Evaluation of Quality Improvement Program Plan Effectiveness FY2022
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

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Overview

An evaluation of the QIP plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives

Performance Indicators

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly, and quarterly reports are compiled and submitted to the PIHP for analysis and regional benchmarking and to MDHHS. In the event that CMHA-CEI performance is below the identified goal, the QI team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval.

Changes in PI reporting standards were adopted beginning FY 20 Q3, which removed exceptions and exclusions for Indicators 2 and 3, while also eliminating the 95% standard for those indicators.

Indicator #1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%

Indicator #2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95% for Q1 and Q2, no standard.

Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. Standard = 95% for Q1 and Q2, no standard.

Indicator #4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%

Indicator 5#: The percentage of Face-to Face Assessment with Professionals that result in decisions to deny CMHSP services (only submitted for full population)

Indicator #10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

FY22 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4	Total
1 - Total	**96%**	**96%**	**96%**		
1 - Children	92%	95%	97%		
1 - Adults	97%	97%	96%		
2a - Total	**51%**	**49%**	**54%**		
2a – IDD-C	31%	11%	26%		
2a – IDD-A	61%	20%	38%		
2a – MI-C	61%	68%	77%		
2a – MI-A	47%	44%	46%		
3 - Total	**46%**	**50%**	**49%**		
3 – IDD-C	63%	64%	73%		
3 – IDD-A	23%	38%	36%		
3 – MI-C	41%	41%	37%		
3 – MI-A	47%	58%	54%		
4a - Total	**100%**	**98%**	**98%**		
4a - Children	--	100%	100%		
4a - Adult	100%	9%	97%		
10 - Total	**10%**	**10%**	**12%**		
10 - Children	9%	6%	8%		
10 - Adults	11%	10%	13%		

FY22 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4	Total
1 - Total	**94%**	**95.5%**	**96%**		
1 - Children	91%	94%	96%		
1 - Adults	97%	97%	96%		
2a - Total	**49%**	**37%**	**53%**		
2a – IDD-C	26%	8%	18%		
2a – IDD-A	67%	18%	39%		
2a – MI-C	59%	67%	75%		
2a – MI-A	45%	28%	46%		
3 - Total	**47%**	**50%**	**49%**		
3 – IDD-C	62%	64%	70%		
3 – IDD-A	33%	40%	40%		
3 – MI-C	44%	42%	40%		
3 – MI-A	47%	57%	54%		
4a - Total	**96%**	**99%**	**98.5%**		
4a - Children	95%	100%	100%		
4a - Adult	97%	98%	97%		

5 - Total	**14%**	**10%**	**7%**		
10 - Total	**9%**	**10%**	**12%**		
10 - Children	3%	6%	9%		
10 - Adults	11%	10%	12%		

Indicators were submitted to MSHN and MDHHS quarterly.

Performance Improvement Project

Name of Project:

Racial or Ethnic Disparities between the black/African American Medicaid recipients and the white Medicaid recipients having received PIHP managed services.

Summary of Project:

The Performance Improvement Project (PIP) was chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided.

Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. After reviewing the numbers, it was determined that the Non-clinical Performance Improvement Project will address access to services for the largest historically marginalized group, Black/African American, within the MSHN region. The identification of barriers for access to services for this group will result in action, ensuring all Black/African American individuals served have the same opportunities to be healthy both mentally and physically. The MSHN Quality Improvement Council, through consensus, recommended this topic to Operations Council for approval. Operations Council supported the PIP topic for 2022-2025.

Is this project optional or required? If required by whom?

The study topic is one of two required PIPs for MSHN. The topic itself is not required.

Aim Statement

Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate of those who are eligible for Medicaid services?

Population definition: Medicaid eligible individuals in the 834-enrollment file within the Midstate Health Network region. The African American/ Black and the white race and ethnicity will be obtained through the race/ethnicity field included in the 834 file.

Enrollment requirements (if applicable): Individuals who are eligible for Medicaid services. All Medicaid enrollees included in the Medicaid enrollment file provided to MSHN by MDHHS monthly will be included in this project. The length of enrollment is a minimum of one month during the measurement period. This is not continuous enrollment. Services received have occurred during the time period in which the individual was enrolled in Medicaid.

Member age criteria (if applicable): Includes all members, adult and child.

Inclusion, exclusion, and diagnosis criteria:

Inclusion: Service encounters submitted by the Community Mental Health Specialty Programs (CMHSP), including those CMHSP participants who are a Certified Community Behavioral Health Clinic (CCBHC). Substance use services provided through a CCBHC, with an encounter submitted by the CMHSP will be included.

Exclusion: The data for those who are receiving substance use services from a substance use only provider are not currently available for aggregation and analysis. Therefore, will be excluded from the numerator for this project. SUD services are defined as those services delivered by the PIHP through a subcontractor licensed to operate as a substance use treatment and or rehabilitation program in accordance with the provisions of Act 368 of the Public Act of 1978 and the Administrative rules (R 325.14101-R 325.14928) of Michigan Department of Licensing and Regulatory Affairs**.**

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): There are currently no excluded codes for this project submitted by the CMHSP participants.

Goal: The goal of the indicator is to reduce or eliminate racial or ethnic disparities between the African American/Black minority penetration rate and the index (white) penetration rate.

Indicator 1:

Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service.

Indicator 2:

Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service.

Denominator:

The number of unique Medicaid eligible individuals within the Mid State Health Network region.

Data Collection Process:

The PIP will utilize administrative data for the analysis. The data source will be a programmed pull form claims/encounters and the 834 eligibility files. The report used is a standard report within REMI. Estimated percentage of reported administrative data completeness at the time the data are generated is 95% complete.

Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported:

Claims and encounters are submitted to MDHHS from all types of providers. MDHHS will not accept claims/encounters into the warehouse without meeting the minimum standards for submission. Providers are required to submit Medicaid encounters to MDHHS within 30 days after the service was provided. Transactions will not be accepted if they do not meet

completeness requirements. Typically, over 95% of the transactions are submitted within the 30 days after service datetime frames. Completeness is estimated by looking at expected levels of service and BH TEDS data based on historical counts of services provided, received and processed through REMI. Completeness is defined as those Medicaid encounters that have been submitted to MDHHS successfully and matched with monthly reconciliation reports.

Step 1: MSHN, through REMI (Managed Care Information System) receives automated downloads of the Medicaid eligibility files (834) from the FTS.
Step 2: CMHSP collect, enter, and validate encounter data in their data systems and submit (no less than monthly) to MSHN through REMI.
Step 3: MSHN combines, validates, and submits files to MDHHS (weekly)
Step 4: MSHN retrieves MDHHS response files from the FTS and loads into REMI (Managed Care Information System) to update the status of each encounter/claim.
Step 5: The eligible population (denominator) will be the unique number of enrollees in the MDHHS Medicaid eligibility file (834).
Step 6: The eligible population (numerator) will be the unique number of enrollees in the service table where the Medicaid ID matches the Medicaid eligible enrollees in the denominator.

To ensure the completeness and accuracy of the data in determining the study indicator rate, the PIHP will take into account the time lag allowed for the submission of claims for the CMHSP consumers. The data utilized to determine the study indicator rate will be retrieved foranalysis 60 days after the end of the measurement period.

Indicator Results:
Baseline Narrative: CY21 (1/01/2021 to 12/31/2021)

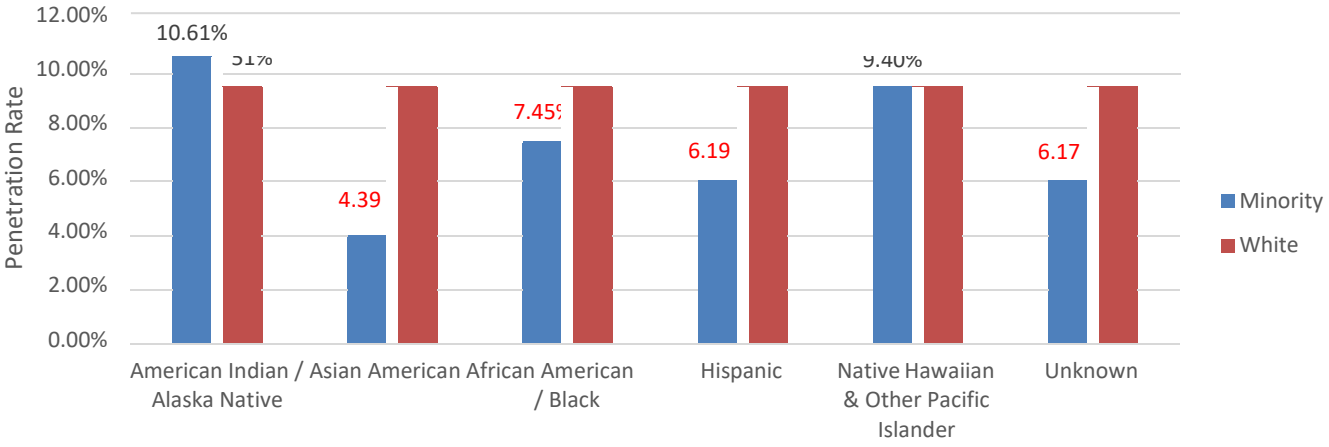
Race/Ethnicity	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper	Chi-Square Statistic (p-value)
American Indian/Alaskan Native	7,078	10.61%	0.72%	9.89%	11.33%	9.8282 (p=0.0017)
Asian American	3,147	4.39%	0.72%	3.67%	5.10%	95.5179 (p<0.0001)
African American / Black	70,267	7.45%	0.19%	7.26%	7.65%	299.4162 (p<0.0001)
Hispanic	29,710	6.19%	0.27%	5.91%	6.46%	360.8898 (p<0.0001)
Native Hawaiian & Other Pacific Islander	553	9.40%	2.43%	6.97%	11.84%	0.0068 (p=0.9343)
Unknown	40,486	6.17%	0.23%	5.93%	6.40%	488.3443 (p<0.0001)
White (Index)	373,783	9.51%	0.09%	9.41%	9.60%	Reference

Baseline data was obtained for CY2021. The data was drawn from a reporting process currently being developed in REMI, the MSHN Managed Care Information System. The individuals were broken down by race/ethnicity into the following categories: African American / Black, American Indian / Alaskan Native, Asian American, Hispanic, Native Hawaiian & Other Pacific Islander, Unknown, and White. A numerator and denominator (see Step 5) were obtained for each racial/ethnic group, and the rate was calculated by dividing the numerator by the

denominator. Using a 95% confidence interval and a calculated margin of error, the upper and lower control limits were calculated. The upper and lower control limits were used to identify if a minority group penetration rate was significantly higher or lower than the white penetration rate. If the upper control limit of the minority group was lower than the lower control limit of the white group, the result was that the minority rate was significantly lower than the white rate. If the lower control limit of the minority group was higher than the upper control limit of the index group, the result was that the minority rate was significantly higher than the white rate. The focus of the improvement efforts will be on the minority group that demonstrates a rate that is significantly lower than the white group and where interventions will impact the largest number of individuals.

A chi-square test was performed to determine which minority groups had statistically significant lower penetration rates than the index (white) group and to calculate p values for each relationship. There were four groups that had significantly lower penetration rates ($p < 0.0001$) than the white group rate of 9.51% (95% CI: 9.41, 9.60) (Table 1). The African American / Black penetration rate was 7.45% (95% CI: 7.26, 7.65); the Hispanic rate was 6.19% (95% CI: 5.91, 6.46); the Asian American rate was 4.39% (95% CI: 3.67, 5.10); and the "Unknown" rate was 6.17% (95% CI: 5.93, 6.40). The other minority group rates were either significantly higher than the white rate (American Indian / Alaskan Native) or not statistically significant (Native Hawaiian & Other Pacific Islander). Figure 1 visually demonstrates the penetration rate comparison between the minority and white groups. Significantly lower penetration rates are highlighted in red.

Figure 1: Penetration Rate by Race/Ethnicity Compared to White Penetration Rate



There may be factors affecting the validity of the baseline and remeasurement findings. Primarily, there could be some people who were unsure about their race/ethnicity and as a result, marked the wrong category. Additionally, there could be people who didn't understand the question and chose the wrong category as a result. It is likely, however, that these were not factors for most individuals and will not greatly impact the results. The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period

in CY2023 in order to determine if the intervention strategies were a success. No other factors that might threaten the comparability of the measurement periods were identified.

Baseline CY21 (1/01/2021 to 12/31/2021)
Gap Year CY22 (1/01/2022 to 12/31/2022) Identify causal factors and interventions
Gap Year CY22 (1/01/2022 to 6/30/2022) Monitoring
Gap Year CY22 (1/1/2022 to 12/31/2022) Monitoring
Remeasurement Period One- (1/01/2023 to 12/31/2023)
Remeasurement Period Two- (1/01/2024 to 12/31/2024)

Grievances, Appeals, and Fair Hearings

When a consumer/guardian has a Compliant they can file a grievance through the QCSRR office. Staff then work with representatives of the CMHA-CEI Program in question respond to the grievance, send an acknowledgement letter within 3 days of the receipt of the grievance and then a disposition letter with the determination of the resolution of the grievance within 90 days. Consumers can file a Local appeal or an Administrative Fair Hearing (if they are a Medicaid Beneficiary) and have been denied a requested service(s) or have had their current service(s) delayed, reduced, suspended or terminated.

	Total in FY22
# of Grievances	16
# of Appeals	7
# of Fair Hearings	0

Incident Reporting

The Critical Incident Review Committee provides oversite of the critical/sentinel event processes, which involve the reporting of all unexpected incidents involving the health and safety of the consumers within the CMHA-CEI's service delivery area. Incidents include consumer deaths, medication errors, behavioral episodes, arrests, physical illness and injuries. Membership consists of the Director of QCSRR, Medical Director, compliance staff, QI staff, and representation from all four clinical programs as applicable. The goal of CIRC is to review consumer deaths and assign a cause of death, and to review critical incidents, including consumer deaths, to ensure a thorough review was conducted and, if needed, provide a plan to ensure similar incidents do not reoccur. Incident report data is reviewed by CIRC for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

Category	Incident Reports
Exposure to Blood/Bodily Fluid	4
Arrest	5
Choking	7
Missing Recipient	8
Serious Self Injury	20
Serious Property Damage	35
Death	113
Serious Aggressive Event	309
Emergency Care	405
Other General Incident	892
Med	894
Total	**2692**

Medication IRs

In FY22, the process error mentioned above led to a large number of medication incident reports that were not reviewed, which led to a staggering drop in numbers compared to the previous year.

Med IR Category	Number of Reports
Adverse Reaction	7
Wrong Person/Med	20
Wrong Time/Day	37
MAR Error	43
Wrong Dose	46
Missed	741
Total	894

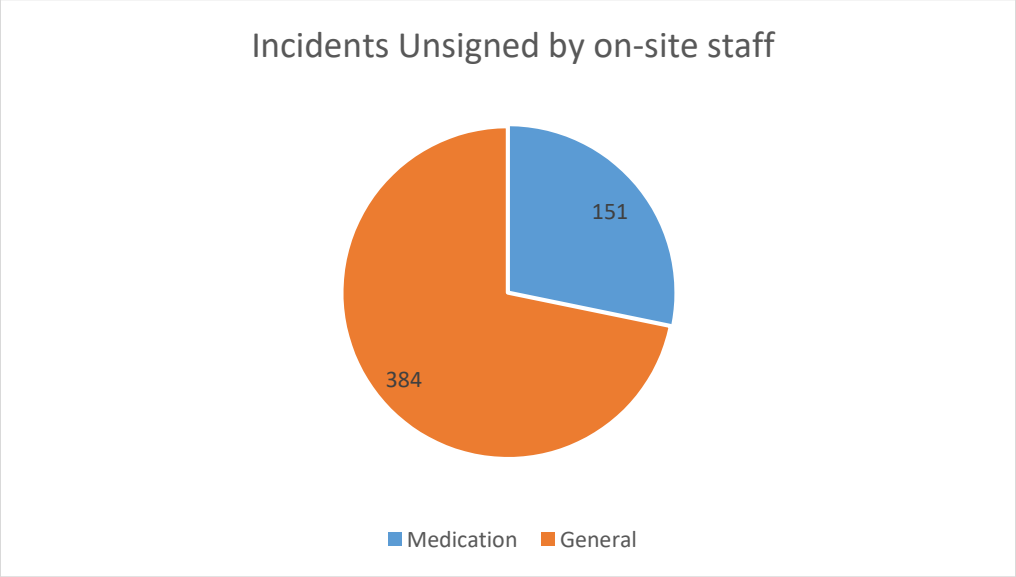
Summary of missed Meds:

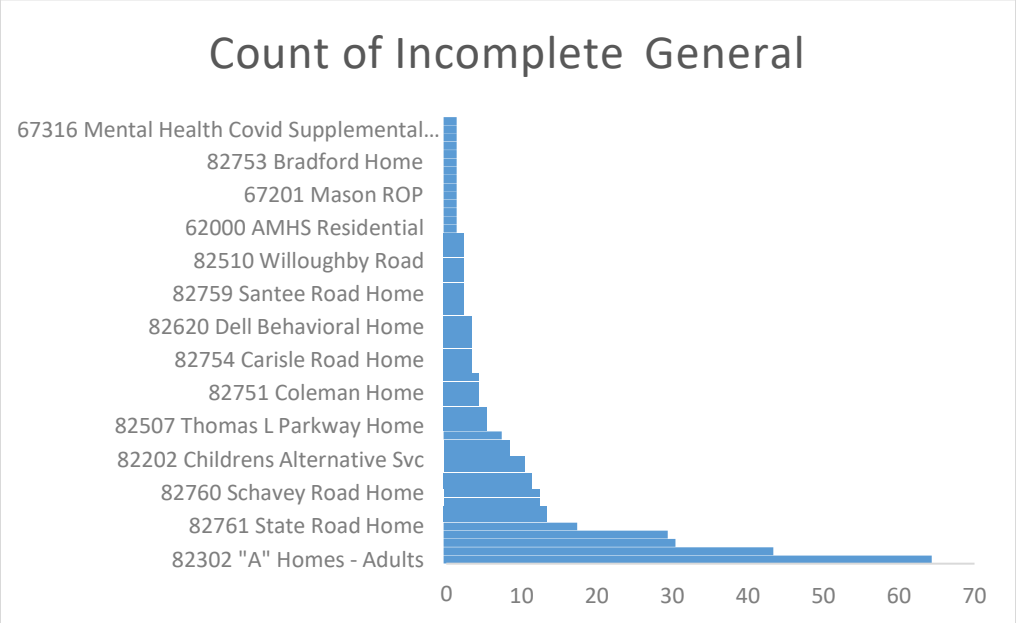
Reason	IRs
Other	110
Staff Error	135
Consumer Refused	496
Total	741

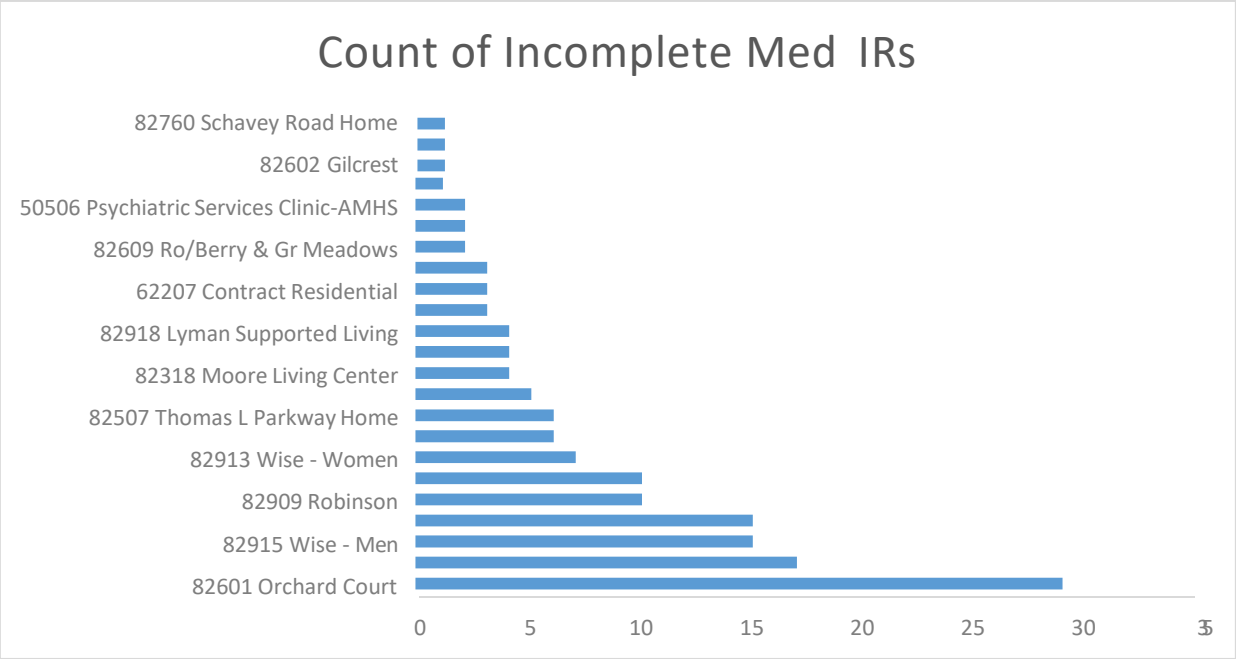
Emergency Care IRs

	Total
Illness	**207**
EMT	133
Hospitalization	59
No hospital or EMT	14
Neither	1
Injury	**87**
EMT	76
Hospitalization	7
No hospital or EMT	4
	5
EMT	2
Hospitalization	2
Neither	1
Total	**299**

End of Year Incidents Unsigned by on-site staff (Stuck in web portal)

