committee
- Utilization Management Committee
- Credentialing Committee

Access to Provider Network

MCCMH will determine member access to its Provider Network by ensuring geographic accessibility of choice of providers via mapping of the Provider Network by level of care, identifying provider-to-member ratios, auditing samples of progress notes to ensure that a choice of providers is consistently offered, and observing penetration rates to determine possible barriers to access.

Quality Measurements

MCCMH annually reviews the demonstration of appropriate quality measurements to ensure it is providing high-quality care and working toward achieving the Quadruple Aim.

Annual Evaluation

MCCMH provides an annual report on required standards within timeframes specified to evaluate the impact and effectiveness of the QI program and includes an analysis of internal Quality processes and initiatives. As part of the annual evaluation, MCCMH conducts an annual written evaluation of the QI program that includes a description of completed and ongoing activities that address the safety of clinical care and quality of service, trending of measures to assess performance of clinical care and quality of service, and an analysis and evaluation of the overall effectiveness of the QI program. MCCMH annually shares results of its current QI program evaluation with its members and Provider Network in the MCCMH Annual Report. Once the QAPIP program documents are formally approved by the Board, MCCMH disseminates this information annually to network providers, stakeholders, members through the CAC, and members upon request. Formally approved QAPIP materials—the QAPIP Narrative, Workplan, and Evaluation—are published on MCCMH's website at www.mccmh.net. Notice of the updated and published documents is disseminated through MCCMH's Workforce Update Emails and Provider Network Newsletters to providers on at least an annual basis and discussed at the CAC. Areas of the QAPIP's work plan and program effectiveness are standing agenda items in the monthly Provider Quality Meeting. The MCCMH Board also receives at least quarterly updates and provides feedback.

Provider Profiles

MCCMH builds provider profiles based on the following Performance Measures:

1. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period.
2. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
3. Plan All-Cause Readmissions (PCR): The number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
4. Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

5. Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness.
6. Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
7. Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which there was follow-up.
8. Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment.
9. Follow-Up Care for Children Prescribed ADHD Medication (ADD): The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

II.   QUALITY IMPROVEMENT STRUCTURE

The Quality Improvement Division consists of the following units: Complaints and Grievances, Quality Monitoring, Quality Evaluation, and Quality Improvement.

Complaints and Grievances Unit

The MCCMH Ombudsman assists persons served with informal concerns and filing grievances. When the Ombudsman receives a grievance, if the member requests someone else to represent them in the process, the Ombudsman will request that this be in writing. The Ombudsman sends a written acknowledgement of the grievance and ensures that those deciding and assisting in the grievance are appropriate individuals to do so. Once a grievance is resolved, the MCCMH Ombudsman sends a written notice of the resolution containing the results of the grievance, the closing date of the grievance, and information on how to access a State Fair Hearing.

MCCMH ensures members receive reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Quality Monitoring Unit

Provider Teaming
A meeting of an interdisciplinary group of individuals representing MCCMH is convened when MCCMH becomes aware of a significant provider-related issue(s). Any MCCMH Officer or MCCMH staff person, in consultation with the Chief Quality Officer, can convene a Provider Teaming. Depending on the nature of the concern, staff representing Quality, Compliance, Chief Medical Office, Provider Network, Clinical, Customer Services, Information Technology (IT), and other division staff may be included in the Provider Teaming. It should be noted that although any

MCCMH staff member can request a Provider Teaming, the staff member's direct supervisor must be consulted prior to the request being made.

<u>Quality Concerns</u>
Typically generated by the Quality or Clinical Division and/or Chief Medical Office as a result of clinical and service request reviews or Network Operations or Customer Services regarding significant member incidents and member concerns when members do not want to file a formal complaint.

<u>Quality Improvement Plan (QIP)</u>
A written document that identifies areas of clinical quality concerns, an intervention plan to bring services to an acceptable standard of care, specification of the staff responsible for implementation, and the target dates to resolve concerns. The following domains are considered in a QIP:
- Severity (high versus low)
- Category (clinical versus non-clinical)
- Duration (chronic versus short-lived)
- Frequency (multiple versus one)

Quality Evaluation Team

The Quality Evaluation Team leads provider audit activities that ensure MCCMH members receive services that are safe, effective, person-centered, timely, efficient, and equitable.

<u>Provider Performance Evaluation</u>
Quality Evaluation works in conjunction with the Clinical Division to develop or select performance measures that reflect the treatment goals of MCCMH-funded programs. Performance Evaluation is also responsible for the evaluation of the MCCMH network for State-mandated performance measures, such as HEDIS measures.

Quality Evaluation Team works closely with the Quality Improvement Team on planning, designing, implementing, and conducting provider service quality improvement activities based on evaluation results for State initiatives and NCQA accreditation.