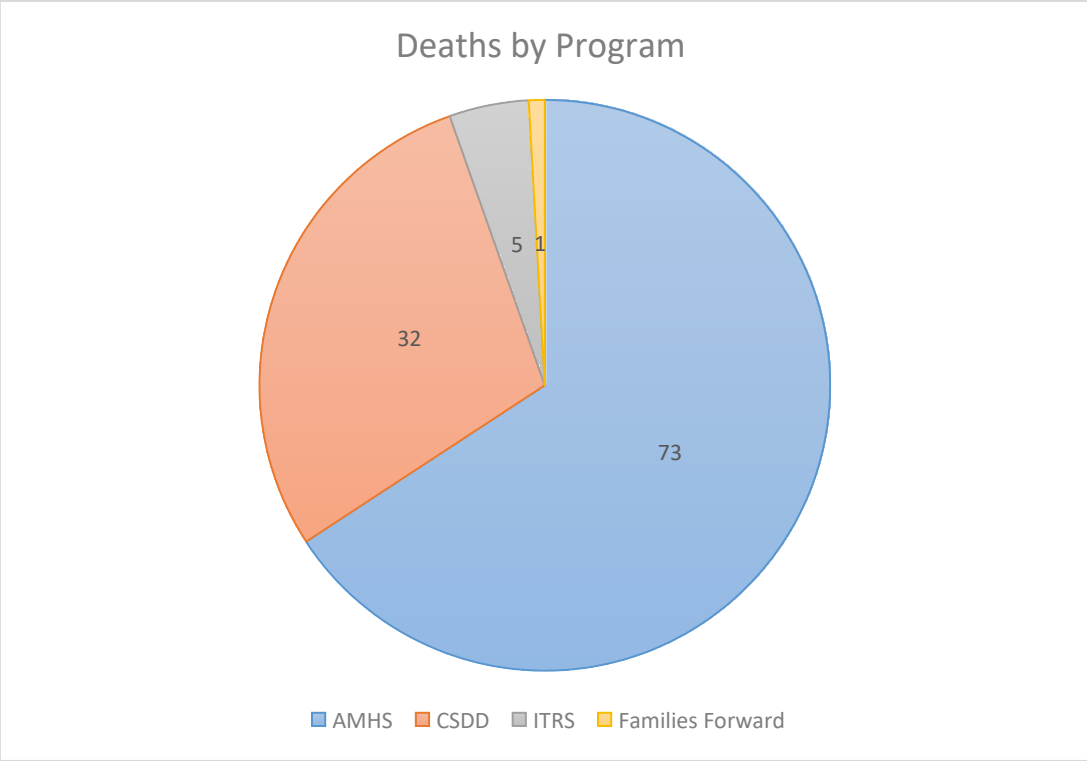


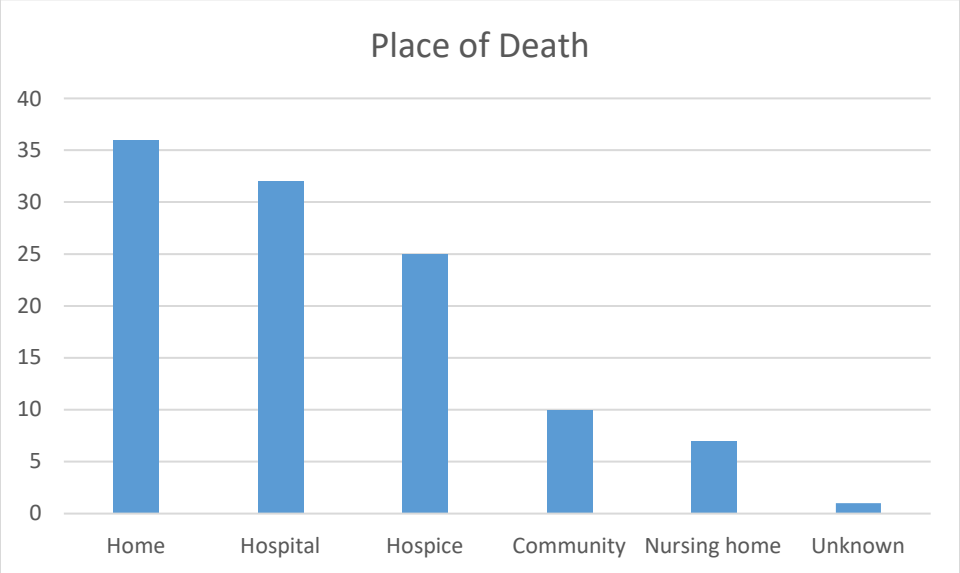




Deaths

Cause	Count
Natural - Diabetes	18
Natural - Vascular disease	15
Accident - Overdose	11
Natural - Unknown	10
Natural - Lung Disease	8
Natural - Pneumonia	7
Natural - neurological	6
Accident	6
Natural - Aspiration	5
Natural - Cancer	5
Natural - Acute bowel disease	5
Natural - Infection (COVID-19)	4
Homicide	3
Suicide	2
Natural - Kidney disease	2
Natural - Infection	2
Natural - Liver Disease	1
Total	111





Age	
Range	**17-91**
Average	**58**
Median	**62**

Vehicles Accidents

In FY22 CMHA-CEI employees reported three vehicle accidents.

Sentinel Events

CMHA-CEI reported two sentinel events in FY2022. A consumer in Life Consultation was found dead in their AFC home after falling down the stairs overnight. A second consumer was struck by a vehicle outside of their AFC home. QCSRR completed a root cause analysis for both of these events and reported them to CARF and to MSHN.

Two additional events were reviewed as possible sentinel events, and root cause analysis was completed for consumers who died from choking related incidents.

Medicaid Event Verification Audit

For FY22, there were two Medicaid Event Verification audits held by MSHN. June and December 2022.

Findings from the June 2022 MEV are as follows:

- Lines 176 thru 181. Claims for H2015 Community Living Supports were submitted without supporting documentation thus resulting in an inability to confirm documentation of service agrees to claim date and time of the service.
- Line 475. Documentation of place of contact for H0036 Home Based Services does not match place of contact on claim submission. Documentation within body of the progress note indicates service was provided in the office; claim submission (SAL) lists place of contact as community.
- Lines 610, 617, 618. Claims for T1020 Personal Care in Licensed Specialized Residential Setting were submitted without supporting documentation thus resulting in an inability to confirm documentation of service agrees to claim date of the service.
- Lines 611, 616, 619. Claims for H2016 Community Living Supports (per diem) were submitted without supporting documentation thus resulting in an inability to confirm documentation of service agrees to claim date of the service.
- Lines 2, 4 thru 9, 14, 16, 17, 20 thru 27, 29 thru 34. Incorrect use of U7 modifier. The U7 program modifier is not required if fiscal intermediary is used in a respite-only arrangement.
- Lines 2, 4 thru 9, 14, 16, 17, 20 thru 27, 29 thru 34. Claims for T1005 Respite Services were submitted without the required provider credential modifier (HM-DSP, TD-Registered Nurse or TE-Licensed Practical Nurse).
- Line 3, 10, 11, 13, 15, 18, 28, 36, 37. Claims for 97530 Occupational Therapy provided by an Occupational Therapist were submitted without the required provider credential modifier (HN-Bachelor's level, HO-Master's level or HP-Doctoral level).
- Lines 12, 35, 144, 168, 170, 186, 197, 211, 293 339, 370, 379, 549, 550, 575. Claims for T1017 Targeted Case Management provided by a Master's level clinician were submitted without the required HO provider credential modifier.
- Line 19. Claim for T2025 Fiscal Intermediary Services was incorrectly submitted with the U7 modifier. FI services are provided through a contract between the FI and CMHSP and do not meet requirements for the U7 modifier.
- Lines 51, 57. Claims for H0039 Assertive Community Treatment provided by a Limited Licensed Psychologist were incorrectly submitted with the HO provider credential modifier. Psychologists (both licensed and limited licensed) should report services with the AH modifier.
- Lines 73, 77, 78, 81, 82, 86, 90, 91, 95, 96, 97, 101, 104, 105, 108, 113, 116, 434, 437, 440, 441, 444, 447, 454, 455 458, 459 462, 466, 470, 473 thru 477, 479, 480, 482, 485, 486 thru 488, 491, 492, 494, 498. Claims for H0036 Home Based Services provided by a Master's level clinician were submitted without the required HO provider credential modifier.
- Lines 76, 85, 94, 102, 111, 112, 117. Claims for H2022 Wraparound Services provided by a Bachelor's level clinician were submitted without the required HN provider credential modifier.
- Lines 87, 109. Claims for 99214 Evaluation and Management of Established Patient provided by a Psychiatrist were incorrectly submitted with the AG provider credential modifier. Specialty physicians should report services with the AF modifier.
- Line 222. Claim for 99213 Evaluation and Management of Established Patient provided by a Psychiatrist were submitted without the required AF provider credential modifier.

- Lines 298, 300 thru 306, 308 thru 310, 312 thru 314, 316 thru 319, 321, 322, 324 thru 328, 330 thru 332, 335 thru 338, 340, 341, 344, 345, 347, 348, 350 thru 357, 359 thru 361, 363 thru 366, 368, 369, 371, 372, 374, 376, 378, 380 thru 385, 387 thru 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425 thru 429. Claims for 97153 ABA Adaptive Behavior Treatment provided by a behavior technician were submitted without the required HM provider level modifier.
- Line 435. Claim for 90792 Psychiatric Diagnostic Evaluation with Medical Services provided by a psychiatrist was submitted without the required AF provider credential modifier.
- Lines 445, 450, 464, 484, 489. Claims for 99214 Evaluation and Management of Established Patient provided by a Psychiatrist were submitted without the required AF provider credential modifier.
- Line 452. Claim for T1023 Prescreening for Impatient Program provided by a Limited Licensed Psychologist was incorrectly submitted with the HO provider credential modifier. Psychologists (both licensed and limited licensed) should report services with the AH modifier.
- Line 538. Claim for T1017 Targeted Case Management provided by a Limited Licensed Psychologist was submitted without the required AH provider credential modifier.
- Lines 625, 648. Claims for T1017 Targeted Case Management provided by a Bachelor's level clinician were submitted without the required HN provider credential modifier.
- Line 485. Claim for H0036 Home Based Services was incorrectly submitted with the HS modifier. Documentation indicates clinician met with client and parent jointly.
- Lines 176 thru 181. Claims for H2015 Community Living Supports were submitted without supporting documentation thus resulting in an inability to confirm documentation of service falls within scope of the service billed.
- Lines 380 thru 385, 387. Claims for 97153 ABA Adaptive Behavior Treatment were submitted with incorrect rendering provider. According to documentation, rendering provider was Jessica Dent not Garrison Hocker as submitted on the claim.
- Line 386. Claim for 97155 ABA Clinical Observation and Direction of Adaptive Behavior Treatment was submitted with incorrect rendering provider. According to documentation, rendering provider was Meaghan Olger not Garrison Hocker as submitted on the claim.
- Lines 388, 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425 thru 429. Claims for 97153 ABA Adaptive Behavior Treatment were submitted with incorrect rendering provider. According to documentation, rendering provider was Jessica Dent not Meaghan Olger as submitted on the claim.
- Lines 380 thru 385, 387 thru 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425. Unable to locate evidence beneficiary specific IPOS training occurred prior to staff person, Jessica Dent, providing 97153 ABA Adaptive Behavior Treatment. Training record located confirmed training date as 12/6/21.
- Line 472. Claim for 90791 Psychiatric Diagnostic Assessment without Medical was submitted with incorrect rendering provider. According to documentation, rendering provider was Aziza Adawe not Sarah Greenwood as submitted on the claim.
- Lines 513, 531. Unable to locate evidence beneficiary specific IPOS training occurred prior to staff person Andrienne Ruggerio, proving H2015 Community Living Supports. Per Shaina, CEI QI will work with AMHS program and create a CAP for long term correction.
- Lines 610, 617, 618. Claims for T1020 Personal Care in Licensed Specialized Residential Setting were submitted without supporting documentation thus resulting in an inability to confirm documentation of service falls within scope of the service billed.
- Lines 611, 616, 619. Claims for H2016 Community Living Supports (per diem) were submitted without supporting documentation thus resulting in an inability to confirm documentation of

service falls within scope of the service billed.

The following Corrective Action Plan was submitted and accepted by MSHN to address the above finding:

- Lines 176 thru 181. The provider billed services incorrectly. A fund recoupment was sent to the provider on 5/5/22.
- Line 475. CMHA-CEI Finance-Claims unit is working with the Families Forward program to verify and correct the claim and place of contact.
- Lines 610, 611, 616, 617, 618, 619 . Additional documentation obtained from provider that verify service dates and submitted to Box. Lines 176 thru 181. The provider billed services incorrectly. A fund recoupment was sent to the provider on 5/5/22.
- Lines 380 thru 385, 387. CMHA-CEI Finance Claims department is working with the provider to verify and make corrections to the claims.
- Line 386. CMHA-CEI Finance Claims department is working with the provider to verify and make corrections to the claims.
- Lines 2, 4 thru 9, 14, 16, 17, 20 thru 27, 29 thru 34. CMHA-CEI Finance department completed modifier corrections for listed claims.
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- Line 3, 10, 11, 13, 15, 18, 28, 36, 37. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 12, 35, 144, 168, 170, 186, 197, 211, 293 339, 370, 379, 549, 550, 575. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 19. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 73, 77, 78, 81, 82, 86, 90, 91, 95, 96, 97, 101, 104, 105, 108, 113, 116, 434, 437, 440, 441, 444, 447, 454, 455 458, 459 462, 466, 470, 473 thru 477, 479, 480, 482, 485, 486 thru 488, 491, 492, 494, 498. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 76, 85, 94, 102, 111, 112, 117. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 87, 109. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 222. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 298, 300 thru 306, 308 thru 310, 312 thru 314, 316 thru 319, 321, 322, 324 thru 328, 330 thru 332, 335 thru 338, 340, 341, 344, 345, 347, 348, 350 thru 357, 359 thru 361, 363 thru 366, 368, 369, 371, 372, 374, 376, 378, 380 thru 385, 387 thru 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425 thru 429. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 435. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 445, 450, 464, 484, 489. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 452. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 538. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 625, 648. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 485. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 176 thru 181. The provider billed services incorrectly. A fund recoupment was sent to the provider on 5/5/22.

- Lines 380 thru 385, 387. CMHA-CEI Finance Claims department is working with the provider to verify and make corrections to the claims.
- Line 386. CMHA-CEI Finance Claims department is working with the provider to verify and make corrections to the claims.
- Lines 388, 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425 thru 429. CMHA-CEI Finance Claims department is working with the provider to verify and make corrections to the claims.
- Lines 380 thru 385, 387 thru 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425. The claims will be corrected by CMHA-CEI Finance Department.
- Line 472. Rendering provider on claim has been corrected.
- Lines 513, 531. QI is working with the AMHS program to determine a long term correction. QI will attend AMHS staff and/or manager meetings and provide assistance with creating and implementing IPOS training documentation sheets.
- Lines 610, 617, 618. Additional documentation obtained from provider that verify service dates and submitted to Box.
- Lines 611, 616, 619. Additional documentation obtained from provider that verify service dates and submitted to Box.
- Lines 2, 4 thru 9, 14, 16, 17, 20 thru 27, 29 thru 34. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 2, 4 thru 9, 14, 16, 17, 20 thru 27, 29 thru 34. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 3, 10, 11, 13, 15, 18, 28, 36, 37. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 12, 35, 144, 168, 170, 186, 197, 211, 293 339, 370, 379, 549, 550, 575. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 19. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 51, 57. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 73, 77, 78, 81, 82, 86, 90, 91, 95, 96, 97, 101, 104, 105, 108, 113, 116, 434, 437, 440, 441, 444, 447, 454, 455 458, 459 462, 466, 470, 473 thru 477, 479, 480, 482, 485, 486 thru 488, 491, 492, 494, 498. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 76, 85, 94, 102, 111, 112, 117. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 87, 109. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 222. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 298, 300 thru 306, 308 thru 310, 312 thru 314, 316 thru 319, 321, 322, 324 thru 328, 330 thru 332, 335 thru 338, 340, 341, 344, 345, 347, 348, 350 thru 357, 359 thru 361, 363 thru 366, 368, 369, 371, 372, 374, 376, 378, 380 thru 385, 387 thru 389, 391, 394 thru 401, 404 thru 408, 410, 411, 414 thru 416, 418 thru 423, 425 thru 429. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 435. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 445, 450, 464, 484, 489. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 452. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 538. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Lines 625, 648. CMHA-CEI Finance department completed modifier corrections for listed claims.
- Line 485. CMHA-CEI Finance department completed modifier corrections for listed claims.

Findings from the December 2022 MEV are as follows:

- Line 235. Documentation states that service was 90 minutes, 6 units should be billed, not 15. Per CEI, finance team has corrected claim. Please upload evidence of voided/corrected encounters to Box.
- Line 241. Documentation states that service was 60 minutes, 4 units should be billed, not 15. Per CEI, finance team has corrected claim. Please upload evidence of voided/corrected encounters to Box.
- Lines 22, 23, 25, 27, 28, 29, 31, 32, 33, 35, 37, 39, 40. Unable to verify IPOS training for Danni DiTrapani and Geanina Luis.
- Lines 42-57, 59-61. Unable to locate IPOS training for Jordon Taylor.
- Line 154. Unable to locate IPOS training for Bethany Long.
- Lines 211-220, 222-230. Unable to locate IPOS training for Judy B. for case selection dates (4/4/22 -5/16/22). (IPOS training form uploaded is for Sept 2022)
- Line 287. Unable to locate Artimese King IPOS training.
- Line 307. Progress note has no narrative (and no goals addressed).
- Lines 326, 327, 330, 331, 336, 337, 340, 341, 344. IPOS training form provided is for 11/18/22 and occurred after the dates of services (4/1/22 – 4/9/22). Need IPOS training form for Sara D.

The Corrective Action Plan for the December 2022 MEV Review will be finalized and submitted to MSHN in February, 2023 to address the above findings.

FY22 Chart Review Results

Chart Review Process

Chart reviews are completed on a quarterly basis by the Quality Improvement and Utilization Management team. Specific programs to be chart reviewed are selected through the Quality Improvement and Compliance Committee and Program Need. A random sample of charts are selected with the unit's charts that are being reviewed that quarter.

Reviews will be completed at least quarterly and will address:

a. Quality of service delivery as evidenced by the record of the consumer;
b. Appropriateness of services;
c. Patterns of services utilization; and
d. Model fidelity, when an evidence-based practice is identified.

QCSRR compiles the aggregate data and forward to the Clinical Programs. QI will schedule a meeting with the clinical program to review results, determine areas of improvement, and develop a plan to address the issues identified, if needed.

The clinical record review results will be discussed quarterly at the Quality Improvement and Compliance Committee.

Chart Review Schedule

Timeframe is when the actual chart reviews were completed, Reviews include documentation from the previous 12 months prior to the review quarter.

Timeframe	Programs for Chart Review
FY22 1st Quarter	Autism/ABA
FY22 2nd Quarter	ITRS
FY22 3rd Quarter	Outreach and MROP
FY22 4th Quarter	HSW

Chart Review Results

Aggregate Chart Review Standard Ratings	
Completely Met	100% Compliance
Substantially Met	85-99% Compliance
Partially Met	70-84% Compliance
Not Met	69% and Below

FY22 Q1 Chart Review Results

Autism/ABA Chart Review FY22 Quarter 1		
Standard	**# of charts reviewed**	**Overall**
For closed cases, was the discharge summary/transfer completed in a timely manner? (consistent with CMSHP policy)	13	84.6%
Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and b. Individual's status /condition at discharge	13	96.2%
Does the discharge record include a plan for re-admission to services if necessary?	12	100.0%
Does the documentation include: a. Recommendations. b. Referrals; and c. Follow up contacts	12	87.5%
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	30	78.3%
Are consumer's needs & wants are documented?	31	98.4%
Consumer chart reflects input and coordination with others involved in treatment?	31	100.0%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	31	93.5%
Substance use (current and history) included in assessment?	27	64.8%
Current physical health conditions are identified?	29	100.0%
Current health care providers are identified?	31	100.0%
Previous behavioral health treatment and response to treatment identified?	29	96.6%

Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	31	61.3%
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	31	75.8%
Pre-planning addressed when and where the meeting will be held.	30	93.3%
Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	31	96.8%
Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	31	93.5%
Pre-planning addressed who will facilitate the meeting.	31	93.5%
Pre-planning addressed who will take notes about what is discussed at the meeting.	31	93.5%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	31	53.2%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	29	98.3%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	31	82.3%
There is documentation of any restriction or modification of additional conditions & documentation includes: 1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.	5	60.0%

3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.		
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	31	95.2%
Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services	12	100.0%
If applicable, the IPOS addresses health and safety issues.	28	96.4%
If applicable, identified history of trauma is effectively addressed as part of PCP.	17	79.4%
Autism Only: Beneficiaries IPOS addresses the needs. A. As part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk. For example, a risk factor might be how to ensure consistent staffing in the event a staff did not show up. The backup plan is that the agency has a staff who is already trained in this child's IPOS and that staff person can be sent in the event a staff does not show up to provide a service.	30	86.7%

Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	31	75.8%
Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease?	18	100.0%
The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid consumers with written Service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.	16	100.0%
Reasons for decisions are clearly documented and available to the recipient.	18	97.2%
The involved provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested.	6	100.0%
A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	11	100.0%
Are services being delivered consistent with plan in terms of scope, amount and duration?	28	51.8%
For medication services: • informed consent was obtained for all psychotropic medication • evidence consumer informed of their right to withdraw consent at any time	4	37.5%

Is there a physician prescription or referral for each specialized service (Physical Therapy, Occupational Therapy, Speech Therapy, etc.)?	8	18.8%
Is there evidence of outreach activities following missed appointments?	21	78.6%
Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline?	30	51.7%
For Autism Benefit/Applied Behavioral Analysis: Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP.	29	74.1%
For Autism Benefit/Applied Behavioral Analysis: Beneficiaries IPOS are reviewed at intervals specified in the MSA 15-59 (minimally every three months) and if indicated, adjusting the service level and setting(s) to meet the child's changing needs.	30	68.3%
For Autism Benefit/Applied Behavioral Analysis: Beneficiaries whose average hours of ABA services during a quarter were within the suggested range for the intensity of service plus or minus a variance of 25%.	29	25.9%
For Autism Benefit/Applied Behavioral Analysis: Observation Ratio: Number of Hours of ABA observation during a quarter are > to 10% of the total service provided.	28	71.4%
For all applicable Waiver Programs: The IPOS is updated at least annually/365 days For 1915(i)- formal review of plan with individual and/or guardian completed.	19	89.5%
For all Waiver Programs: Individual served received health care appraisal.	23	65.2%
Total Charts Reviewed	40	

FY22 Q2 Chart Review Results

ITRS Chart Review FY22 Quarter 2		
Standard	**# of charts reviewed**	**Overall**
Screen/Admission/Assessment		
At point of initial contact, provider collected the following: • Date of initial contact, Signature of Staff Person Collecting Information, Follow-up Communication(s) • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination	19	89.0%
Provider obtains the following information: • Medical Information including o Primary Care Provider Name, Address, Telephone o Date of Last Physical o Relevant Medical Information • Mental Health background & present issues • SUD History – Use & Treatment • Legal background and present issues • Emergency Contact • Financial Information (Block Grant Only)	19	76%
In addition to required screening information captured in REMI, there is evidence of screening for: • HIV/AIDS, STD/Is, TB, Hepatitis • Trauma	19	74%
Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment • Advanced Directives • Member Handbook • SUD Recipient Rights	19	97%

Consumer strengths are documented. Examples of strengths might be a health support network, stable housing, a willingness to participate in counseling, etc.	19	97%
FASD The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral: When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the client will be referred to the primary care physician for further assessment. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation.	8	88%
Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care • MDOC referred individuals provided assessment regardless of screening documentation	18	83%
Screening completed for Gambling Disorder in REMI. If screen was positive, the 10-question assessment was completed.	14	86%
Individual Treatment/Recovery Planning and Documentation		
The amount, scope, and duration are identified in the treatment/recovery plan and appropriate for consumer's identified goals and objectives.	18	69%
Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 3rd session • Residential – within 72-hours of admission • Detoxification – within 72-hours of admission	17	94%
Is there evidence of strength-based treatment and recovery planning	18	81%

Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • History/Risk/Present Trauma • Gambling	17	65%
Plan includes the following: 1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan. 2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients. 3. Measurable objectives – The ability to determine if and when an objective will be completed. 4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan. 5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature. 7. Recovery planning activities are taking place during the treatment episode	18	44%
Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. • Outpatient – minimal 90-day • Residential/Withdrawal Management – 7-day	11	64%

The treatment and recovery plan progress review to check for: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	14	57%
Case management services shall be guided by each client's individualized treatment plan. Treatment plan review(s) will incorporate case management goals and outcomes with targeted completion dates that are consistent with the treatment plan and are reflected and/or modified in treatment plan review(s).	14	71%
An evidence-based practice was used and documented in the record for trauma.	15	53%
An evidence-based practice was used and documented in the record.	17	94%
Record Documentation & Progress Notes		
Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals.	16	75%
Services are provided as specified in the plan(s).	17	76%
Coordination of Care		
There is evidence of primary care physician coordination of care efforts.	14	54%
here is evidence of coordination of care with external entities including, but not limited to, legal system, child welfare system, behavioral healthcare system. • MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent	17	94%
There is evidence of effective coordination of care for any consumer currently or previously enrolled with external SUD provider and coordinating care efforts align with best practice guidelines.	12	88%
There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	14	79%
Discharge/Continuity in Care		

Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc.	14	64%
Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	15	80%
Residential detoxification At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. Residential The recipient record for residential service categories shall also include medical history and physical examination	8	100%
Residential Treatment PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission	8	100%
Chart reflects services provided in accordance with the ASAM LOC Determination. • 3.1 = 5 hours Core Services & 5 hours Life Skills/week • 3.3= 13 hours Core Services & 13 hours Life Skills/week • 3.5 & 3.7 = 20 hours Core Services & 20 hours Life Skills/week	10	85%
Consent to Share		
Resident chart includes the following information: • Standard demographic information • Releases of Information (MSHN, Medical, Treatment Provider, Emergency Contact) • Signed Acknowledgement of Rules	12	75%
Total Charts Reviewed	19	

Outreach and MROP FY22 Quarter 3							
Standard			**# of Charts Reviewed**		**Overall %**		
	# of Charts Reviewed	Overall		MROP	%	Outreach CM	%
Intake/Assessment							
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	25	62.0%		12	70.8%	13	53.8%
Are consumer's needs & wants are documented?	25	100.0%		12	100.0%	13	100.0%
Consumer chart reflects input and coordination with others involved in treatment?	24	95.8%		12	91.7%	12	100.0%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	24	95.8%		12	91.7%	12	100.0%
Substance use (current and history) included in assessment?	25	100.0%		12	100.0%	13	100.0%
Current physical health conditions are identified?	25	100.0%		12	100.0%	13	100.0%
Current health care providers are identified?	24	87.5%		11	72.7%	13	100.0%
Previous behavioral health treatment and response to treatment identified?	25	92.0%		12	83.4%	13	100.0%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	25	86.0%		12	83.3%	13	88.5%
Did crisis screening and other life domain needs screening occur?	25	100.0%		12	100.0%	13	100.0%
Was consumer offered the opportunity to develop a Crisis Plan?	25	100.0%		12	100.0%	13	100.0%
Pre-Planning							
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	25	60.0%		12	54.2%	13	65.4%

Pre-planning addressed when and where the meeting will be held.	25	96.0%		12	100.0%	13	92.3%
Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	25	96.0%		12	100.0%	13	92.3%
Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	25	96.0%		12	100.0%	13	92.3%
Pre-planning addressed who will facilitate the meeting.	25	96.0%		12	100.0%	13	92.3%
Pre-planning addressed who will take notes about what is discussed at the meeting.	25	96.0%		12	100.0%	13	92.3%
Person Centered Planning /IPOS							
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	25	96.0%		12	100.0%	13	92.3%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	25	94.0%		12	95.8%	13	92.3%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	25	56.0%		12	62.5%	13	50.0%
The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs, community resources, and natural supports.	25	100.0%		12	100.0%	13	100.0%

The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	24	97.9%	11	95.5%	13	100.0%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	25	100.0%	12	100.0%	13	100.0%
Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.	25	100.0%	12	100.0%	13	100.0%
The services which the person chooses to obtain through arrangements that support self-determination.	18	100.0%	8	100.0%	10	100.0%
The estimated/prospective cost of services and supports authorized by the CMHSP	25	100.0%	12	100.0%	13	100.0%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	25	82.0%	12	66.7%	13	96.2%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	25	24.0%	12	20.8%	13	26.9%
A timeline for review.	25	100.0%	12	100.0%	13	100.0%

Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services	18	94.5%		8	100.0%	10	90.0%
If applicable, the IPOS addresses health and safety issues.	25	96.0%		12	91.7%	13	100.0%
If applicable, identified history of trauma is effectively addressed as part of PCP.	22	79.5%		11	72.7%	11	86.4%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	25	22.0%		12	16.7%	13	26.9%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	25	98.0%		12	95.8%	13	100.0%
Documentation							
Consumer was provided written information related to Recipient Rights?	25	96.0%		12	100.0%	13	92.3%
Was consumer was informed of Informal Conflict Resolution?	25	100.0%		12	100.0%	13	100.0%
Consumer was given accurate and timely information about the Grievance and Appeal Process?	25	100.0%		12	100.0%	13	100.0%
Customer Service							
Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease?	20	100.0%		9	100.0%	11	100.0%

The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid consumers with written Service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.	2	100.0%		1	100.0%	1	100.0%
Reasons for decisions are clearly documented and available to the recipient.	20	100.0%		9	100.0%	11	100.0%
A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	8	100.0%		1	100.0%	7	100.0%
Delivery and Evaluation							
Are services being delivered consistent with plan in terms of scope, amount and duration?	24	45.8%		12	54.2%	12	37.5%
Monitoring and data collection on goals is occurring according to time frames established in plan?	25	88.0%		12	95.9%	13	80.8%
Are periodic reviews occurring according to time frames established in plan?	24	87.5%		12	91.7%	12	83.3%
Program Specific Service Delivery							
For medication services: • informed consent was obtained for all psychotropic medication • evidence consumer informed of their right to withdraw consent at any time	25	30.0%		12	62.5%	13	0.0%
Is there direct access to a specialist, as appropriate for the individual's health care condition?	10	100.0%		5	100.0%	5	100.0%

Is there evidence of outreach activities following missed appointments?	20	80.0%		11	81.8%	9	77.8%
Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline?	25	12.0%		12	12.5%	13	11.5%
Discharge/ Transfers							
For closed cases, was the discharge summary/transfer completed in a timely manner? (consistent with CMSHP policy)	1	100.0%		1	100.0%	1	100.0%
Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and b. Individual's status /condition at discharge	1	100.0%		1	100.0%	1	100.0%
Integrated Physical and Mental Health Care							
The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	23	82.6%		11	81.8%	12	83.3%
As authorized by the consumer, the CMHSP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.	20	95.0%		10	100.0%	10	90.0%

The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	10	35.0%		6	33.3%	4	37.5%
Total Charts Reviewed	27			12		14	

FY22 Q4 Chart Review Results

HSW FY21 Quarter 4		
Standard	**# of Charts Reviewed**	**Overall %**
Intake/Assessment		
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	65	79%
Are consumer's needs & wants are documented?	65	99%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	65	98%
Substance use (current and history) included in assessment?	65	83%
Current physical health conditions are identified?	62	99%
Current health care providers are identified?	64	99%
Previous behavioral health treatment and response to treatment identified?	65	98%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	63	79%
Did crisis screening and other life domain needs screening occur?	65	98%

Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	64	91%
Pre-Planning		
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	65	92%
Pre-planning addressed when and where the meeting will be held.	64	95%
Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	65	91%
Pre-planning addressed the specific PCP format or tool chosen by the person to be used for PCP.	64	22%
Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	65	95%
Person Centered Planning /IPOS		
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	64	67%
if person has a guardian, the guardian should be included as well	64	95%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	63	99%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	63	66%

The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	64	88%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. Make note if there are any ranges used for services and give a 1 (MDHHS cited for med clinic, psychology, CLS)	63	69%
HSW review: BTP are documented in Smartcare, or if the TX plan has restrictive language, is there a BTP? a) Positive support plans don't necessarily need a BTP, but if there is a restrictive plan then YES they need a BTP There is documentation of any restriction or modification of additional conditions & documentation includes: 1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs. 3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.	14	50%
The services which the person chooses to obtain through arrangements that support self-determination.	32	97%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	61	84%

The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	63	82%
A timeline for review. (Are reviews occuring at least every 6 months?)	62	65%
Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services	22	100%
If applicable, the IPOS addresses health and safety issues.	63	97%
If applicable, identified history of trauma is effectively addressed as part of PCP.	29	59%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	62	72%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	62	85%
Customer Service		
Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease?	31	94%
The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid consumers with written Service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.	29	88%
Reasons for decisions are clearly documented and available to the recipient.	26	83%
ABDN present if a service was authorized and did not start within 14 days of authorization/delayed start due to lack of provider availability. (partial score if there is a note, full score if there is an ABDN)	24	85%
A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	12	92%
Delivery and Evaluation		

Are services being delivered consistent with plan in terms of scope, amount and duration? Pay close attention to Case Management! (score 0 if services are not occuring as authorized) Look at June, July, August months	63	39%
Monitoring and data collection on goals is occurring according to time frames established in plan?	63	83%
Are periodic reviews occurring according to time frames established in plan?	54	72%
Program Specific Service Delivery		
For medication services: • informed consent was obtained for all psychotropic medication • evidence consumer informed of their right to withdraw consent at any time	38	17%
Is there a physician prescription or referral for each specialized service (Physical Therapy, Occupational Therapy, Speech Therapy, etc.)? **script needs to include specific service, amount, and duration of services** (maybe a timeframe like 1 year etc.)	21	24%
Is there direct access to a specialist, as appropriate for the individual's health care condition?	29	100%
Is there evidence of outreach activities following missed appointments?	25	80%
Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline? the COC letter needs to have medications listed if consumer is with our Med Clinic	62	46%
Integrated Physical and Mental Health Care		
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	50	29%
Total Charts Reviewed	65	

Provider Monitoring

Overview

CMHA-CEI has 3 quality advisors who conduct site visits for contract sites for the following contract types:

- Applied Behavior Analysis/Autism provider
- Hospitals
- Community Living Support (CLS)/Respite/Nursing
- Residential type A & B
- Pre-Vocational Training/Skill Building
- CMH-CEI-Residential and Non Residential

Quality advisors conduct 3 types of site visits annually, a recipient rights review, a quality and compliance review, and a home and community based review, if necessary. Items reviewed during the site visits include:

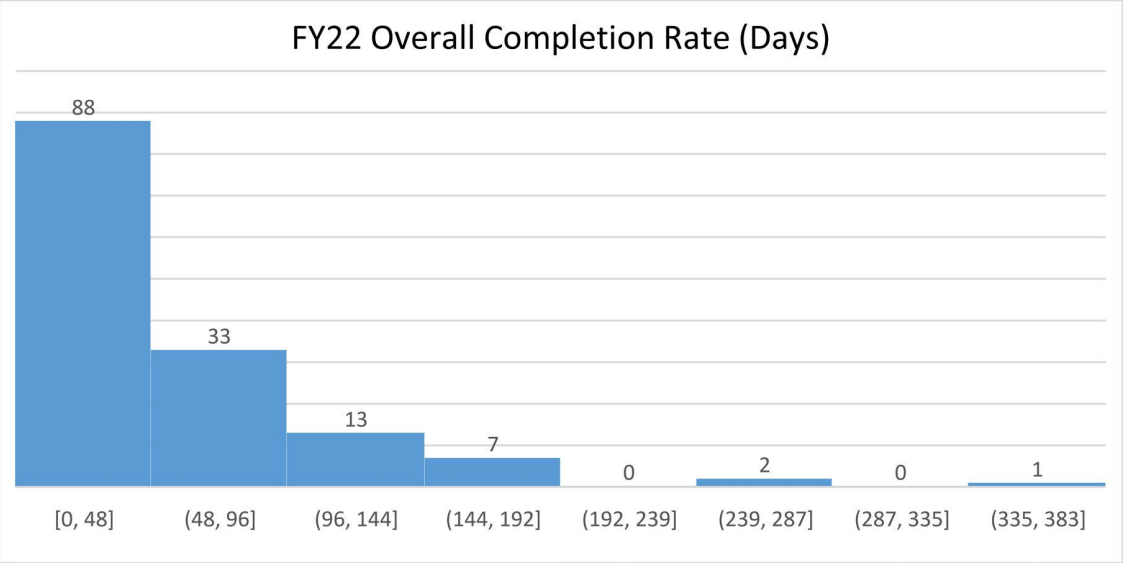
- Recipient Rights training dates for all staff (initial and annual)
- CMHA-CEI required staff training
- Background checks
- Person Centered Plan training and implementation
- Community inclusion documentation
- Documentation related to restrictions (if applicable)
- Medicaid Event Verification – documentation of billed services
- Tour of the site/facility for health or safety concerns
-

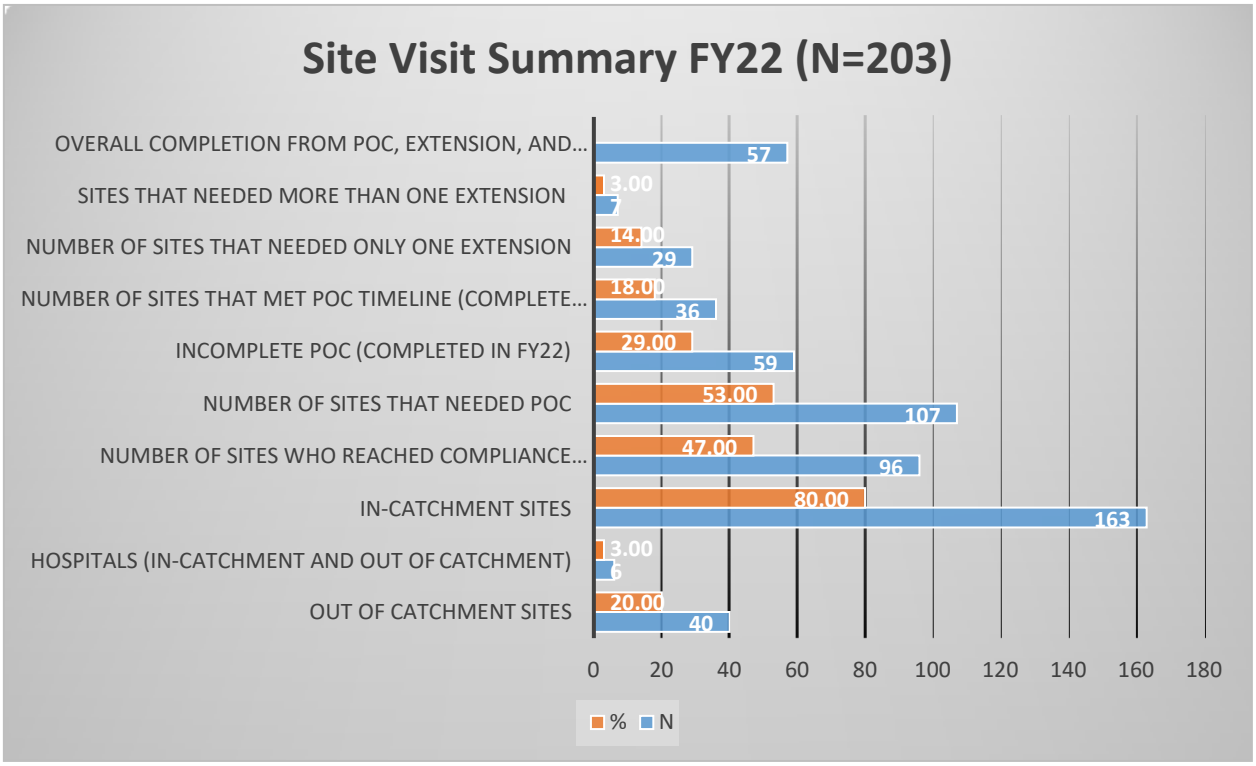
Some in-person site reviews resumed in August 2021 for follow-up on previous review findings and required corrective action plans. Site reviews during FY22 were conducted virtually and in person.

MDHHS waived some provider requirements in FY21 due to ongoing COVID-19 challenges. Quality Advisors focused on assisting providers in navigating COVID-19 protocol, reporting requirements, and other burdens providers experienced.

Site Visit Overview

- 203 Site reviews were conducted in FY22
- Overall completion rate (from initial visit date to full compliance for Recipient Rights Reviews) was an average of 50 days, which was an improvement from 57 days for FY21
    - 59 sites are still waiting full compliance for FY22.
    - 53% of sites required a Plan of Correction for either the Recipient Rights or Quality and Compliance portion of the review compared to 53% in FY21.
    - 47% of sites were found to be in full compliance at the time of review, and did not require a POC, compared to 47% in FY21





Improvement Opportunities

Quality advisors along with Contract & Finance Dept. and Clinical programs will continue to assist providers in the following areas in the coming year:

- Improved online training system (i.e., CMHA-CEI online system, Improving MI Practices system)
- Allocation of more online resource to cut down operating cost (utilize free online services for human resource management i.e., OIG checks, IChat, etc.)
- Collaborate with other CMHs to improve review process for Out of Catchment sites (i.e., Reciprocity process-MCHE web group)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Assisting providers navigate unique challenges caused and continued by the COVID-19 pandemic

Policy and Procedure Review

All Policies and Procedures were reviewed within the one-year timeline, for 100% compliance. CMHA-CEI began transitioning all Policies, Procedures, Guidelines, Forms, and Plans into a cloud-based Policy Management System. The system will automate prompts for annual updates and reviews to maintain CARF Compliance

Background

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Michigan Department of Health and Human Services (MDHHS) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), 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.

As MDHHS' EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted PIHPs delivering services to members enrolled in the Michigan Behavioral Health Managed Care Program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

The state fiscal year (SFY) 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance review for Michigan PIHPs consist of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021), and a review of the remaining seven standards in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 1-1 outlines the standards reviewed over the three-year review cycle.

Table 1-1—Compliance Review Standards

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: May 27, 2022.

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan Medicaid health plans. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[3] This standard includes a comprehensive assessment of a PIHP's information systems (IS) capabilities.

Summary of Findings

Table 1-2 presents an overview of the results of the SFY 2022 compliance review for **Mid-State Health Network**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Mid-State Health Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	84%
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	100%
Standard XI—Practice Guidelines	7	7	7	0	0	100%
Standard XII—Health Information Systems	12	12	11	1	0	92%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	93%
Total	119	119	105	14	0	88%

M = Met; NM = Not Met; NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Mid-State Health Network achieved full compliance in two of the seven standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of Sub contractual Relationships and Delegation and Practice Guidelines. The remaining five standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to Provider Selection and Grievance and Appeal Systems, as these areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Plan Process

For any program areas requiring corrective action, **Mid-State Health Network** is required to conduct a root cause analysis (RCA) of the finding and submit a CAP to bring the element into compliance.

The CAP must be submitted to MDHHS and HSAG within 30 days of receipt of the final report. For each element that requires correction, **Mid-State Health Network** must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG has prepared a customized template under Appendix B to facilitate **Mid-State Health Network**'s submission and MDHHS' and HSAG's review of corrective actions. The template includes each standard with findings that require a CAP.

MDHHS and HSAG will review **Mid-State Health Network**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **Mid-State Health Network** will be required to revise its CAP until deemed acceptable by MDHHS and HSAG.