Quality Evaluation team members also work closely with the MCCMH Network Operations Division in the development of program monitoring and evaluation plans included in requests for proposals for pilot and demonstration programs. As part of this process, in addition to developing and implementing program evaluation and monitoring plans, Quality Evaluation team members provide technical support for continuous quality improvement at provider programs.

Quality Improvement Team

The Quality Improvement (QI) Team is responsible for developing, monitoring, and reporting quality improvement efforts across MCCMH for State and National reporting requirements. The team leads the following initiatives:

<u>Performance Improvement Projects</u>
The QI Team is responsible for developing the Performance Improvement Projects (PIPs) required by MDHHS, including the development, monitoring, and reporting of quality improvement activities and performance measures. PIPs are approved through the Quality Committee. The

purpose of PIPs is to achieve, through ongoing measurement, demonstratable and sustained improvement in clinical and non-clinical areas that benefit health outcomes and member satisfaction. MCCMH incorporates the following in its PIPs:

1. Measurement of performance using objective quality indicators.

2. Implementation of interventions to achieve improvement in the access to and quality of care.

3. Evaluation of the effectiveness of the interventions based on the performance of measures.

4. Planning and initiation of activities for increasing or sustaining improvement.

Integrated Care Planning
The Quality Improvement Team is responsible for providing ongoing quality improvement support to Integrated Care Planning (ICP). Ongoing review and monitoring of performance measures and intervention effectiveness is conducted quarterly.

National Committee for Quality Assurance
The NCQA is a private, nonprofit organization dedicated to improving healthcare quality and offers accreditation to healthcare plans. The Chief Quality Officer is responsible for assessing MCCMH for compliance with NCQA accreditation standards in the areas of Quality Improvement, Utilization Management, Care Coordination, Members Rights, and Credentialing and Re-Credentialing.

Quality Improvement Activities
The QI team is responsible for process and performance improvement activities and utilizes a standardized QI framework to ensure that all process and performance improvement activities are conducted efficiently and effectively to achieve the best outcomes.

Staffing Structure/Support

1. Chief Quality Officer
   The Chief Quality Officer has the overall responsibility for implementation of the Quality Improvement Program. The Chief Quality Officer also oversees the Quality Sub-Committees and Units. The Chief Quality Officer provides daily technical oversight in quality incident screens, validity of system entries, severity ratings, category assignments, investigation, and determination of response levels. The Chief Quality Officer conducts root cause analyses for variance patterns and trends with incidents, serious complaints, and other quality measures. The Chief Quality Officer is responsible for the development, implementation, and reporting of performance measures and uses those performance measures to evaluate the effectiveness of provider performance and quality improvement activities across initiatives.

2. Chief Clinical Officer
   The Chief Clinical Officer and the Chief Quality Officer are responsible for leading the Quality Committee. The Chief Quality Officer is responsible for participating in the implementation of continuous quality improvement throughout the Provider Network, as

well as within departments at MCCMH. The Chief Quality Officer oversees KPIs and performance standards and provides leadership for maintenance of NCQA standards. The Chief Clinical Officer participates in the ongoing development and monitoring of clinical practice guidelines.

3. Quality Administrators
    Quality Administrators are responsible for ongoing oversight and implementation of Quality initiatives, programs, policies, and procedures. Quality Administrators collaborate with the Quality Committee and other committees in developing and implementing special initiatives, projects, audits, and accreditations.

4. Quality Coordinators
    Quality Coordinators provide support to Quality initiatives, programs, and accreditation pursuits. Quality Coordinators are available to assist with required reporting for the agency and ensure quality and compliance of programs and duties.

5. Quality Case Managers
    Quality Case Managers maintain network monitoring lists, schedule monitoring visits with providers, and utilize monitoring and audit tools. They coordinate, consult, and provide liaison work with providers and other MCCMH divisions to ensure quality of services.

6. Ombudsman
    The MCCMH Ombudsman assists members in voicing their wishes and concerns so that they are heard and understood by MCCMH providers, facilitates resolution of Medicaid Grievances and Non-Medicaid Grievances, assists members with accessing the MCCMH ORR to pursue formal processes when a Mental Health Code issue arises, and maintains documentation of Medicaid Grievances and Non-Medicaid Grievances.

7. Managed Care Operation (MCO) Physician Advisors
    MCO Physician Advisors participate in quality reviews for medical necessity determinations, hospital appeals, quality improvement plans, and practitioner chart reviews.

8. Director of Clinical Informatics
    The Director of Clinical Informatics works with the Quality Improvement Department to review/develop and implement metrics for measuring the outcomes of the activities and goals described in the Quality Improvement Work Plan.