To ensure the CAP is fully implemented, **Mid-State Health Network** will be required to submit periodic progress reports on the status of each action plan. A progress report template and instructions for completing and submitting the progress reports will be provided after the approval of **Mid-State Health Network**'s CA

MSHN Audit

MSHN conducted a complete virtual desk audit of CMHA-CEI in June 2022. Findings were as follows:

Delegated Managed Care Tool	Finding
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.4	No expedited review for the chart reviewed last year. However, reviewer able to see reference to an additional intrusive technique (Arms Reach) written into the plan dated 10.4.2021, but not reviewed or approved by the BTPRC on 10.18.21 or on 2.28.2022. This technique was first reviewed, based on documentation provided, on 2.28.2022 and no evidence of this as an emergent need or that an expedited review took place (or that this technique had been approved prior to implementation).
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.5	Reviewer unable to find evidence that this standard has been addressed again this year. This is a repeat citation and will need to be addressed within 30 days of this report.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.8	Reviewer able to see a document dated 10.4.2021, although this document doesn't contain any information. The entire assessment references review of another document, or left blank. CEI to ensure that an FBA is completed with fields on the template filled out whenever recommending any restrictive/intrusive interventions. As part of the CAP, CEI to provide both case specific as well as systemic remediation to adequately address this standard
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.9	Reviewer unable to see evidence of approve CAP implementation from 2021: "The plans for the BTP and AUT charts selected will be updated to contain results of inquiries about any medical, psychological or other factor that might put the individual subjected to intrusive or restrictive techniques at high risk of death injury or trauma and then be reviewed by the BTRC on 10/18/21. The updated plans and the BTRC review will be provided by 10/30/21." CEI to demonstrate that this standard has been addressed for the chart selected for this review and also evidence of systemic remediation to address this standard within 30 days of this report
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.10.	Reviewer able to find evidence of CAP implementation from 2021: " By 12/1/21 the Behavior Plan template will be updated to include language related to amount, scope and duration of the use of positive supports as part of the rationale for recommendation of more restrictive/intrusive strategies, as well as other BTPRC standards, prior to review, approval, and implementation." CEI to demonstrate that this standard has been addressed for the chart selected for this review and also evidence of systemic remediation to address this standard within 30 days of this report.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.14	The plan dated 10.4.21 includes a plan for monitoring and staff training. However, the Arms Reach intervention identified in that plan not reviewed or approved by the BTPRC until 2.28.22. Furthermore, this intrusive intervention not included as an intervention on the psychologists Quarterly Review Form that covers the dates of 11.4.21-2.4.2022. As a result, this standard not appropriately addressed and no way to ensure consistent implementation and/or documentation of this new intrusive technique.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.19	Reviewer unable to see evidence of full CAP implementation related to this standard from 2021: "The plan for the BTP chart selected will be updated to contain plan Review- frequency of reviewing collected data and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21." Reviewer able to see frequency of reviews listed in the BTPRC monitoring notes, but dates wrong and inconsistent (review dated 10.18.2021 says next review 2.13.21 and that next review of medications annually). Neither of the upcoming review dates on this document meet the standards for review.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.20.	Plan dated 10.4.21 includes responsibility for staff training, but reviewer unable to determine when the plan was fully implemented, as the arms reach was added to the plan but not reviewed by the committee for over 4 months. Additionally, reviewer unable to see evidence of staff training/in-servicing as well as full approval of the plan prior to implementation (despite approved CAP from 2021).
ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT) 13.2	○ The policy provided did not include the identification of all incidents that are currently required for the SUD residential providers. ○ Primary source verification-The 3 events reviewed were submitted to MSHN on 7/20/2022 past the required due date of 7/15/2022. ○ Two of the three events were reported as sentinel, however, when requesting the RCA it was indicated the events were inaccurately reported as sentinel. CEI has already initiated an improvement process for the sentinel event review. ○ It is recommended that the SUD events be included in the policy or a separate policy be developed.
Behavior Treatment Plan Review Committee	
1.3	CEI to ensure that approved CAP from 2021 is implemented across charts. CEI to provide evidence that signed consent is obtained for charts recommending restrictive and intrusive measures. Also, CEI to ensure that when plans are modified, then there is a clear indication of the date of the modification on the document. MSHN noted several versions of a behavior plan all with the same date but no reference to the changes, reason for the changes, date of implementation, and/or signed consent. This is a repeat finding, so MSHN asking for CEI to provide evidence of systemic remediation within 30 days of this report.
1.4	Reviewer able to see evidence of trainings and updated processes related to appropriate implementation of BTPRC standards. However, the process in place did not catch the challenges with this plan, as written, or lead to an identification of a need for an expedited review independently. MSHN

	reviewed the CAP that was approved last year to address this standard, and it does not appear that this CAP has been fully implemented, or effective, as it relates to this standard.
1.5	CEI to ensure that this standard is addressed and there is evidence that it is in practice within 30 days of this report.
1.6	CEI to provide evidence of a process to ensure that stakeholders are not writing in/recommending physical intervention in plans of service of behavior treatment plans. Furthermore, CEI to develop a process to ensure that instances of physical intervention ARE reported, as directed, when Medicaid paid supports are present and/or involved in the intervention. Then, CEI to ensure that this standard is adequately addressed if and when physical management or use of law enforcement are used more than 3 times in a 30 day period with evidence of both base specific and systemic remediation.
1.9	CEI to provide evidence of both case specific and systemic remediation to ensure that this standard is addressed.
1.12	CEI to ensure that all plans recommending restrictive/intrusive interventions contain all standards and are approved PRIOR to implementation. CEI to provide evidence of both case specific as well as systemic remediation to adequately address this standard.
1.13	CEI to ensure that all plans recommending restrictive/intrusive interventions contain all standards and are approved PRIOR to implementation. CEI to provide evidence of both case specific as well as systemic remediation to adequately address this standard
1.14	CEI to ensure that all plans recommending restrictive/intrusive interventions contain all standards and are approved PRIOR to implementation. CEI to provide evidence of case specific remediation to ensure that all parties have been trained on the current plan and the changes in the recommendations related to restrictive/intrusive measures that have all been removed from the plan.
1.18	CEI to ensure that all plans recommending restrictive/intrusive interventions contain all standards and are approved PRIOR to implementation. CEI to provide evidence of both case specific as well as systemic remediation to adequately address this standard.
1.20	CEI to ensure that all plans recommending restrictive/intrusive interventions contain all standards and are approved PRIOR to implementation. CEI to provide evidence of both case specific as well as systemic remediation to adequately address this standard.
Non Waiver	
Autism/ABA 8.7	- Auditor Response: Reviewer unable to review credentialing files for consumer. Please provide credentialing for current staff (BCBA/QBHP, BTs)

Autism/ABA 8.9	Evidence of CMHSP Corrective Action in response to the MDHHS ASD Site Review Auditor Response: Several cited areas still not in compliance. Please review findings and corrective action plan
Wavier Specific	
HSW 1.6	Evidence of CMHSP Corrective Action in response to the MDHHS HSW Site Review Auditor Response: Unable to see corrective action implementation for several standards for individual chart reviewed. Please refer to chart review for details and provide evidence within given timeframes.
SUD Delegated Managed Care Review	
4.5	Standard 4.5: Provider must utilize state developed Adverse Benefit Determination provided by MDHHS. Denied: Minutes to meeting provided but do not address standard. As this is a repeat finding, CEI to submit evidence of compliance with corrective action
4.11	Receipt of each grievance and appeal is acknowledged. The state developed acknowledgement letters provided by MSHN are utilized. Denied: Minutes to meeting provided but do not address standard. As this is a repeat finding, CEI to submit evidence of compliance with corrective action.
4.12	A written notice of the disposition of a grievance and appeal is provided and reasonable efforts to provide oral notice of an expedited resolution is made. The state developed MSHN resolution notice letters provided by MSHN are utilized. ○ Denied: Minutes to meeting provided but do not address standard. As this is a repeat finding, CEI to submit evidence of compliance with corrective action.
SUD Program Specific	
HOC 1.1	• Verified ITRS leadership minutes from 8.27.2022 uploaded met the initial corrective action response. • Please note this was not verified in the screening for REMI ID 926916 completed on 3/4/2022. This was discussed at the 6/10/2022 and it was shared that level of care determinations are not being completed at the first contact. Per discussion the provider will begin completing these. Please provide documentation example of a completed screening and level of care determination at the first contact with the corrective action response
HOC 2.1	• The documents uploaded include training on treatment plans including amount, scope, and duration. • Two separate plans were reviewed for recent clients. One was randomly selected by MSHN and one was provided by the agency. Neither treatment plan included amount. The plans reviewed had the scope (group/individual) and duration identified by a target date.

	Neither plan included an amount of groups or individuals that would be provided. Please ensure that the amount of services that are medically necessary to meet the treatment goals are documented in the plan. An example is group 3x a week for 15 days. Please provide an example of a treatment plan that includes amount, scope, and duration with the CAP response.
TRC 1.1	• Meeting minutes 8.27.2022 uploaded met the initial corrective action response • Please note this was verified in a record using REMI. ID 840308. Though it is noted the LOC was completed at the point of contact on 5/4/2022 it was not added to REMI until 6/7/2022. This indicates the standard is still not being met. • Met with CEI 6/10/2022 and they confirmed the level of care is not being done at the first point of contact. They have a plan to complete them at first contact going forward. Please submit an example with the CAP response of a screening completed at first contact.
TRC 2.1	Please note amount this was not documented in the treatment plan 5/10/2022. The nursing monitoring goal does contain this but the other goals do not. The have the scope (counseling, group) and duration (3 days from admission) but not the amount. Please ensure the amount is included (example individual counseling 1x per day for 5 days) to meet the goals identified in the plan. Please provide an example of a treatment plan that includes the amount, scope, and duration with the corrective action submission.

MSHN approved the following Corrective Action Plan to address the above findings:

Delegated Managed Care Tool	Finding
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.4	This BTP has been revised and went to BTC for approval on 8/1/22
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.5	QI completed a stakeholder survey and presented the results at the 8.1.22 BTC meeting. Uploaded BTC Survey July 2022, BTRC Agenda 8.1.22
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.8	Case Specific - This BTP has been revised and went to BTC for approval on 8/1/22. Systematic remediation – This standard has been added to the CEI BTP template. For non CEI plans QI will review plans to assure they

	meet all of the needed standards prior to the BTRC review. Uploaded Annual Assessment and Behavior Plan, Initial Assessment and Behavior Plan, BTC Review
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.9	Case Specific - This BTP has been revised and went to BTC for approval on 8/1/22. The AUT chart is not restrictive/intrusive therefore does not need to meet this standard. – provided BTRC notes regarding this. Systematic remediation – This standard has been added to the CEI BTP template. For non CEI plans QI will review plans to assure they meet all of the needed standards prior to the BTRC review. Uploaded Annual Assessment and Behavior Plan, Initial Assessment and Behavior Plan, BTC Review
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.10.	Case Specific - This BTP has been revised and went to BTC for approval on 8/1/22. Systematic remediation – This standard has been added to the CEI BTP template. For non CEI plans QI will review plans to assure they meet all of the needed standards prior to the BTRC review. Uploaded Annual Assessment and Behavior Plan, Initial Assessment and Behavior Plan, BTC Review
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.14	This BTP has been revised and went to BTC for approval on 8/1/22.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.19	This BTP has been revised and went to BTC for approval on 8/1/22.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.20.	This BTP has been revised and went to BTC for approval on 8/1/22.

ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT) 13.2	CMHA-CEI ITRS staff have developed a specific ITRS Incident Reporting Operating guideline. - QI attended an ITRS meeting and provided a training refreshed on incident reporting.
Behavior Treatment Plan Review Committee	
1.3	- Systemic remediation: All plans presented to BTRC will need to have special consent prior to approval by the committee. QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. Case specific – Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.4	A QI specialist has been attending and assisting Behavior Treatment Review Committee. The QI specialist will assist in training for Behavior Treatment Plans and increase compliance with MDHHS policy on behavior treatment plans. The QI Specialist will respond to current Corrective action plans and complete chart reviews, reviewing plans for restrictive language. In addition, we now have administrative assistance support at the BTRC to take minutes, and review timelines for BTP review. We also created a specific email group for the BTRC so that emergent emails can be sent to the group as a whole and prevent missing emails. QI staff is currently conducting chart reviews to look for restrictive language. This month we are reviewing HSW and sending to BTC. Next quarter QIi is looking for restrictive language throughout the agency
1.5	QI completed stakeholder survey, results discussed at 8.1.22 BTC Meeting.
1.6	QI is reviewing all incident reports for the use of physical management and law enforcement and completing analysis of if there are more than 3 in a 30-day period and submitting to the BTRC for review.

1.9	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.12	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. - Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.13	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. - Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.14	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. - Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.18	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. - Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
1.20	- Systemic remediation: QI will be completing review of plans prior to the BTRC meeting to assure the plan meets all of the requirements. - Case specific – After review, this consumer does not receive any services paid for through Medicaid. All of this consumer's ABA services are billed through Blue Care Network.
Non Waiver	
Autism/ABA 8.7	Uploaded staff credentialing documents

Autism/ABA 8.9	The 2019 MDHHS Corrective Action Plan was found to be not met in the 2021 MSHN audit. We submitted a new Corrective Action Plan in 2021 to address the items found out of compliance, and it was accepted. From the 2021 Corrective Action Plan, providers were trained, we completed the chart review and Autism Benefit Tracker to monitor ABA services. The 2022 audit findings again referenced the 2019 MDHHS Corrective Action Plan - we were not aware that we needed to again continue items from the 2019 MDHHS Corrective Action Plan. Our Autism program staff have taken many steps to improve the system and address program needs while working toward compliance.
Wavier Specific	
HSW 1.6	HSW Chart review responses uploaded. Documentation provided within chart review response.
SUD Delegated Managed Care Review	
4.5	CMHA-CEI Compliance Officer attended an ITRS leadership meeting and presented on Grievance and Appeals, ABDN. Meeting minutes and PowerPoint are provided. Uploaded Meeting Minutes 07-29-2022 and Grievance and Appeal Process - Revised_07.15.22
4.11	CMHA-CEI Compliance Officer attended an ITRS leadership meeting and presented on Grievance and Appeals, ABDN. Meeting minutes and PowerPoint are provided. Uploaded Meeting Minutes 07-29-2022 and Grievance and Appeal Process - Revised_07.15.22
4.12	CMHA-CEI Compliance Officer attended an ITRS leadership meeting and presented on Grievance and Appeals, ABDN. Meeting minutes and PowerPoint are provided. Uploaded Meeting Minutes 07-29-2022 and Grievance and Appeal Process - Revised_07.15.22
SUD Program Specific	
HOC 1.1	HOC has assigned a rotating clinical staff to be responsible for the prescreening process daily. If the clinical staff is not available to take the phone call, then the clerical or Program Coordinator will complete the prescreening process in real time in REMI.
HOC 2.1	HOC will start using the full treatment plan document in the EHR, SmartCare which includes prompting and separate data entry to include amount, scope, and duration noted for each goal/objective

TRC 1.1	○ TRC will work with the Access Department to continuing to develop a process for a warm handoff (transfer) to occur to TRC staff. Then the screening process can be completed as timely as possible with the client. TRC is also piloting with the Access Department to screen their own calls one day a week so they can complete the REMI prescreening process simultaneously.
TRC 2.1	TRC is transferring from their paper treatment plan to the initial treatment plan in the EHR, SmartCare. TRC staff will also be informed of the significance of including the amount, scope, and duration noted for each goal/objective.

MDHHS Audit

Every two years, MDHHS audits the three waiver programs: SEDW, CWP, and HSW. Quality Improvement staff work with the clinical departments to meet the standards MDHHS has set for these programs.

In 2022, CMHA-CEI underwent a full site review by MDHHS for SEDW, CWP, and HSW. The site review was conducted for the full MSHN region and included all 12 CMHSPs in the region. The review was completed virtually. For CMHA-CEI 7 HSW charts, 2 CWP charts, and 11 SEDW charts were reviewed by MDHHS. Areas reviewed were case files, provider qualification, and administrative processes related to health and welfare.

Children's Waiver Program

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
A. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4. AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards	1	0	See HSW report.	
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents. 42 CFR 438.230(b)(4) 42 CFR 438.810	1	0	See HSW report.	

Medicaid Managed Specialty Supports and Services contract, Section 6.4. AFP Sections 2.5, 3.8, 3.1.8 Waiver Assurance for Participant Safeguards				
A.1.3 Review and verify that the process is being implemented according to policy. Waiver Assurance for Participant Safeguards	1	0	See HSW report.	
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	See HSW report.	
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.	1	0		

• PIHP/CMHSP provides evidence of the policy • Review of PIHP/CMHSP provisional approval documents				
A.2.CWP				
A.2.2. Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)	12	1	**<u>Saginaw County CMH Authority</u>** **WSA# 69313:** Respite reflected in Plan as H0045, CLS being provided/invoiced in facility-based location (not allowed under CWP).	**CMHSP/PHIP Response**: **Individual Remediation:** **SCCMH** ☒ By 9/30/2022 Case Holder will conduct meeting between consumer/family and Respite Provider to discuss respite requirements under CWP benefit and/or to re-evaluate CLS goal to determine if consumer requires additional CLS services in lieu of Respite. Addendum to IPOS will be completed to clarify where Respite Services will be provided moving forward, either in consumer's home or in community (if plan includes community integration goa); or CLS goal will be updated to reflect need for additional services. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic

				remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **SCCMH** ☒ BY 11/30/22 SCCMHA will develop a procedure to ensure Respite Services are provided to individuals receiving services under CWP benefit only in home or community settings. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found (see below/other)** ☒ No systemic remediation found (see below/other ☐ No timelines indicated ☒ **Other:** **For SCCMHA**: Remediations do not appear to address the citations. • For Respite, the citation was for using an incorrect

				code (H0045) within plan/authorizations. Only CPT code T1005 can be used for respite, under CWP. • For CLS, Citation was for providing CLS service in a location (facility based) not allowed under CWP. Please revise both individual and systemic remediations. **CMHSP/PHIP 2nd Response**: **SCCMHA Individual Remediation:** By 11/30/2022 addendum to IPOS will be completed to clarify only T1005 Respite Services will be provided moving forward. By 11/30/2022, addendum to IPOS will be completed to clarify where CLS Services will be provided moving forward, either in consumer's home or in community (if plan includes community integration goal). **SCCMHA Systemic Remediation:** By 11/30/2022, SCCMHA will work with facility-based CLS/Respite Providers to move CLS/respite services provided in

				these settings to instead be provided in a community-based setting. Or, if possible, SCCMHA will work with facility-based CLS/Respite Providers to ensure their facilities are approved by MDHHS as a licensed respite facility. By 9/30/2022, SCCMHA will present information regarding this requirement for CLS/respite services at the ABA Provider meeting. Due to this requirement, disruption of CLS/respite services may occur for some individuals as a result of fixed number of Respite Providers available to provide this service in a community-based setting. For some individuals, providing CLS/respite services in a facility ensures a safe location to receive the service. **MDHHS Response**: ☒ **Response accepted, with the expectation that by the 90-day review, SCCMHA/MSHN/R5 will have documented evidence of moving all CLS and Respite services to locations allowed under the CWP.**
E. <u>ELIGIBILITY</u> (Medicaid Provider Manual, Menta Health / Substance Abuse)				
E.1. CWP				
E.1.1 Child is developmentally disabled. Evidence:	13	0		

1. Three or more areas of substantial functional limitations are identified. Within the last 12 months, assessments have been completed and/or supporting documentation obtained that reflect all of the consumer's current functional abilities and any current substantial functional limitations identified in the areas of self-care, understanding and use of language (expressive and receptive), learning (functional academics), mobility, and self-direction. For consumers age 16 and older, functional abilities and any current substantial functional limitations are identified in the areas of capacity for independent living and economic self-sufficiency. Or 2. If the consumer is a minor from birth to age 9, documentation is provided of a related condition and the current rationale to support a high probability of developing a developmental disability. (PM-B-3)				
E.1.2 The child is in need of active treatment. (evidence: Within the last 12 months, assessments have been completed of the need for health and habilitative services designed to assist the consumer in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings). (PM B-3) Medicaid Provider Manual, Section 15	13	0		
F. FREEDOM OF CHOICE (Medicaid Provider Manual, Menta Health / Substance Abuse)				

F.1. CWP				
F.1.1 Parent was informed of right to choose among qualified providers. (evidence: Parents signature on the certification form) (PM-D-10)	13	0		
F.1.2 Parent was informed of their right to choose among the various waiver services. Evidence: 1. administrative records policies and procedures, 2. individual records. 3. consumer/Family interviews (PM-D-9)	13	0		
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1. CWP				
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)	10	3	**Repeat Citation** **LifeWays** **WSA# 176591:** No evidence of offering Independent Facilitation and Choice Voucher/ self-directed services to WSA/ family. **CMH Authority of CEI Counties** **WSA# 20369:** Pre Plan and Treatment Planning Meeting held on the same day with no rationale found in record.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that 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. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

			<u>Saginaw County CMH Authority</u> **WSA# 57036:** No evidence of offering Choice Voucher/Self Directed services to WSA/ Family, noted as not eligible in Pre-Plan. Lack of transition planning information offered/provided to family, in anticipation of WSA aging out of CWP.	**Individual Remediation:** **Lifeways** ☒ By 12/15/22 WSA # 176591 will be offered Self-Determination / Independent Facilitation with documentation in the record by the 90-day f/u site review. ☒ By 12/15/22, WSA # 176591 will have pre-planning occurs to better inform IPOS process, with evidence in the record by the 90-day f/u site review. **CEI** ☒ By 10/17/22 pre-planning will occur to better inform IPOS process, with evidence in the record by the 90-day f/u site review. For WSA # 20369 **SCCMH** ☒ By 9/30/2022 WSA # 57036 will be offered Self-Determination / Independent Facilitation with documentation in the record by the 90-day f/u site review. ☒ Other: (See response below) On 7/20/2022, Community Liaison met with consumer/family and new HSW Case Holder to discuss transition planning for consumer to move from participating in CWP benefit to participating in HSW benefit. **Systemic Remediation:**

				MSHN ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **Lifeways** ☒By 12/15/22, staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. ☒ By 12/15/22, EMR will be adjusted to include this information as required fields in the pre-planning document. **CEI** ☒ Effective 10/1/22, CM Supervision will monitor a random selection of records quarterly to monitor for this requirement. **SCCMH** ☒ By 11/30/2022, staff training will be provided on the requirement of pre-planning activities

				that must inform person-centered planning. ☒ Other: (See response below) Director of I/DD Services will also provide training to Case Holders for Waiver Consumers which addresses the CWP benefit and consumers aging up to eligibility for HSW benefit. In addition, training will be provided to Self-Determination Coordinators to ensure understanding of this service for consumers receiving CWP and HSW services. Trainings will be completed by 11/30/2022. Brochures will be created for consumers/families as a resource to explain the CWP and HSW benefits and what services are available under each. These will be completed for distribution by 11/30/2022. **MDHHS Response**: ☒ **Response accepted, with documented evidence of the above expected at the 90-Day Review.**
P.1.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	12	1	**Repeat Citation** **CMH for Central MI** **WSA# 37898:** CLS/Respite assessed as needed, not reflected in Plan.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS addresses all service needs reflected in the assessments. The plan must be submitted

				within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ Other: (See response below) For WSA #37898, a discussion with the consumer and guardian will occur by 11/15/2022 with the case holder to go over respite/CLS being assessed as needed and not reflected in the plan. If respite/CLS are determined at that time to be medically necessary and requested by consumer/guardian, an amendment will be completed to the IPOS. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the

				systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ By 12/1/2022 staff training will be conducted by the Waiver Review team focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. (CMHCM) **MDHHS Response**: ☒ **Response accepted, with documented evidence of the above expected at the 90-day review.** **CMHCM Revision.** **Individual Remediation** "For WSA #37898, a discussion with consumer and guardian will occur by 12/15/2022 to go over respite/CLS being assessed as needed and not reflected in the plan. If respite/CLS are determined at that time to be medically necessary and requested by consumer/guardian, an amendment will be completed to the IPOS. **Systemic Remediation.** By 12/15/2022 staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS.

				MDHHS Response: ☒ **Response accepted (with adjusted target date), with documented evidence of the above expected at the 90-day review.**
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)	11	2	**Repeat Citation** **Bay-Arenac Behavioral Health** **WSA# 51842:** Lack of Coordination of Care letter with primary care physician. **WSA# 51845:** Lack of Coordination of Care letter with primary care physician (will need to include psychotropic meds prescribed by BABH) and lack of medication consent.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care physicians. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** ☒ By 9/30/22 the following will be completed/reflected in the record. - Psychiatric Eval - Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter noted below. - Other (See below)

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒ By 9/30/22, additional training will be provided to the staff at large regarding the required elements of addressing health / safety, coordination of care, psychiatric evaluations, and medication consents. **MDHHS Response**: ☒ **Response accepted. with the expectation (under individual remediation) that the documented evidence of the above will be provided, for both WSA's listed, at the 90-day review**.

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)	1	12	**Repeat Citation** **CMH Authority of CEI Counties** **WSA# 48404:** Lack of specific amount scope duration within Plan for CM services. **WSA# 20369:** Lack of specific amount scope duration within Plan for Respite services. **LifeWays** **WSA# 176591:** Lack of active treatment (service) within Plan. **Saginaw County CMH Authority** **WSA# 20440:** Lack of specific amount scope duration, within Plan for CLS services. **(Case Closed).** **WSA# 69313:** Lack of measurable objectives and for providing Respite/CLS in a setting not allowed under CWP (facility-based). **Bay-Arenac Behavioral Health** **WSA # 51842:** Lack of specific amount scope duration within Plan	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒By 11/23/22 the plans will be amended for resolving lack of measurable goals/ objectives/ timeframes. WSA #s: 48404, 20369. **Lifeways** ☒Plan for WSA#176591 will be amended, by 12/15/22 to include active treatment service. **SCCMH** ☒ By 6/27/2022 the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☒ Other: (See response below) WSA# 20440: Please refer to the MSHN action to address the Lack of

			for CM, Medication Reviews. Nursing services not outlined in Plan. **WSA# 51845:** Lack of specific amount scope duration of all services, within Plan, and measurable objectives. **<u>CMH for Central MI</u>:** **WSA# 49285** Lack of specific amount scope duration within Plan for CM, CLS and Respite services. **WSA# 38468:** Lack of specific amount scope duration within Plan for CM, CLS and Respite services. **WSA# 37898:** Lack of specific amount scope duration of services within Plan, lack of measurable objectives, lack of active treatment goal/objective/service under CWP funding. **WSA# 20255:** Lack of specific amount scope duration of services within Plan. **<u>The Right Door</u>** **WSA# 39431:**	specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. In addition, Consumer has passed away, unable to make updates to the plan for individual remediation. WSA# 69313: Addendum to IPOS was completed on 6/27/2022 to include measurable objectives for provided respite services. Case Holder will conduct meeting between consumer/family and Respite Provider to discuss Respite requirements under CWP benefit and to re-evaluate CLS goal to determine if consumer requires additional CLS services in lieu of Respite. Additional addendum to IPOS will be completed to clarify where Respite Services will be provided moving forward, either in consumer's home or in community, if plan includes community integration goal; or CLS goal will be updated to reflect need for additional services. Meeting and resulting addendum will be completed by 9/30/2022 to address correct provision of respite services.

			Lack of specific amount scope duration within Plan for CSM, Nursing, CLS and medication reviews.	**BABH** ☒ Plan will be amended, by 9/30/22 to include number or reviews recommended. **CMHCM** ☒ Other: (See response below) Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **The Right Door** **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site

				reviews for each CMHSP to occur in 2023. ☒ By 6/1/22, MSHN will coordinate a regional training using an external source for the implementation of Person-Centered Planning, highlighting documentation of measurable goal and objectives, amount scope and duration. **CEI** ☒ By 11/15/22, staff training will be conducted on developing measurable goals **Lifeways** ☒ By 12/15/22, staff training will be conducted on including active treatment for individuals. **SCCMH** ☒ By 11/30/22, staff training will be conducted on developing measurable goals ☒ Other: (See response below) Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. By 11/30/2022, SCCMHA will work with facility-based Respite Providers to move respite services provided

				in these settings to instead be provided in a community-based setting. Or, if possible, SCCMHA will work with facility-based Respite Providers to ensure their facilities are approved by MDHHS as a licensed respite facility. By 9/30/2022, SCCMHA will present information regarding this requirement for respite services at the ABA Provider meeting. Due to this requirement, disruption of respite services may occur for some individuals as a result of fixed number of Respite Providers available to provide this service in a community-based setting. For some individuals, providing respite services in a facility ensures a safe location to receive the service and provide **BABH** ☒ By 9/30/22, staff training will be conducted on developing measurable goals Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **CMHCM**

				☒ Other: (See response below) Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **The Right Door** **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual/systemic remediation found regarding citations for lack of specific amt scope duration of services within the plan. Some individual remediations do not appear to be addressing the citations (i.e. WSAs under CEI, SCCMHA, BABH) in the limited individual remediation found.** **Also, SCCMHA did not address lack of measurable goal/objectives for WSA# 37898.** **For MSHN, systemic remediation timelines (for planned regional training) pre-dates the MDHHS site review. Systemic remediations require timelines that**

				fall within 90 days of the approved CAP. Please revise. ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **MSHN Systemic Remediation** Mid-State Health Network (MSHN) acknowledges receipt of the email from the Michigan Department of Health and Human Services (MDHHS) as to feedback to MSHN regarding the need to reflect the specific amount, scope, duration, and frequency of services deemed medically necessary in the individual plan of service (IPOS). MSHN fully intends on following the MDHHS/PIHP Contract, the Michigan Medicaid Provider Manual (MMPM), and related guidance in implementing the required documentation practices in representing the service amount elements as codified. MSHN, however, is unable to identify a standard that indicates that a specific service amount must be identified and represented in a singular

				number of units. This is of concern as any amount of service provided less than is noted in the IPOS, for any reason, will trigger an adverse benefit determination notice. Individual service patterns often vary and require more or less units of service based on the needs at the moment of the person served. The expectation of a rigid specific amount does not allow for the flexible, recovery-oriented means of service delivery. MSHN wishes to formally appeal the MDHHS decision not to accept reasonable ranges as an alternative to the use of a specific service amount. **MSHN** ☒ By 1/14/2023, MSHN will coordinate a regional training using an external source for the implementation of Person-Centered Planning, highlighting documentation of measurable goal and objectives, amount scope and duration. **SCCMHA Individual:** For 69313: As of 6/27/2022 the plan for this consumer has been amended to resolve lack of measurable goals/ objectives/ timeframes. By 11/30/2022, addendum to IPOS will

				be completed to clarify where CLS/Respite Services will be provided moving forward, either in consumer's home or in community (if plan includes community integration goal). **SCCMHA Systemic:** By 11/30/2022, SCCMHA will work with facility-based CLS/Respite Providers to move CLS/respite services provided in these settings to instead be provided in a community-based setting. Or, if possible, SCCMHA will work with facility-based CLS/Respite Providers to ensure their facilities are approved by MDHHS as a licensed respite facility. By 9/30/2022, SCCMHA will present information regarding this requirement for CLS/respite services at the ABA Provider meeting. Due to this requirement, disruption of CLS/respite services may occur for some individuals as a result of fixed number of Respite Providers available to provide this service in a community-based setting. For some individuals, providing CLS/respite services in a facility ensures a safe location to receive the service. **BABH Individual Remediation**

				Plan for WSA#51842 will be amended, by 11/1/22 to include specific amount, scope, and duration for active treatment services. Plan for WSA#51845 will be amended, by 11/1/22 to include specific amount, scope, and duration for active treatment services. **BABH Systematic Remediation** By 12/1/2022 BABH staff will be trained on how to include goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. **CMHCM Individual Remediation** By 12/15/22, WSA #37898, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #20255, plan will be amended to include exact amount scope duration of recommended supports. **CMHCM Systemic Remediation** By 12/15/2022, staff training will be conducted on the requirement of including specific amount, scope, and duration of services in the plan and

				discontinuing use of ranges when authorizing services. Additionally, by 12/15/22, a UM monitoring section will be added to the IPOS Review of Progress document to ensure services are delivered as authorized and medically necessary. Finally, the CMHCM EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022. **CEI Individual Remediation** By 11/23/22 the plans will be amended for resolving lack of amount, scope and duration of services identified WSA #s: 48404 (CM), 20369 (respite). **CEI Systemic Remediation** By 11/15/22, staff training will be conducted on developing measurable goals. By 12/1/22 quarterly monitoring random sample of IPOS plans for CWP will occur by Supervisory staff to ensure compliance. **Individual The Right Door** The Right Door will update the person-centered plan for WSA# 39341 to include the specific amount, scope and duration for case management, nursing,

				CLS and medication reviews by 11/26/2022. **Systemic The Right Door** By 11.26.2022, staff training will be conducted on amount, scope and duration of services as well as measurable objectives being identified in the plan section of the PCP. Additionally, training will be provided to waiver staff on the use of ranges. Additionally, by 12/31/22, a UM monitoring section will be added to the Clinical Record Review module to ensure services are delivered as authorized and medically necessary. Finally, The Right Door EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022. **MDHHS 2nd Response**: ☒ **Response not accepted. –** **For MSHN:** The request to appeal the decision by MDHHS not to allow ranges is under review. Outcome pending. **For SCCMHA:** No systemic remediation found for the need to reflect services, within the Plan, in specific amt scope duration. (Though individual remediation is not possible, for WSA# 20440 due to case closure, systemic

				remediation is still required). Please revise. **<u>For CEI:</u>** Systemic remediation (staff training) does not appear to include the need to reflect services in specific amt scope duration within the Plan. Please revise. **<u>For BABH</u>**: Individual and systemic remediation for 54815 does not include addressing lack of measurable objectives. Please revise. *Technical Assistance for BCBH: Amt scope duration of services is required for **all** CWP funded services (including Respite, TCM), not just active treatment services (such as CLS, Specialty Services, etc).* **<u>For CMHCM</u>**: Individual and systemic remediation for 37898 does not address the citations lack of measurable objectives and lack of active treatment goal/objective/service under CWP funding. Please revise. **CMHSP/PHIP 3rd Response**: **CMHCM Individual Remediation** By 12/15/22, WSA #37898, plan will be amended to include exact amount scope duration of recommended supports. Additionally, the plan will

				be amended to update objectives to ensure they are measurable, as well as to include CWP services. By 12/15/22, WSA #20255, plan will be amended to include exact amount scope duration of recommended supports. **CMHCM Systemic Remediation** By 12/15/2022, staff training will be conducted on the requirement of including specific amount, scope, and duration of services in the plan and discontinuing use of ranges when authorizing services. By 12/15/2022, staff training on ensuring objectives are measurable and IPOS's include active treatment goals/objectives/services under CWP will be completed by CMHCM waiver services staff. Additionally, by 12/15/22, a UM monitoring section will be added to the IPOS Review of Progress document to ensure services are delivered as authorized and medically necessary. Finally, the CMHCM EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022. **SCCMHA Systemic:** By 11/30/2022, staff training will be conducted

				on the need for the IPOS to include specific amount, scope, and duration for all services listed. **BABH Individual Remediation** Plan for WSA#51842 will be amended, by 11/1/22 to include specific amount, scope, and duration for treatment services. Plan for WSA#51845 will be amended, by 11/1/22 to include measurable objectives and specific amount, scope, and duration for active treatment services. **BABH Systematic Remediation** By 12/1/2022 BABH staff will be trained on how to include measurable goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. These Quality of Care Record reviews contain questions such as: Services written in the plan of service are delivered at the consistency identified, services to be provided include specifics on the amount, scope and duration of supports are clinically justified and person centered, and the goals and objectives are SMART (specific, measurable, achievable,

				relevant, time-based). Any question that is found to be out of compliance is addressed with the staff by the supervisor. Additionally, aggregate analysis of trends and findings are written in a quarterly report with action steps for improvement. **CEI Systemic**: By 11/15/22, staff training will be conducted on developing measurable goals, and having specific amount, scope, and duration in the IPOS.
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.4. CWP				
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)	12	1	**Repeat Citation** **CMH Authority of CEI Counties** **WSA# 20369:** Insufficient narrative to support Category of Care/ Intensity of Care determination.	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that a current narrative supports the identified Category of Care/Intensity of Care determination and services are authorized and provided accordingly. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

				Individual Remediation: **CEI** ☒ By9/12/22, Category of Care/ Intensity of Care determination will be completed. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** ☒ By 11/15/22, staff training will be conducted on the requirement of COC / Intensity of Need to be reflected in the plan as driving level of services recommended. **MDHHS Response**: ☒ **Response accepted**

P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM-D-7)	3	10	**Repeat Citation** **Bay-Arenac Behavioral Health** **WSA# 51842.** Medication Reviews not provided as specified (authorized) in Plan **WSA# 51845:** RN and CLS services not provided as specified in Plan. **CMH Authority of CEI Counties** **WSA# 48404:** Respite notes not provided to determine if service was provided at recommended amount, Speech not occurring as recommend in Plan. **WSA# 20369:** TCM, Therapy and CLS not provided as specified in Plan. **CMH for Central MI** **WSA# 49285:** Respite notes not provided to determine if service was provided at recommended amount. CLS provided above recommended amount per week.	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that services and supports are provided as specified in the IPOS, including amount, scope, duration and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** ☒ By 9/30/22, plan will be amended for resolving/addressing service provision as recommended. Comment sheet for WSA# 51842 says that citations for P.4.2 have been moved to P.1.4. Remediation language can be found under P.1.4. **CEI** ☒WSA 48404 and 20369 By 11/15/22 Case managers will document review of services, including CLS and respite documentation in monthly service notes. WSA 48404: As part of the PCP planning

			WSA# 38468: Respite notes not provided to determine if service was provided at recommended amount. **WSA# 37898:** RN services (provided) not reflected n Plan. **<u>LifeWays</u>** **WSA# 176591:** CM services not provided as recommend in Plan. **<u>Saginaw County CMH Authority</u>** **WSA# 57036:** TCM services not provided as specified in Plan. **WSA# 69313** TCM, CLS, and Respite services not provided as specified in Plan.	process, case manager will assess the continued need for speech services and frequency and update the annual IPOS accordingly no later than 11/23/22. **CMHCM** ☒ By 11/15/2022 Case Manager will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. WSA 49285, WSA 38468, WSA 37898 **Lifeways** ☒By 12/15/22, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. **SCCMH** ☒ By 11/30/2022, plan will be amended for resolving/addressing service provision as recommended. ☒ By 11/30/2022, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☒ Other: (See response below) Case Holder will document within the record via progress note to indicate why services were not being provided as recommended within the plan. Moving forward, staff will provide services

				as indicated within the plan. If services are not provided as indicated, staff will document within a progress note as to why services did not occur as indicated. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** **CEI** ☒ By 11/15/22, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **CMHCM**

				☒ By (Date) 12/1/2022 staff training will be conducted by the Waiver review team, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **Lifeways** ☒By 12/15/22, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **SCCMH** ☒ By 11/30/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** • **For BABH,** more information is needed under individual remediation. What Plan (for what specific WSA(s)) will be amended to address /resolve service provision as recommended? Also, no systemic remediation

				reflected/found under BABH • **For CEI**, WSA 48404, no individual remediation found for lack of evidence of Respite services being provided. Also, though CAP reflects review of services (for both WSAs) the CAP does not specify what will be done as a result of the review (i.e., will rationale be added to record if services are not provided as specified, and/or will plan be amended if services are not needed at current levels?) • **For CMHCM,** no individual remediation (for 49285 and 38468) found for lack of evidence of Respite services being provided as recommended. • **For SCCMHA**, the individual remediations do not appear to be case specific (singular language reflects only one WSA

				being remediated, but two were cited). Please specify WSA# that individual remediations are being recommended for. Please revise ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **SCCMHA Individual Remediation** By 11/30/2022, plans for WSA #s 57036 and 69313 will be amended for resolving/addressing service provision as recommended. By 11/30/2022, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity for WSA#s 57036 and 69313. Other: (See response below) Case Holder will document within the record via progress note to indicate why services were not being provided as recommended within the plan for WSA #s

				57036 and 69313). Moving forward, staff will provide services as indicated within the plan. If services are not provided as indicated, staff will document within a progress note as to why services did not occur as indicated. C**MHCM Individual Remediation** By 12/15/2022 CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. WSA 49285, WSA 38468, WSA 37898 **CMHCM Systemic Remediation** By 12/15/2022 staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **BABH Individual Remediation:** By 12/1/22, a new plan of service will be written for WSA#51842 to include defined amount, scope, and duration for all services authorized in the plan. By 12/1/22, the plan for WSA#51845 will be amended to reflect the amount, scope, and duration the consumer is receiving for RN and CLS services.

				BABH Systematic Remediation: By 12/1/22, BABH staff will be trained on how to include goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. **CEI Individual**: WSA 48404 and 20369 By 11/15/22, Case managers will document review of services, including CLS and respite documentation in monthly service notes and will include in their note on rationale if services are not being provided as authorized (example of provider staff issues, family cancellations, etc.) and amend treatment plan as clinically needed. **MDHHS 2nd Response**: ☒ **Response not accepted** **For BABH**, systemic remediation does not appear to address the citations (of services provided as recommended). What will BABH do to address, systemically, the need for case holders to monitor service utilization and address possible barriers, on-going, if services are not being

				provided as recommended? **CMHSP/PHIP 3rd Response**: **BABH Systematic Remediation** By 12/1/2022 BABH staff will be trained on how to include goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. These Quality of Care Record reviews contain questions such as: Services written in the plan of service are delivered at the consistency identified, services to be provided include specifics on the amount, scope and duration of supports are clinically justified and person centered, and the goals and objectives are SMART (specific, measurable, achievable, relevant, time-based). Any question that is found to be out of compliance is addressed with the staff by the supervisor. Additionally, aggregate analysis of trends and findings are written in a quarterly report with action steps for improvement. Additionally, staff education will be provided about reviewing

				and documenting utilization during periodic reviews and will include rationale for under or over utilization. The treatment plan will be updated as necessary to reflect any changes to the amount, scope, and duration.
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)	1	0	NA: 12	
P.4.5: Physician-signed and dated prescriptions for locally authorized waiver durable medical equipment and supplies are in the file. (PM-D-4)	2	0	NA: 11 .	
P.4.6: The IPOS was updated at least annually. (PM-D-5)	13	0		
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)	11	2	**CMH Authority of CEI Counties WSA# 48404:** Plan does not indicate how often it will be reviewed **CMH of Central MI WSA# 20255:** Lack of amended Plan when changes to individual's needs resulted in reduced respite services (per May 2022 advance notice).	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the IPOS is reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

				CMHSP/PHIP Response: **Individual Remediation:** **CEI** ☒By 11/15/22, the IPOS will be updated to include review timelines and will be formally reviewed with adjustment (as needed) to the recommended dates for the remaining reviews. **CMHCM** ☒ By (Date) 11/15/2022 the IPOS will be formally reviewed with adjustment (as needed) to the recommended dates for the remaining reviews for WSA 20255. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site

				reviews for each CMHSP to occur in 2023. **CEI** ☒ 11/15/22, staff training will be conducted on the need to ensure that the IPOS has review timeline included and is reviewed/ amended as recommended/ needed. **CMHCM** ☒ By 12/1/2022 staff training will be conducted by the Waiver Review team on the need to ensure that the IPOS is reviewed/ amended as recommended/ needed (CMHCM) **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☒ Other: (See response below) **For CMHCM**, individual remediation for WSA# 20255 does not appear to address the citation. Please revise. **CMHSP/PHIP 2nd Response**: **CMHCM Individual Remediation** "For WSA 20255, the IPOS effective 3/20/2021 include respite authorizations equaling 4992 units per year. The CWP program limits for respite services are 4608 units per year. Therefore, when the plan was completed in April of

				2022, the NABD was sent to provide advance notice of the reduction in respite authorization based on the maximum allowable units and medical necessity. This NABD was reflecting the change between the 2021 and 2022 IPOS's. As the case holder was currently working on the 2022 IPOS, the IPOS intervention was completed to reflect the reduction in service as noted in the NABD. Therefore, an amendment is not necessary at this time. By 12/15/2022, a formal review of progress will be completed, and respite authorization will be discussed at that time and adjustments to the IPOS will be made as needed/discussed. " By 12/15/2022 staff training will be conducted on the need to ensure that the IPOS is reviewed/ amended as recommended/ needed. **CMHCM Systemic Remediation** By 12/15/2022 staff training will be conducted on the need to ensure that the IPOS is reviewed/ amended as recommended/ needed. **MDHHS 2nd Response**: ☒ **Response accepted**
B. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1				

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.	1	0	See HSW Report	
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement	1	1	NA: 11 **Bay-Arenac Behavioral Health**	Submit a plan that reflects both individual and systemic

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.			**WSA# 51845:** Lack of current BTPRC involvement (all elements) for restrictive/ intrusive staffing (2:1) recommended in Plan.	remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: ☒ The following remediation plans have been developed by each CMHSP receiving a citation for the standard. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **Individual Remediation:** **BABH** ☒This case was no longer 2:1. The IPOS has been revised to reflect the change of the

				case no longer being 2:1. Primary case holder was educated on the importance of updating all details and making sure details are correct when annually completing an IPOS. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒ Staff education will be provided during individual supervision and peer supervision about the need to make sure the narrative language matches the goals/objectives/authorizations in the plan of service.