9. Chief Network Officer
    The Chief Network Officer is responsible for developing and maintaining high-quality and satisfied Provider Networks within MCCMH's service area. This includes the functions of credentialing and recredentialing organizational providers. They are also responsible for

contract review, for language update and revision, and for establishment/oversight of the contract library. The Chief Network Officer has oversight of the provider database and accuracy of provider listings in the Provider Directory.

III.   QUALITY PROGRAM DOCUMENTATION AND TOOLS

QAPIP Description

The QAPIP Description is the formal document that explains how MCCMH structures, governs, and operates its quality improvement program. It lays out the framework that MCCMH uses to ensure high-quality, safe, and effective services. It is the blueprint for how MCCMH ensures continuous quality improvement across all clinical and nonclinical operations.

QAPIP Evaluation

The QAPIP Evaluation is a formal, annual review of how well MCCMH's quality improvement program is functioning. It measures whether the organization met its goals, follows required standards, and improved outcomes for the people it serves. The QAPIP evaluation typically includes:

- Review of the organization's quality structure—how quality oversight is organized and governed.
- Assessment of the QAPIP work plan—whether planned quality improvement activities were completed and effective.
- Analysis of KPIs data showing performance in areas like access, safety, clinical outcomes, and customer service.
- Review of performance measure activities—how the organization monitored, analyzed, and improved specific quality measures.
- Auditing and monitoring results—findings from internal audits, compliance checks, and monitoring activities.

State and federal regulations require these evaluations for Medicaid specialty health plans, and they must align with standards such as the Balanced Budget Act and 42 CFR 438.358.

Quality Workplan

The QAPIP Workplan outlines the annual QI activities required by MDHHS, CARF, NCQA, and other regulatory entities. Progress on the activities outlined in the Quality Workplan is assessed at regular intervals and reported quarterly.

The format of the work plan includes the following elements:
- Target Objective
- SMART Goals
- Planned Activities
- Responsible Staff/Department

- Quarterly Updates
- Evaluation
- Barrier Analysis
- Next Steps

Goals on the Quality Work Plan require ongoing review to ensure that performance is on target. Goals experiencing challenges or obstacles undergo a root cause/barrier analysis process to identify barriers to goal achievement.

Identifying Opportunities for Improvement
Traditional quality improvement tools such as brainstorming and priority matrices may be utilized, as deemed appropriate, to address encountered obstacles. Interventions will be developed and implemented using a continuous quality improvement framework.

MCCMH utilizes the Deming Cycle (Plan-Do-Study-Act) in its approach to ongoing quality improvement.

1. The Deming Cycle begins with the **Plan** step, which involves identifying a goal or purpose, formulating a theory, defining success metrics, and putting a plan into action.

2. These activities are followed by the **Do** step, in which the components of the plan are implemented.

3. Next is the **Study** step, where outcomes are monitored to test the validity of the plan for signs of progress and success, or problems and areas for improvement.

4. The **Act** step closes the cycle, integrating the learning generated by the entire process, which can be used to adjust the goal, change methods, or reformulate a theory.

   These four steps are repeated as part of the iterative cycle of continual improvement.

Analytic Resources

A variety of data sources are utilized to support the ongoing needs of measuring quality in the QI Program. These sources include:

- Medical Records
- Satisfaction Surveys
- Complaint and Appeal data
- Utilization Management Systems
- Claims Data
- Credentialing and Re-Credentialing data
- HEDIS measurements
- Enrollment data

The QI program is responsible for identifying and collecting data to evaluate program performance and service use. This data is then used to drive the organization's quality management and continuous quality improvement decisions and activities. The Clinical Informatics Team works

with Quality Team to design and produce reports and dashboards that accurately identify quality improvement opportunities, which are presented to the QI committee for review.

The following definitions describe some of the types of measures utilized by MCCMH:

1. Outcome Measures
   Achievement of goals and/or effectiveness of actions requires baseline data collection and periodic updates to capture changes in status over time.

2. Fidelity Measures
   Verification that evidence-based practices have been implemented in a manner consistent with prescribed models.

3. Process Measures
   Compliance with defined timelines, methodologies, and tools; includes administrative and clinical processes; generally, includes a desired level of performance.

4. Satisfaction
   Degree of stakeholder approval of performance, including primary and secondary persons served, referral sources, providers, and employees.

Compliance with the Balanced Budget Act of 1997

MCCMH continues to monitor and improve its compliance with the Balanced Budget Act (BBA) of 1997 as outlined in the contract with MDHHS and the Federal Regulations. MCCMH continually reviews its compliance with the requirements of the BBA, as identified by MDHHS and the protocols developed by CMS and implemented by the External Quality Review Organization (EQRO).

IV.   EXHIBITS

A. MCCMH Governing Body Form