				MDHHS Response: ☐ **Response accepted** ☒ **Response not accepted.** – No individual remediation found ☐ No systemic remediation found ☒ No timelines indicated F**or BABH systemic** remediation, no timelines found. By what date will the training occur? For **individual** remediation, what date was the Plan revised/amended to remove this intrusive intervention?, Will it be provided as evidence at the 90 day review? ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **BABH Individual Remediation:** Plan of Service for WSA#51845 was updated on 8/25/22 to remove 2:1 reference for ABA services. Evidence will be provided at the 90 day review. **BABH Systematic Remediation:** Individual supervision was completed on 8/18/22 and Family Support Peer Supervision training was completed on 9/21/22 to educate staff on removing 2:1 reference in the plan of service at it is no longer relevant.

				Evidence will be provided at the 90-day review. **MDHHS Response**: ☒ **Response accepted**
G. **WAIVER PARTICIPANT HEALTH AND WELFARE**				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	12	1	**Bay-Arenac Behavioral Health** **WSA# 51845**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual is provided information/education on how to report abuse/neglect/exploitation and other critical incidents. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PIHP Response**: **Individual Remediation:** **BABH** ☒Primary case holder will work with family to update the Acknowledgement of Receipt by 9/30/22. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to

				address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒Bay Arenac Behavioral Health: By 11/30/22, the EMR will be adjusted to include this PM in the consent to treat document. **MDHHS Response**: ☒ **Response accepted with the expectation that "Acknowledgement of Receipt:" contains the needed information that gives evidence of this information being conveyed to the WSA/family, and that updated documentation of this conveyance will be provided in 90 days.**
G.2 Individual served received health care appraisal.(Date/document	13	0		

confirming_____ _____)				
Q. STAFF QUALIFICATIONS				
Q.1 CWP				
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)	18	5	**Repeat Citation** A total of 23 Professional staff were review under the CWP. **CMH Authority of CEI Counties** **WSA# 48404:** *Insufficient proof of QIDP, or supervision by a QIDP, upon hire.* **Dana Anayi** **Saginaw County CMH Authority** **WSA# 57036:** *Insufficient proof of QIDP, or being supervised by a QIDP, upon hire. (Resumes do not indicate working with people with cognitive/developmental disabilities.)* **Shamon Johnson Tracey Riley** **CMH for Central MI** **WSA#s 37898:** *Insufficient evidence of QIDP, or supervision by a QIDP, upon hire.* **Maria Nolen** **WSA#s 20255:** *Insufficient evidence of QIDP,*	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that clinical service providers and case managers are credentialed by the CMHSP prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ By 11/1/22, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. **SCCMH** ☒ By 11/30/2022, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. **CMHCM** ☒ Other: (See response below)

			or supervision by a QIDP, upon hire. **Brianna Cass**	Maria Nolen and Brianna Cass Competency assessment forms for each of the employees are currently in place which indicates the experience necessary to prove staff qualifications for QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** ☒ Other: (See response below) for future audits, will ensure to provide documentation to MDHHS that meet requirement to show

				QIDP status (hiring letter along with job description to show worked with Population. **SCCMH** ☒ Effective 11/30/2022 the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☒ Other: (See response below) SCCMHA now has a credentialing committee which meets monthly to review initial credentialing and re-credentialing packets. SCCMHA has posted a job description to hire a full-time credentialing coordinator to prevent future repeat issues in this area. **CMHCM** ☒ Other: (See response below) The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all new employees hiring on to CMHCM. • An MS Teams survey will be developed by the CMHCM HR

				department by 11/15/2022 questions that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. • The CMHCM competency assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** **For CMH for Central Michigan**: No individual remediation found. A "competency assessment form" showing QIDP eligibility, without the documentation that the HR reviewed to make that determination, is insufficient evidence. Primary source documentation is required (ie, resume/updated resume that reflects the experience of working with the target population, job application, if it reflects population worked with, etc). Please revise.

				☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CEI,** regarding systemic remediation, what will CEI do to ensure, ***at time of hire*** the TCM is a QIDP, or will be supervised by a QIDP for the first year, if not yet a QIDP? The systemic remediations do not appear to address this. Further, no timelines indicated (that fall within the 90-day remediation period). Please revise. **CMHSP/PHIP 2nd Response**: **CMHCM Individual remediation.** WSA# 37898, WSA 20255 By 11/30/2022, primary source verification will be completed to verify QIDP eligibility. **CMHCM Systemic Remediation** Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. **CEI Systemic Remediation** By 11/1/22 CEI will review and update if

				necessary the job description language to ensure it has language to show the employment requirements of one-year experience working with the population. HR staff will conduct primary source verification and all HR reviews and approves credentialing. **MDHHS 2nd Response**: ☒ **Response accepted** **Response accepted with documented evidence of review/update of job description (for CEI) and/or process language (for CMHCM) to ensure work experience with target population is captured, and with documented evidence of HR conducting primary source verification of approved credentialing.**
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)	20	3	**CMH Authority of CEI Counties** **WSA# 48404:** *Insufficient proof of QIDP, or supervision by a QIDP, ongoing.* Dana Anayi **CMH for Central MI** **WSA#s 37898:** *Lack of evidence of QIDP, or supervision by a QIDP (on-going)* Maria Nolen **WSA# 20255:** *Lack of evidence of QIDP, or supervision by a QIDP (on-going)*	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that clinical service providers and case managers are credentialed by the CMHSP, on-going. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI**

			Brianna Cass	☒ By 11/1/22, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. **CMHCM** ☒ Other: (See response below) QIDP (on-going) Maria Nolen and Brianna Cass Competency assessment forms for each of the employees are currently in place which indicates the experience necessary to prove staff qualifications for QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation

				plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒MSHN will continue to work with MDHS with the implementation of the Universal Credentialing in the CRM. **CEI** ☒ Other: (See response below) For future audits, will ensure to provide documentation to MDHHS that meet requirement to show QIDP status (hiring letter along with job description to show worked with Population. **CMHCM** ☒ Other: (See response below) The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all new employees hiring on to CMHCM. • An MS Teams survey will be developed by the CMHCM HR department by 11/15/2022 questions

				that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. • The CMHCM competency assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** Please see comments under Q.1.1 **CMHSP/PHIP 2nd Response**: **CMHCM individual remediation**. By 11/30/2022, primary source verification will be completed to verify QIDP eligibility. **CMHCM Systemic.** Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. **CEI Systemic**

				By 11/1/22 CEI will review and update, if necessary, the job description language to ensure it has language to show the employment requirements of one-year experience working with the population. HR staff will conduct primary source verification and all HR reviews and approves credentialing. **MDHHS 2nd Response**: ☒ **Response accepted** **Response accepted with documented evidence of review/update of job description (for CEI) and/or process language (for CMHCM) to ensure work experience with target population is captured, and with documented evidence of HR conducting primary source verification of approved credentialing**
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, CPR, and that staff is employed by or on	32	13	**Repeat Citation** A total of 45 Aide level staff were reviewed under the CWP. **CMH Authority of CEI Counties** **WSA# 48404:** *Lack of evidence for Recipient Rights training (lack of trainer name and score on test)* Monica Virgina Roller-Perez **WSA# 48404:** *Lack of evidence for First Aid Training (expired 6/5/19)* Jasmine Garrett	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI**

contract with the CMHSP or hired through Choice Voucher arrangements.) (PM C-3)			**<u>CMH for Central MI</u>** **WSA# 38468:** *Lack of evidence for emergency procedures (lacks trainer name)* Brenda Winters **WSA# 49285:** *Lack of Blood Borne Pathogens Training (lack of name of trainer)* Shayla Letts **WSA# 49285:** *Lack of evidence of Emergency Procedures Training (lacks trainer name)* *Shayla Letts **Saginaw County CMH Authority** **WSA# 69313:** *Lack of evidence of Recipient Rights Training (test lacks scoring and trainer name)* Ashlyn Leo Caleb Wallace Tia Robertson **WSA# 69313:** *Lack of evidence of Emergency Procedures Training* Melody Drosser **WSA# 20440:** *Lack of evidence for Blood Borne Pathogens training* Alexandra Barrett Emily Haroon Rylea Grassmid **WSA#20440:**	☒ Other: (See response below) trainings have been completed and evidence of trainings will be provided to MDHHS during 90-day review. (RR training and First aid training) **CMHCM** ☒ Other: (See response below) • Provider Network will obtain documentation for WSA #38468 staff and will provide at 90 day follow-up. • Provider Network will obtain documentation for WSA#49285 staff and will provide at 90-day follow-up. • Provider Network will obtain documentation for WSA #49285 staff and will provide at 90-day follow-up **SCCMH** ☒ Other: (See response below) By 11/30/2022, all staff listed who are still employed and working with WSA# 69313 will have completed Recipient Rights Training which shows scoring and trainer name on proof of completion. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic

			Lack of evidence of First Aid Training *Alexandra Barrett *Emily Haroon **WSA#20440:** *Lack of Recipient Rights Training* *Alexandra Barrett *Emily Haroon **WSA# 20440:** *Lack of Emergency Procedures Training* *Alexandra Barrett **WSA# 57036:** *Lack of evidence for Blood Borne Pathogens Training* Precious McCullough Tiffany Harper **WSA# 57036:** *Lack of evidence for Recipient Rights Training* *Precious McCullough *Tiffany Harper **WSA# 57036:** *Lack of evidence of First Aid Training* *Tiffany Harper	remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 1/14/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be modified to include the required timeframes. **CEI** ☒ Other: (See response below). QI staff will review credentialing documents prior to submission to MDHHS to ensure all needed elements (trainer signature, updated dates, etc.) are included. **CMHCM** ☒ By 11/15/22, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. **SCCMH** ☒ Effective 11/30/2022 the CMHSP/HR Dept will randomly select a staff

				sample to review quarterly for required trainings. ☒ Other: (See response below) A plan of correction will be requested by the provider/staff/or supervisor of the staff person for when the staff person will be in compliance with training standards. The plan of correction will be monitored by the SCCMHA Auditing unit during annual audit reviews. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** **For SCCMHA**: No individual remediation found for several staff specific to lack of BBP, Emergency Procedures and First Aid trainings that were cited. ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CEI,** systemic remediation insufficient. What will be done by CEI to ensure that providers are sufficiently credentialed on an on-going basis (not just prior to site reviews). Please revise, with timelines (for completing such steps) that will occur within 90 days of the approved CAP.

				For SCCMHA: No timelines found for the second step of the systemic remediation (securing corrective action plan from providers). By what date will this occur (that will need to fall within 90 days of the approved CAP). **CMHSP/PHIP 2nd Response**: **SCCMHA** ☒ Other: By 11/30/2022, all staff listed who are still employed and working with WSA# 69313 will have completed Emergency Procedures Training and Recipient Rights Training which shows scoring and trainer name on proof of completion. ☒ Other: By 11/30/2022, all staff listed who are still employed and working with WSA# 20440 will have completed Blood Borne Pathogens Training, First Aid Training, Emergency Procedures Training and Recipient Rights Training which shows scoring and trainer name on proof of completion. ☒Other: By 11/30/2022, all staff listed who are still employed and working with WSA# 57036 will have completed Blood Borne Pathogens Training, First Aid Training, and Recipient Rights Training

				which shows scoring and trainer name on proof of completion. ☒ Other: A plan of correction will be requested by the provider/staff/or supervisor of the staff person for when the staff person will be in compliance with training standards. This will be obtained no later than 11/30/22. The plan of correction will be monitored by the SCCMHA Auditing unit during annual audit reviews. **CEI Systemic** By 11/15/22, CEI will meet with provider to review requirements related to staff credentialing. Other: (See response below). As of 11/1/22 QI staff will review credentialing documents during each provider's annual site visit to ensure proper documentation (trainer signature, updated dates, etc.) are included. Any provider to be found out of compliance will be put on 90-day monitoring and will be required to submit documents for 90 days for CEI to review. **MDHHS 2nd Response**: ☒ **Response accepted**
Q.1.4 All CWP providers meet training requirements including training of CLS staff on the implementation of the IPOS by	31	14	**Repeat Citation** **CMH Authority of CEI Counties**	Submit a plan that reflects both individual and systemic

the appropriate professional. (Evidence: case file notes identifying the who, what and when of training, personnel files with documentation of training). (PM C-4)			**WSA# 48404:** Adrian VanBuren (outdated) Vada Murray **<u>Saginaw County CMH Authority</u>** **WSA# 69313:** Aaron Schmidt Ashlyn Leo Caleb Wallace Courtney Dingman Jessica Nickell Madeline Osterhagen Melody Drosser Tia Robertson **WSA# 20440:** (*Lack of evidence of trainer being trained*) Adam Coenis Rylea Grassmid **WSA# 57036:** (*Lack of evidence of trainer being trained*) Elissa Droste Tiffany Harper	remediation with time frames to ensure that all CSP providers meet training requirements including training of CLS staff on the implementation of the IPOS by the appropriate professional. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ Other: (See response below) trainings have been completed and evidence of trainings will be provided to MDHHS during 90-day review. WSA 48404. **SCCMH** ☒ By 11/30/2022, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each

				remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be modified to include the required timeframes. **CEI** ☒ Other: (See response below) QI staff will review training documents prior to submission to MDHHS to ensure all needed elements are included. **SCCMH** ☒ By 11/30/2022, CMHSP/PIHP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). ☒ Other: (See response below) SCCMHA to ensure IPOS training

				documentation includes "4 elements required as evidence for training: 1) Date of Training, 2) Content of Training (including date of IPOS), 3) Who was Trained (legible names), 4) Who did the Training (legible name/title). SCCMHA will require use of the Individual Plan of Service Staff Training Log to document completed trainings which addresses each of these areas. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CEI,** systemic remediation insufficient. What will be done by CEI to ensure that providers are sufficiently credentialed (provided beneficiary specific IPOS training, prior to delivering services) on an on-going basis, not just prior to site reviews. Please revise, with timelines (for completing such steps) that will occur within 90 days of the approved CAP. Please revse. **For SCCMHA:** No timelines found for the

				second step of the systemic remediation (securing corrective action plan from providers). By what date will this occur (that will need to fall within 90 days of the approved CAP). Please revise **For MSHN**: Systemic remediations must occur within 90 days of the approved CAP. A June ’23 target date is outside that timeline. Please revise. **CMHSP/PHIP 2nd Response**: **MSHN Systemic Remediation** By 1/14/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be modified to include the required timeframes. **SCCMHA Systemic Remediation** Other: SCCMHA to ensure IPOS training documentation includes “4 elements required as evidence for training: 1) Date of Training, 2) Content of Training (including date of IPOS), 3) Who was Trained (legible names), 4) Who did the Training (legible name/title). SCCMHA will require use of the Individual Plan of Service Staff Training Log to document completed

				trainings which addresses each of these areas. These changes will take place no later than 11/30/2022. **CEI: Systemic Remediation** By 11/15/22, CEI will meet with provider to review requirements related to staff credentialing. Other: (See response below). As of 11/1/22 QI staff will review credentialing documents during each provider's annual site visit to ensure proper documentation (trainer signature, updated dates, etc.) are included. Any provider to be found out of compliance will be put on 90-day monitoring and will be required to submit documents for 90 days for CEI to review. **MDHHS 2nd Response**: ☒ **Response accepted** For CEI, response accepted with the expectation that meeting will occur with those providers responsible for providing this service (of beneficiary specific IPOS training), the TCMs of record., system wide.
H. HOME VISITS/TRAINING/INTERVIEWS				
H.1. CWP HOME VISIT				
H.1.1 The current IPOS is in the home and the parent /guardian and staff have access to it.			No home visits were conducted as a part of this Site Review.	

(evidence: a copy of the plan is in the home)			For Recipient Interviews, conducted under all three Waivers, please see the HSW Report.	
H.1.2 The parent is offered a formal opportunity to express his/her level of satisfaction with the CWP. (evidence: as reported to the surveyor by the parent and documented by the surveyor's notes)				
H.1.3 Protocols for managing individual health and safety issues are identified in the IPOS and implemented by staff and parents. Evidence: 1. Crisis and Safety Plans are current, accessible and – per report of the child/youth, parent and staff - responsive to need. 2. Staff and parents know what the protocol is, where it is, and how to implement it				

Habilitation Supports Waiver Program

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
C. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4;	1	0	Critical incident format very good. Provided great information.	

AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards				
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents. 42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 2.5, 3.8, 3.1.8 Waiver Assurance for Participant Safeguards	1	0		
A.1.3 Review and verify that the process is being implemented according to policy. Waiver Assurance for Participant Safeguards	1	0		
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.	NA	NA	NA	

• PIHPs/CMHSPs incorporate ongoing monitoring tools for SEDW to ensure service and supports are provided as specified in the plan.				
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	1	0	Process very straight forward.	
A.3.HSW				
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)	3	0	NA = 38	
F. FREEDOM OF CHOICE				
F.2. HSW				
F.2.1 Individual had an ability to choose among various waiver services. (HSW PM D-10)	**41**	**0**		

Medicaid Provider Manual, Section 15				
F.2.2 Individual had an ability to choose their providers. (HSW PM D-11) Medicaid Provider Manual, Section 15	41	0		
P. <u>IMPLEMENTATION OF PERSON-CENTERED PLANNING</u> Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	35	6	**REPEAT CITATION** **<u>CMH Authority of CEI Counties</u>** **WSA# 74021:** Expressed desire to see sibling, get a job and find a girlfriend not addressed in Plan. **<u>CMH for Central Michigan</u>** **WSA# 74939:** Expressed desire to lose weight, get a cat and a job not addressed in Plan. **WSA# 8584:** Expressed desire to see family and work at Hope Network not addressed in Plan. **WSA# 12160**: Current IPOS is exactly the same as the previous year's Plan. **<u>Saginaw County CMH Authority</u>** **WSA# 4685:** Many goals/preferences expressed not addressed in Plan. **WSA# 55113**: Expressed desire to see family and for preferred community activities not addressed in Plan.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately identifies the individual's goals and preferences. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

				Individual Remediation: **CEI** By 11/30/22 for WSA # 74021, the plan will be amended to reflect his/her goal/preferences. **CMHCM** By 11/15/2022 for WSA #'s 74939,8584,12160 the plan will be amended to reflect his/her goal/preferences after a discussion with the consumer/guardian indicates this to be necessary. If consumer/guardian does not want to address these goals and preferences in the current IPOS, rationale for that will be provided in the record by the case holder. **SCCMHA** ☒By 10/31/2022 for WSA # _4685, the plan will be amended to reflect his/her goal/preferences. Other: (See response below) By 9/30/2022 for WSA# 55113 a new IPOS will be completed to reflect/address

				his/her goal/preferences . A new plan is being created in lieu of previous plan being amended due to new plan being due. **Systemic Remediation:** **MSHN** The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** By 11/30/22, staff training will be provided on the need to adequately address the

				preferences and desires of the individual served. Effective 9/1/22, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so ensure compliance **CMHCM** By 12/1/2022 staff training will be provided by the Waiver review team on the need to adequately address the preferences and desires of the individual served. **SCCMHA** ☒ By 11/30/2022, staff training will be provided on the need to adequately address the preferences and desires of the individual served. **MDHHS Response**: ☒ **Response accepted** **Individual Remediation:** **CMHCM revision:** By 12/15/2022 for WSA #'s 74939,8584,121

				60 the plan will be amended to reflect his/her goal/preferences after a discussion with the consumer/guardian indicates this to be necessary. If consumer/guardian does not want to address these goals and preferences in the current IPOS, rationale for that will be provided in the record. **Systemic Remediation: CMHCM revision**: By 12/15/2022 staff training will be provided on the need to adequately address the preferences and desires of the individual served. **MDHHS 2nd Response**:☒ **Response accepted with adjusted target dates by which these remediations will occur.**
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.	41	0		

P.2.4. The individual plan of service is modified in response to changes in the individual's needs. (HSW PM D-6)	38	3	**REPEAT CITATION** **Shiawassee Health & Wellness** **WSA# 10493:** Need for an increase in psychiatric services was not reflected in the Plan through an amendment. **CMH for Central Michigan** **WSA# 4774**: No addendum completed when WSA discharged from nursing facility, reflecting a change in need **Tuscola Behavioral Health Systems** **WSA# 176051**: No amendment found to reflect an increase in CLS from 8 hrs/day to 11 hrs/day.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered plan is modified in response to changes in the individual's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **SHW** ☒ By 11/15/20252 for WSA # 10493, the record will reflect at least quarterly opportunities in which he/she provides feedback on supports/services and progress. **CMHCM** ☒ By 11/15/2022, for WSA #4774 a

				formal review of the plan will be completed to ensure the current IPOS adequately meets the current needs. An amendment will be completed at that time if IPOS updates are needed. **TBHS** ☒ This record is unable to be remediated, as this is a closed case. However, this was a self-determination case with an individualized budget and at times, CLS hours fluctuated based on consumer/family needs. In the future, staff will review utilization of services and supports more frequently (e.g., monthly) and make revisions based on medical necessity/needs. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each

				remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **SHW** ☒ By11/15/2022, staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). **CMHCM** ☒ By 12/1/2022 staff training will be provided by the Waiver review team on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). **TBHS**

				☒ By 11/01/2022, Staff will be re-educated on the revision/amendment process during an upcoming staff meeting with documentation maintained in the form of meeting minutes. Supervision will review a random sample of HSW records on a quarterly basis throughout FY23 to ensure revisions are being made in a timely manner based on medical necessity and utilization. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found.** **For SHW**: No individual remediation found for the citation noted (failure to amend the plan, to increase psychiatric services, when individual's needs changed).

				Instead, another performance measure appears to be addressed (P.2.3?). Please revise **For TBHS**: The WSA does not currently reflect the case as closed. Further, SD arrangements do not negate the requirement to reflect specific amt scope duration of services based on medical necessity. Services cannot be increased from levels reflected as medically necessary in the plan, without amendment. Re systemic remediation, timeline unclear for second step of remediation (supervisor reviewing random sample). Systemic remediations (evidence of this specific step) are required within 90 days of approved CAP. ☐ No systemic remediation found ☐ No

				timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **SHW Individual Remediation** By 11/15/2022, for WSA 10493, a formal review of the plan will be completed to ensure the IPOS adequately meets the current needs of the individual. An amendment will be completed at that time if IPOS updates are needed. **TBHS Individual Remediation** This record is unable to be remediated, as this case is closed to TBHS. The individual moved to Bay County in June 2022 and was reassigned in the WSA as of 7/1/22. The individual will still show in the WSA due to remaining within the MSHN region but is not actively receiving services through TBHS. In the future, staff will review utilization

				of services and supports more frequently (e.g., monthly) and amend the plan as necessary based on medical necessity/needs. **TBHS Systemic Remediation** By 11/01/2022, Staff will be re-educated on the revision/amendment process during an upcoming staff meeting with documentation maintained in the form of meeting minutes. Supervision will review a random sample of HSW records on a quarterly basis throughout FY23 to ensure revisions are being made in a timely manner based on medical necessity and utilization. The first supervisory review will be conducted by 12/31/22. **CMHCM Individual Remediation revision:** By 12/15/2022, for WSA #4774 a formal review of the plan will be completed to ensure the current IPOS adequately

				meets the current needs. An amendment will be completed at that time if IPOS updates are needed. **CMHCM Systemic remediation revision:** By 12/15/2022 staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). **MDHHS 2nd Response**: ☒ **Response not accepted** **For CMHCM** Systemic Remediation does not appear to address the citation. Instead, it appears to be addressing a different performance measure (P.2.3?) Please revise. **CMHSP/PHIP 3rd Response**: **CMHCM** Systemic Remediation

				By 12/15/2022 staff training will be provided on the need to revise the plan of service in response to changes in the individual's needs as evidenced by staff attendance log for the training.
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)	37	4	**REPEAT CITATION** **CMH Authority of CEI Counties** **WSA# 74021** **Saginaw County CMH Authority** **WSA# 55113** **WSA# 4685** **The Right Door for Hope, Recovery and Wellness** **WSA# 28567**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

				CMHSP/PHIP Response: **Individual Remediation:** **CEI** ☒By 11/30/22 for WSA # 74021, the plan will be amended to reflect/address his/her community inclusion needs. **SCCMHA** ☒ By 10/31/22 for WSA #4685, the plan will be amended to reflect/address his/her community inclusion needs. ☒ Other: (See response below) By 9/30/2022 for WSA# 55113 a new IPOS will be completed to reflect/address his community inclusion needs. A new plan is being created in lieu of previous plan being amended due to new plan being due. **The Right Door** ☒ This individual (WSA 28567) is closed to the waiver, there cannot be individual remediation.

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** ☒ By 11/30/22, staff training will be provided on the need to on the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life.

				☒ Effective 9/1/22, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. **SCCMHA** ☒ By 11/30/2022, staff training will be provided on the need to on the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. **The Right Door** ☒ By 11.26.2022, staff training will be provided on the need to on the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. **MDHHS Response**: ☒ **Response accepted**

P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	28	1 3	**REPEAT CITATION** **<u>The Right Door to Health, Recovery and Wellness</u>** **WSA# 40806: URGENT ISSUE** Environmental modification needs not sufficiently addressed for health/safety (i.e., no evidence of home modifications being offered when equipment needs did not resolve bathing needs). Lack of coordination of care with primary care physician over the last 12 months. **WSA# 28567:** Lack of coordination of care with primary care physician. **<u>Huron Behavioral Health</u>** **WSA# 33852:** Coordination of Care with Primary Care physician did not include psychotropic meds prescribed by HBH **<u>CMH Authority of CEI Counties</u>** **WSA# 74021, 73417, 8697, 247943, 12025:** Lack of Coordination of Care with Primary Care physician that include psychotropic meds prescribed by CEI. **WSA# 18584:** Same as above and lack of medication consent. **<u>CMH for Central MI</u>** **WSA# 8584:** Lack of medication consent. **<u>Lifeways</u>** **WSA# 5353:** Lack of coordination of care with primary care physician for 2021. **<u>Newaygo County Mental Health Center</u>** **WSA# 13568** Lack of coordination of care with primary care physician.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS addresses health and safety, including coordination with primary care providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **The Right Door** ☒ By 11.26.2022 for WSA # 40806 (28567 no longer on the HSW), the following will be completed/reflected in the record: - Psychiatric Eval

			<u>Saginaw County Mental Health Authority</u> **WSA# 4685:** Lack of coordination of care with primary care provider.	- Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter noted below. - Obtain Occupational Therapy (OT) prescription from PCP. o Completed June 26, 2022 - Amend the PCP to add OT services. o Complet

				ed June 29, 2022 - OT will complete an evaluation to determine the needed environmental modifications. ○ Completed July 8, 2022 - Three bids will be obtained for the environmental modifications and one contractor selected

				to complete needed work. ○ Completed August 26, 2022. - Approved contractor will complete the environmental modifications. ○ Pending - Once completed, environmental modifications will be reviewed and approved for

				final payment to the contractor. ○ Pending **Huron** ☒ By 8/31/2022 for WSA #33852, the following will be completed/reflected in the record: – Psychiatric Eval – Coordination of Care – Documenting current prescribed psychotropic medications – Medication consent reflecting all meds – Resolution of the health and safety matter noted below. – Other (See below) **CEI**

				☒ By 9/30/22 for WSA # 74021, 73417, 8697, 247943, and 12025, the following will be completed/reflected in the record: - Psychiatric Eval - Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter noted below. - Other (See below) ☒ By 9/30/22 for WSA # 18584, the following will be completed/reflected in the record: - Coordination of Care - Medication consent reflecting all meds **CMHCM** ☒ By 10/1/2022 for WSA # 8584 the following will be completed/reflected in the record: - Psychiatric Eval

				- Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter noted below. **Lifeways** ☒ By 12/15/22 for WSA # 5353, the following will be completed/reflected in the record: - Coordination of Care with PCP **Newaygo** ☒ By 9/30/22 for WSA # 13568, the following will be completed/reflected in the record: - Psychiatric Eval - Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter

				noted below. - Other (See below) Case Manager will continue to coordinate with PCP on an as-needed basis. ☒ As of 9/1/22, Case Manager will document PCP coordination in disclosure log and in progress notes. **SCCMHA** ☒ By 9/30/2022 for WSA # 4685, the following will be completed/reflected in the record: - **Coordination of Care** **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will

				monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **The Right Door** ☒By 11.26.2022, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **Huron** ☒ By 9/30/2022, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. ☒ Other: The HBH Standardized "Letter to

				Integrate/Coordinate Care for Medication Reviews" (form 90-546) will be updated to include a requirement to attach the exact psychotropic medication list. **CEI** ☒ Other: By 9/15/22 Medication Clinic staff will begin sending annual coordination of care letter for any consumer enrolled in medication services through CMH to include any CMH prescribed psychotropic medications. Medication Clinic Supervisor will provide training to staff who will be sending these letters and supervisor will provide training to staff on requirement of mediation consent needed. **CMHCM** ☒ By 12/1/2022 additional training will be provided by the Waiver review team to the staff at large regarding the required elements of

				addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **Lifeways** ☒ By 12/15/22, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **Newaygo** ☒ By 9/7/22 the Adult Services Director and Associate Adult Services Director will educate Adult Services Staff regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations, and medication consents. **SCCMHA** ☒ By11/30/2022, additional training will be provided to the staff at large regarding the required

				elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For The Right Door,** WSA# 40806, under individual remediation, timelines not provided for completion of environmental modifications and final review of modification and payment of the contractor. Only “pending” noted. Regarding systemic

				remediations, the offering of environmental modification when appropriate (not found in clinical record, prior to June 2022 when this matter was elevated to an urgent issue and cited as a consequence) not found specifically in proposed content of systemic remediation training. Please revise. **For Huron**, WSA# 33852, the second step of systemic remediation lacks a specific timeline (date by which standardized letter to integrate/coordinate care will be updated). Please revise. **For CEI**, under systemic remediation, timeline for proposed training (specific date by which this will occur) not reflected. Please revise.

				CMHSP/PHIP 2nd Response: **CEI Systemic Remediation** Other: By 9/15/22 Medication Clinic staff will begin sending annual coordination of care letter for any consumer enrolled in medication services through CMH to include any CMH prescribed psychotropic medications. By 9/15/22 Medication Clinic Supervisor will provide training to staff who will be sending these letters and by 11/1/22 supervisor will provide training to staff on requirement of medication consent needed. **The Right Door - Individual Remediation** By 11.26.2022 for WSA # 40806 (28567 no longer on the HSW), the following will

				be completed/reflected in the record: - Psychiatric Eval - Coordination of Care - Medication consent reflecting all meds - Resolution of the health and safety matter noted below. - Obtain Occupational Therapy (OT) prescription from PCP. Completed June 26, 2022 - Amend the PCP to add OT services. Completed June 29, 2022

				- OT will complete an evaluation to determine the needed environmental modifications. Completed July 8, 2022 - Three bids will be obtained for the environmental modifications and one contractor selected to complete needed work. Completed August 26, 2022. - Approved contractor will complete the environmental modifications. Contrac

				tor approved and ½ paid for modification on 9/26/2022 - Once completed, environmental modifications will be reviewed and approved for final payment to the contractor. Project projected to be completed by 12/31/2022. - **The Right Door – Systemic Remediation** By 11.26.2022, additional training will be provided to the staff at large regarding the required elements of addressing health/safety,

				coordination of care, psychiatric evaluations and medication consents. By 11/26/2022 all supervisors and clinicians working with persons on the HSW will receive training on environmental modifications, identifying potential need, discussing medical necessity and how to implement the process of environmental modifications. **Huron-Systemic Remediation** By 10/31/2022, the HBH Standardized "Letter to Integrate/Coordinate Care for Medication Reviews" (form 90-546) will be updated to include a requirement to attach the exact psychotropic medication list. **MDHHS 2nd Response**:

				☒ **Response accepted**
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)	28	13	**REPEAT CITATION** **<u>CMH Authority of CEI Counties</u>** **WSA# 73417, 18584:** Insufficient evidence of attempts to engage guardian in PCP process. **WSA# 15384:** How often the Plan would be reviewed could not be found within the IPOS. **WSA# 74021**: Insufficient evidence of attempts to engage guardian in PCP process (pre-planning, plan development and reviews) and failing to ensure the individual's preferences in the implementation of the IPOS, disrupting a stable living arrangement (having his own apartment in another area of the bldg) to address an administrative need, moving him away from a less restrictive living arrangement (own apartment) to a more restrictive arrangement (shared room situation). **<u>Huron Behavioral Health</u>** **WSA# 33582:** No evidence of guardian involvement in Plan review. **<u>Tuscola Behavioral Health Systems</u>** **WSA# 61994** Insufficient evidence of attempts to engage guardian in PCP process. **<u>Saginaw County CMH Authority</u>** **WSA# 6874** No evidence found of WSA attending their own meeting. **WSA# 54442, 4685:** No evidence of pre-planning meeting. **<u>CMH for Central Michigan</u>** **WSA# 5736:**	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation: CEI** ☒ By 11/9/22 the following will be completed/reflected in the record: for WSA # 73417: - Pre-Planning

			Insufficient evidence of attempts to engage guardian in PCP process. **WSA# 12160**: Pre-Plan and IPOS completed on same day without sufficient rationale **<u>Montcalm Care Network</u>** **WSA# 15435:** Not all goal objectives are measurable. **<u>Newaygo County Mental Health Center</u>** **WSA# 13568** Insufficient evidence of attempts to engage guardian in PCP process. .	Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below) ☒ By 10/6/22 the following will be completed/reflected in the record: for WSA # 18584: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below) **Huron** ☒ By 9/30/2022 the following will be completed/reflected in the record: for WSA #33582: - Pre-Planning

				Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below): HBH Case Manager for WSA #33582 will complete an IPOS addendum to add input from the Huron County Public Guardian to the existing IPOS. - - **TBHS** ☒ By 7/13/2022 the following will be completed/reflected in the record for WSA# 61994: - Pre-Plannin

				g Meetin g - Offer of self-determi nation - Offer of Indepe ndent Facilitat ion Pre-planning was conducted for a new IPOS and guardian participated on 7/13/2022. Documented in pre-planning, progress note, and within the IPOS. **SCCMHA** ☒ By 9/30/22 the following will be completed/refl ected in the record: for WSA #_6874_: - Pre-Plannin g Meetin g - Offer of self-determi nation - Offer of Indepe ndent Facilitat ion - **Other (See below)**

				A new Pre-Planning Meeting and Individual Plan of Service Meeting took place for this consumer in April and June 2022, respectively. Documentation within the IPOS indicates consumer was in attendance during their meeting. ☒ By 9/30/2022 the following will be completed/reflected in the record: for WSA #_54442_: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - **Other (See below)** Copy of the IPOS Pre-Plan for this consumer will be sent to guardian and

				signature will be obtained to show review has occurred. A progress note dated 9/3/2022 will be provided which shows the consumer was present at the IPOS Pre-Planning meeting on this same date. ☒ By 10/31/22 the following will be completed/reflected in the record: for WSA #_4685___: - **Pre-Planning Meeting** **CMHCM** ☒ Other: (See response below) 1. Discussion with the guardian for WSA # 5736 will occur by 11/15/2022 with the case holder to go over the current IPOS and this will be reflected

				in the record. If needed, an amendment will be completed to the IPOS based on guardian feedback/input. 2. Individual remediation for WSA #12160 in terms of updating the record is not possible for the current IPOS. Training will occur with the individual case holder by 11/15/2022 on ensuring sufficient rationale is provided in the record if the pre-plan and IPOS are completed on the same day. **MCN** ☒ By 11/30/22 the following

				will be completed/reflected in the record: for WSA #_15435_____: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below) IPOS will be amended such that all objectives will be measurable. **Newaygo** ☒ By_9/30/22 the following will be completed/reflected in the record: for WSA #13568: - Pre-Planning Meeting - Offer of self-

				determination - Offer of Independent Facilitation - Other (See below) The Case Manager will contact the Guardian for upcoming PCP review and will document in a progress note. **Systemic Remediation: MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the

				performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN QIC will develop a QI Team to review the PCP process steps to assess for efficiencies and value. Actions will be taken based on the results of the QI team. **CEI** ☒ By 11/30/22, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☒ Effective 9/1/22, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☒ Other: Request the Assessment/Pr

				e-Planning document be updated to include guardian/support involvement. (See response below) **Huron** ☒ By 9/30/2022, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☒ Effective 10/1/2022 quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☒ Other: Staff retraining completed by 9/30/22 will include information regarding how to appropriately document a guardian's choice not to participate in the IPOS development process.

				TBHS ☒ By 11/01/2022, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☒ By 11/01/2022, staff will receive education on outreach efforts to engage guardians in the “pre-planning process” as a component of PCP activities. This shall be documented in staff meeting minutes. **SCCMHA** ☒ By 11/30/2022, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☒ Other: (See response below)

				By 10/31/2022 a procedure will be created that will address obtaining input from guardian if they will not be present at the time of the IPOS Pre-Planning meeting. By 11/30/2022, a form will be routinely provided to guardians when they are unable to attend an IPOS Pre-Planning meeting that will allow guardians to provide input on goals for the upcoming year that will be used as discussion points during the IPOS Pre-Planning meeting with the consumer. This form will indicate that guardians have given approval to hold the meeting without their presence. Proof of completed forms will be saved within

				the record for future reference. **CMHCM** ☒ By 12/1/2022 additional training will be provided by the Waiver review team to the staff at large regarding the required elements of the person-centered planning process. **MCN** ☒ Other: 1) By (Date) 11-30-22 additional training will be provided to the HSW team specific to writing measurable goals. 2) Effective (Date) 12-30-22, quarterly monitoring by IDD Community Services Managers and Quality Improvement staff will include a of a random pull of records to

				ensure compliance . **Newaygo** ☒ Other: By 9/7/22 the Coder/Medical Records Coordinator will meet with PCE to discuss if there's an existing means of documenting attempts at involving guardian in PCP process. This may include but is not limited to, a prompt implemented in the EMR related to the guardian's involvement in the PCP meeting, with client approval. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found

				☐ No timelines indicated ☒ Other: (See response below) **For CEI**, WSA#s 73417, 18584: Citations were for no documented evidence of attempts to engage guardian in IPOS process, not found addressed in individual remediations above. Please revise. Also, no individual remediation found for WSA#s 15384 or 74021. Finally, third step of systemic remediation lacked a timeline. Please provide. **HBH:** Systemic remediation (around planned training) does not specifically address the TCM's need to attempt

				engagement of the guardian in the treatment planning process, though how to document when they choose not to participate is reflected. Please revise with how Huron will support successful engagement of guardian involvement in the PCP process. **CMHCM:** No individual remediation found for WSA# 12160. Please provide. **MCN**: The effective dates of systemic remediation must fall within 90 days of the approved CAP (so that evidence of the remediations can be reviewed at the 90-Day review). The second step of the systemic remediation potentially falls outside that 90-day window.

				Please revise with an earlier effective date. **Newaygo**: More information needed for individual remediation. Towards what end will pre-planning be initiated, with the offer of SD and IF? Will guardian/WSA be offered an opportunity to develop a new Plan, given the guardian's lack of opportunity/involvement with current plan (along with contacting the guardian for the upcoming planned review)? Regarding systemic remediation, insufficient remediation noted. What will be done by Newaygo to ensure that attempts to engage guardian in the process will occur and be sufficiently documented, within the next 90 days? Please revise.

				CMHSP/PHIP 2nd Response: **Newaygo Individual Remediation** The PCP Pre-plan meeting occurred with client on 8/11/22 with the Guardian in attendance, which noted the offer of SD and IF. Documentation of this meeting will be provided to MDHHS during the 90 day follow up. As of 10/10/22, PCE added updates to the PCP pre-plan, which now includes added radio buttons as a prompt to remind the Case Manager to contact the guardian by phone and/or email and/or letter to invite them to participate in the PCP process. This will also prompt Case Manager to document if the guardian has selected (if invited by the client) to be in attendance at the PCP meeting or would like to

				provide input by other means. The Adult Services Director and Associate Adult Services Director will communicate with Adult Services Team Staff the PCE changes/updates in November 2022. **CMHCM Individual Remediation:** "Discussion with the guardian for WSA # 5736 will occur by 12/15/2022 to go over the current IPOS and this will be reflected in the record. If needed, an amendment will be completed to the IPOS based on guardian feedback/input" WSA #12160 Training will occur with the individual case holder by 12/15/2022 on ensuring sufficient rationale is provided in the record if the pre-plan and IPOS are completed on the same day. Sufficient rationale needs to be either consumer or guardian driven. A formal review

				of progress will be completed by 12/15/2022 with guardian/consumer input to the plan of service and adjustments made to the plan as requested/needed **CMHCM Systemic Remediation** By 12/15/2022 additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. **MCN Systemic Remediation** 1) By 11-30-22 additional training will be provided to the HSW team specific to writing measurable goals. 2) Effective 12-30-22, quarterly monitoring by IDD Community Services Managers and Quality Improvement staff will include a of a random pull of records to ensure compliance. **Huron-Individual Remediation**

				By 10/31/2022 the following will be completed/reflected in the record: for WSA #_33582: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below): HBH Case Manager for WSA #33582 will complete an IPOS addendum to add input from the Huron County Public Guardian to the existing IPOS. **Huron Systemic Remediation** By 10/31/2022, additional training will be provided to the staff at large regarding the required elements of the

				person-centered planning process including guardian input. Guardian input may include face-to-face participation in the IPOS meeting, supporting written documentation, or consultation Effective 10//2022 quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. Other: Staff retraining completed by 10/31/22 will include information regarding how to appropriately document a guardian's choice not to participate in the IPOS development process. Additionally, the public guardian's office will be provided with informational resources pertaining to the person-centered planning process and the importance of guardian participation. The public

				guardian will be encouraged to participate in all IPOS meetings, whether in-person, virtually, or by submitting written feedback/information. **CEI Individual Remediation** By 11/9/22 the following will be completed/reflected in the record: for WSA # 73417, 18584, & 74021: documented guardian involvement in the PCP process (pre-plan, plan development and plan reviews) WSA#s 15384: By 11/9/22 Treatment plan will be amended to show review frequency. WSA#s 74021: By 11/9/22 Add in documentation in the Record of consumer choice and preference in the individuals' living arraignment. Consumer currently has an individual room. **CEI Systemic** By 11/30/22, additional training will be

				provided to the staff at large regarding the required elements of the person-centered planning process. Effective 9/1/22, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. **MDHHS Response**: ☒ **Response accepted For CEI,** response accepted with expectation that documentation provided on WSA# 74021 (specific to CEI's disruption of his stable living arrangement for administrative reasons) resolves his concerns around his preferred living arrangements, going forward. Systemic remediation accepted with expectation that matters that led to these specific citations are addressed in the proposed training with staff at large.

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).	7	5	**REPEAT CITATIONS** NA = 29 **CMH Authority of CEI Counties** **WSA# 18584:** OT Prescription lacks required elements for on-going services (i.e., specific services and amt or duration prescribed) **The Right Door** **WSA# 40806:** OT Prescription lacks required elements for on-going services (i.e., specific services and amt or duration prescribed) **WSA# 28567**: No current OT script found for OT services. **Tuscola Behavioral Health Systems** **WSA# 5540**: OT Prescription lacks required elements for on-going services (i.e., specific services and amt or duration prescribed). **WSA# 61994:** No OT script found for July 2021 OT eval, or for on-going services.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that services requiring physician signed prescription follow Medicaid Provider Manual requirements. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ By 10/15/22, a physician-signed prescription (with the required elements) will be obtained for OT/PT/PDN

				support and reflected in the record for WSA #18584 **The Right Door** ☒ By 11.26.2022, a physician-signed prescription (with the required elements) will be obtained for OT/PT/PDN support and reflected in the record for WSA #40806 (28567 is no longer on HSW) **TBHS** ☒ Other: (See response below) #5540: The OT prescription was present in the medical record and included the specific services as well as the duration; however, the order referred to the OT assessment as to the specific amount. Education to be provided to the physician/nursing personnel regarding including this information on the actual order to the extent possible in the future. An updated OT order that contains all required elements will be obtained.

				#61994: An order for the July 2021 OT evaluation was located in the medical record. Evidence to be provided when supporting CAP documentation is submitted via Box. Additional required elements are addressed above; updated orders will be obtained. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for

				each CMHSP to occur in 2023. **CEI** ☒ CMHSP will develop/provide a guidance tool to provide to primary care physician, to assist in securing the needed elements of the prescription, by 10/15/22. **The Right Door** ☒ By 11.26.2022, staff training will be conducted, on the need to ensure physician-signed prescriptions for these services, going forward. ☒ CMHSP will develop/provide a guidance tool to provide to primary care physician, to assist in securing the needed elements of the prescription. This was updated on 7.27.2022 and published 9.7.2022. **TBHS** ☒ Other: (See response below) Beginning 10/1/21, Supervision to review a sample of prescriptions for OT services for individuals enrolled in the

				HSW program on a quarterly basis to ensure compliance with standards/requirements. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For TBHS**, WSA#s 5540 ad 61994: No timelines indicated for obtaining an updated order that contains all required elements. Please revise. **CMHSP/PHIP 2nd Response**: **TBHS Individual Response** #5540: The OT prescription was present in the

				medical record and included the specific services as well as the duration; however, the order referred to the OT assessment as to the specific amount. Education to be provided to the physician/nursing personnel regarding including this information on the actual order to the extent possible in the future. An updated OT order that contains all required elements will be obtained by 9/30/22. #61994: An order for the July 2021 OT evaluation was located in the medical record. Evidence to be provided when supporting CAP documentation is submitted via Box. Additional required elements are addressed above; updated orders were obtained on 9/14/22. **MDHHS 2nd Response**: ☒ **Response accepted, with the expectation that the**

				updated documentation now reportedly obtained will reflect the required elements (the lack of which led to these citations).
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.5. HSW				
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)	9	3 2	**REPEAT CITATION** **Bay-Arenac Behavioral Health** **WSA# 8203:** Range language used for TCM, psychology, nursing, medication reviews. Enhanced Pharm not outlined in IPOS **CMH Authority of CEI Counties** **WSA# 74021:** Lack of specific amt scope duration of psychological services in Plan. **WSA# 73417:** Lack of specific amt scope duration of SC/TCM and Psychiatric services (ranges used instead) **WSA# 8697:** Ranges used for SC, Med Reviews, psychology services **WSA# 247943:** Ranges used for SC, Med reviews, CLS **WSA# 15384:** Range used for TCM/SC **WSA# 12025:** Ranges used for TCM, med reviews, psychological services **CMH for Central MI:** **WSA# 7363:** Lack of specific amt scope duration of services in Plan (ranges used, instead). **WSA# 5738:**	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS 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. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected

			Lack of specific amt scope duration of SC/TCM and CLS services in current Plan (ranges noted, instead) **WSA# 74939:** Lack of specific amt scope duration of SC/TCM, CLS and Transportation services in Plan (ranges used, instead) **WSA# 8584:** Lack of specific amt scope duration of SC/TCM and Psychiatric services (ranges used, instead). **WSA#s 16060, 14217:** Range language used for TCM and Med reviews **WSA# 4868:** Range language used for Respite, TCM services **WSA# 12160**: Range language used for TCM **WSA# 17460**: Ranges used for Med Reviews, OT, TCM **<u>Gratiot Integrated Health Network</u>** **WSA# 13569**: Ranges used for TCM/SC, OT, BH psychologist **<u>Huron Behavioral Health</u>** **WSA# 33852:** Lack of specific amt scope duration of services in Plan, and measurable objectives. **WSA# 4762:** CSM services only lists frequency "monthly, CLS no amount specified, Authorized as range. **<u>Lifeways</u>** **WSA# 75020:** Ranges used for TCM services. **<u>Montcalm Care Network</u>** **WSA# 7072:** Lack of specific amt scope duration of SLP and Psychiatric services in Plan.	within 90 days after the corrective action plan has been approved by MDHHS **CMHSP/PHIP Response**: **MSHN (Individual and Systemic)** MSHN has sent a letter (attached) in response to the following citation: *Lack of specific amount, scope and duration (ranges used instead)* to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* propose d the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient

			<u>Newaygo County Mental Health Center</u> **WSA# 13568:** Lack of specific amt scope duration of TCM and Specialized Residential services in Plan. **WSA# 175819:** Ranges used for SC/TCM and CLS services **<u>Saginaw County CMH Authority</u>** **WSA# 55113**: Day programing identified as an assessed need, not resolved in Plan. **WSA# 6874:** Lack of measurable objectives **WSA# 4685**: Ranges used for TCM services. **<u>Shiawassee Health & Wellness</u>** **WSA# 10493:** Lack of specific amt scope duration of services in Plan (ranging of services reflected instead). **<u>The Right Door</u>** **WSA# 40806:** Lack of amt scope duration of services in Plan, and measurable objectives. **WSA# 28567:** Range language used for TCM, Respite, Family training. Amt scope duration of OT services not specified in IPOS. **<u>Tuscola Behavioral Health Systems</u>** **WSA#s 5540, 61994:** Lack of specific amt scope duration of services in Plan. **WSA# 176051:** Range language used for Med reviews **Technical Assistance:** As conveyed through technical assistance two years ago (during the last full Site Review), reflecting	approach to providing care to vulnerable individuals in our system. MSHN Feels that the use of ranges is more aligned with the recovery model of care. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appear overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. Additional action will be identified once a response is received from MDHHS. **Individual Remediation: BABH** By 9/30/22, plan for WSA#8203 will be amended for resolving/addressing service

			medically necessary services using ranges of service, or range language (i.e., "up to", "at least") is no longer acceptable. Plans must specify the amt scope duration of recommended services within the IPOS, per the following source documents: • **Federal** **42 CFR §441.301 and §441.302** **https://www.ssa.gov/OP_Home/ssact/title19/1915.htm** (Social Security Act) • **Medicaid Provider Manual, BH & I/DD SS Chapter, Section 1.7 and Section 2 Program Requirements (2.1 and 2.5/2.5.B)** Definition of Terms • **MHDDS/PIHP Contract and Attachment P.4.1.1.1** *Also, per consult with MDHHS leadership during the course of this Site Review, the following response was provided:* *"MDHHS recognizes that ranges do not offer the specificity required and is likely to result in lower utilization. Furthermore,* ***MDHHS has the authority to set the standards for contractual providers to adhere to****. The specific language identified in the Medicaid Provider Manual (MPM) that defines Amount is included for your reference.* *Section 1.7 Definition of Terms:* *"Amount" is identified as: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.* *This should provide the clarity that the CMHSPs and MSHN are seeking regarding inconsistencies with interpretation of MPM language and validity of MDHHS standards."*	needs identified in assessments. Staff will update IPOS to reflect enhanced pharmacy services. **CEI** ☒ Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **CMHCM** Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **GIHN** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope

				and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **Huron** ☒ By 8/31/22, plan will be amended to include amount scope duration of recommended supports. **Lifeways** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **MCN** ☒ Other: (See response below) By 11-30-22, the IPOS for WSA # 7072 will be amended to ensure amount, scope, duration for SPL and psych services

				is reflected in the IPOS. **Newaygo** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022 **SCCMH** ☒ WSA# 55113: by 9/30/2022, a new Bio-Psychosocial Assessment will be completed which will clearly reflects that consumer is not currently involved in Day Programming Activity services. Per Person Centered Planning meeting completed on 9/17/2020, consumer's guardian did not wish consumer to participate in Day Programming Activity services due to concerns related to COVID. Consumer has

				not been a participant of Day Programming Activity services since this decision was made by guardian. Copy of this IPOS will be provided as proof showing when this decision occurred. WSA# 6874: by 9/30/2022, IPOS will be amended to reflect measurable objectives for Goal #2. WSA# 4685: Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **SHW** ☒ Please refer to the MSHN action to address the lack of specific amount, scope, duration (ranges used instead) as outlined in the Service Range

				Response Letter Subject: 2022 1915c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **The Right Door** ☒ Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **TBHS** ☒#61994: A new plan of service was developed on 8/8/22 which includes specific ASDF for each service authorized. ☒ Please refer to the MSHN action to address the l*ack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report*

				sent by MSHN to MDHHS on 8/17/2022. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒ By 9/30/22, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. Please refer to the MSHN action to

				address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022 **CEI** ☒ Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **CMHCM** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN

				to MDHHS on 8/17/2022 **GIHN** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022 **Huron** ☒ By 9/30/2022, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. ☒ Effective 10/1/2022, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: By 12/31/2022, the IPOS format in PCE EMR (i.e., HERBI) will be amended to reflect specific sections for documenting amount, scope,

				and duration directly in the Goal/Objectives section of the IPOS. **Lifeways** Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **MCN** ☒ Other: (See response below) 1) By 11-30-22, additional training will be provided to the HSW team specific to amount, scope, duration. 2) Effective 12-30-22, quarterly monitoring by IDD Community Services Managers and Quality Improvement staff will include of a random pull of records to

				ensure compliance. **Newaygo** Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022 **SCCMH** ☒ By 11/30/2022, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. ☒ Other: (See response below) By 11/30/2022 staff training will be conducted on the need to include measurable objectives for all goals included in an IPOS. **SHW** Please refer to the MSHN action to address the Lack of specific amount, scope and duration

				(ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022 **The Right Door** ☒ Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022. **TBHS** ☒ Other: (See response below) Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022

				☒Education provided to staff regarding further expansion of ASDF information in each individual goal in addition to ASDF summary already included in the plan of service. Beginning 10/1/22, Supervision to review a sample of goals for ASDF for individuals enrolled in the HSW program on a quarterly basis as part of ongoing supervision meetings to ensure compliance with standards/requirements. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated

				☒ Other: (See response below) **For BABH (WSA# 8203), CEI (all WSAs),, CMHCM (all WSAs)** , **GIHN (WSA# 13569), HBH (both WSAs), Lifeways (WSA# 75020), Newaygo (both WSA#s), SCCMHA (WSA# 4685), SHW (WSA# 10493), the Right Door (WSA# 40806, and second WSA now closed) and DBHS (Both WSA#s),** individual remediation cannot be located for the citations regarding failing to reflect specific amt scope duration of services deemed medically necessary in the Plan (reflecting those services in ranges, instead). MSHN references a response letter, authored by MSHN/Region 5 to Lyndia Deromedi of MDHHS, Section Manager of the Federal Compliance

				Section, dated 8/17/22, requesting, in essence, reconsideration on these citations for the use of ranges. For all the above CMHSP's but TBHS, systemic remediation could not be located for addressing lack of specific amt scope duration, within the plan. A formal response from Lyndia Deromedi, to the letter of 8/17/22 is forthcoming. Please revise your CAPs and re-submit. **CMHSP/PHIP 2nd Response**: Mid-State Health Network (MSHN) acknowledges receipt of the email from the Michigan Department of Health and Human Services (MDHHS) as to feedback to MSHN regarding the need to reflect the specific amount, scope, duration, and frequency of services deemed medically necessary in the individual plan of

				service (IPOS). MSHN fully intends on following the MDHHS/PIHP Contract, the Michigan Medicaid Provider Manual (MMPM), and related guidance in implementing the required documentation practices in representing the service amount elements as codified. MSHN , however, is unable to identify a standard that indicates that a specific service amount must be identified and represented in a singular number of units. This is of concern as any amount of service provided less than is noted in the IPOS, for any reason, will trigger an adverse benefit determination notice. Individu al service patterns often vary and require more or less units of service based on the needs at the moment of the person served. The expectation of a rigid specific amount does not allow for the flexible,

				recovery-oriented means of service delivery. MSHN wishes to formally appeal the MDHHS decision not to accept reasonable ranges as an alternative to the use of a specific service amount. **CMHCM Individual Remediation** By 12/15/22, WSA #7363 plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA 5738, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #74939, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #8584, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #16060, plan will be

				amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #14217, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #4868, plan will be amended to include exact amount scope duration of recommended supports. By 12/15/22, WSA #12160, plan will be amended to include exact amount scope duration of recommended supports. **Lifeways Individual Remediation** By 12/15/22, WSA# 75020's treatment plan will amended to include amount scope duration of recommended supports. **Lifeways Systemic Remediation** By 12/15/22, staff training will be conducted, on ensuring that IPOS's do not use ranges and

				are specific with amount, scope and duration for services within the IPOS. Additionally, formal notice will be issued to all LifeWays and it's Provider Network to not use ranges. **<u>SCCMHA Individual Remediation</u>** For #4685: By 11/30/2022, IPOS will be updated to reflect specific amount, scope, and duration for TCM services. **<u>SCCMHA Systemic Remediation</u>** By 11/30/2022, staff will receive training on appropriate documentation of services within an IPOS. Staff will be trained to no longer use ranges when documenting the amount, scope, and duration of services. Rather, staff will be trained to include specific amounts of amount, scope, and duration for each service listed within the plan. **SHW Individual Remediation**

				By11/15/2022, the plan for WSA 10493 will be amended to include the exact amount, scope, and duration of recommended supports. **SHW Systemic Remediation** By 12/15/2022, staff training will be conducted on the requirement of including specific amount, scope, and duration of services in the plan and discontinuing use of ranges when authorizing services. In addition, by 12/1/2022, the Utilization Management department will use the random quarterly Quality Chart Reviews to confirm services are being provided as authorized and that goals/objectives are measurable. **CMHCM Systemic Remediation** By 12/15/2022, staff training will be conducted on the requirement of including specific amount, scope, and duration of services in the

				plan and discontinuing use of ranges when authorizing services. Additionally, by 12/15/22, a UM monitoring section will be added to the IPOS Review of Progress document to ensure services are delivered as authorized and medically necessary. **Newaygo Individual Remediation** For WSA#13568 – Specialized Residential Services is located under recommendations in the treatment plan, which covers 24/7. Case Manager will complete addendum, interventions will be updated to specify by November 15th, 2022. For WSA#175819 – Case Manager will update the intervention to include language for service changes through the PCP addendum process by November 15th, 2022.

				Newaygo Systemic Remediation By November 15th, The Adult Services Director and Adult Services Associate Director will educate the Adult Team Staff on the use of ranges. NCMH Administration will research options related to the internal specific amount, scope and duration process. **BABH Individual Remediation** By 11/30/22, plan for WSA#8203 will be amended for resolving/addressing service needs identified in assessments and specifically define amount, scope, and duration. Staff will update IPOS to reflect enhanced pharmacy services. **BABH Systematic Remediation** By 11/30/22, staff training will be conducted on the need to address/resolve needs identified in the assessments,

				within the IPOS. BABH staff will be trained on how to include goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. **GIHN Individual Remediation** By 12/1/22, the IPOS for WSA 13569 will be amended to include the exact amount, scope, and duration of recommended supports. **GIHN Systematic Remediation** By 12/30/22, staff training will be conducted on the need to use specific authorization amount, scope, and duration within the IPOS as determined by consumer need/medical necessity. Additionally, by 1/31/23, quarterly monitoring of random samples of IPOSs will occur by supervisory staff, to ensure compliance.

				CEI Individual Remediation WSA# 74021. 73417, 8697, 247943, 15384, 12025: By 11/30/22 plans will be amended to remove ranges and identify specific amount, scope and duration of services. **CEI Systemic Remediation** By 11/30/22, staff training will be conducted, on specific amount, scope, and duration needed in the plan without the use of ranges. By 12/1/22 quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff to ensure compliance. **The Right Door Individual Remediation** WSA# 40806: The plan of service will be amended to include the amt, scope and duration of services in Plan, as well as measurable

				objectives by 11.26.2022. WSA# 28567: This waiver case is closed and individual remediation cannot occur. **The Right Door Systemic Remediation** WSA# 40806 and 28567 - By 11.26.2022, staff training will be conducted on amount, scope and duration of services as well as measurable objectives being identified in the plan section of the PCP. Training will be provided to waiver staff on the use of ranges by 11.26.2022. Additionally, by 12/31/22, a UM monitoring section will be added to the Clinical Record Review module to ensure services are delivered as authorized and medically necessary. Finally, The Right Door EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022.

				Huron Individual Remediation By 10/31/22, plan will be amended to include amount scope duration of recommended supports. **Huron Systemic Remediation:** By 10/31/2022 staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. Effective 10/1/2022, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. Other:(See response below) By 12/31/2022, the IPOS format in PCE EMR (i.e., HERBI) will be amended to reflect specific sections for documenting amount, scope, and duration directly in the Goal/Objectives section of the IPOS .

				TBHS-Individual Remediation Other: (See response below) By 10/31/22, the plan for WSA #5540 will be amended to include amount, scope, and duration of recommended supports. By 10/31/22, the plan for WSA #61994 will be amended to include amount, scope, and duration of recommended supports. Other: (See response below) **TBHS Systemic Remediation** By 12/01/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **MDHHS 2nd Response**: ☒ **Response not accepted.** **For MSHN:** The request to appeal the decision by MDHHS not to allow ranges is under review. Outcome pending.

				For CMHCM, WSA# 17460, no individual remediation found. **For NCMHC**: Cannot determine if individual remediations for #175819 will correct for the citation (as it only indicates amendment to change services, not how the services will be changed). Systemic remediations do not appear to clearly address the need to *discontinue* the use of ranges, in reflecting amt scope duration of recommended services. Please revise. **For HBH**, individual and systemic remediations do not appear to address the citation for lack of measurable objectives. Please revise. **For TBHS**, original systemic remediation (that was found acceptable), appears to have been altered to address PM 5.2. Please revise to

				original, or another systemic remediation that addresses the citation (for lack of specific amt scope duration of medically necessary services reflected in the Plan). ***For BABH:, TA**: Amt Scope Duration citation was related to services being recommended, rather than to goal/objectives. It is under goals/objectives that such information can be placed, but it is specific to the services being recommended, to assist the recipient in reaching their goals. Reviewer wanted to make that clarification, as the language in the CAP seems to conflate the two.* **CMHSP/PHIP 3rd Response**: **For CMHCM,** WSA# 17460, no individual remediation found. Individual remediation was omitted from 2nd CAP in error

				CMHCM individual remediation By 12/15/22, WSA #17460, plan will be amended to include exact amount scope duration of recommended supports. **NCMH Individual Remediation** WSA# #175819: The plan of service will be amended to include the amount, scope and duration of services for SC/TCM and CLS services by 11/30/22. **Huron Individual Remediation** By 10/31/22, plan will be amended to include amount scope duration of recommended supports. Additionally, the IPOS objectives will be amended to ensure that they are written in a manner that is measurable. **NCMH Systemic Remediation** By 11/30/22, The Adult Services Director and

				Adult Services Associate Director will educate the Adult Team Staff on the requirement of including specific amount, scope, and duration of services in the plan and discontinuing use of ranges when authorizing services. **Huron Systemic Remediation:** By 11/10/2022 staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. This training will also include an overview on appropriate documentation of amount, scope, and duration, as well as development of measurable objectives. Effective 10/1/2022, quarterly monitoring random sample

				of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. Other:(See response below) By 12/31/2022, the IPOS format in PCE EMR (i.e., HERBI) will be amended to reflect specific sections for documenting amount, scope, and duration directly in the Goal/Objectives section of the IPOS **TBHS Systemic Remediation** Education provided to staff regarding further expansion of ASDF information in each individual goal in addition to ASDF summary already included in the plan of service. Beginning 10/1/22, Supervision to review a sample of goals for ASDF for individuals enrolled in the HSW program

				on a quarterly basis as part of ongoing supervision meetings to ensure compliance with standards/requirements.
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)	21	20	**REPEAT CITATION** **CMH Authority of CEI Counties** **WSA# 74021:** Psychiatric, TCM, Psychological and RN services not provided as specified in Plan **WSA# 73417:** CLS not provided as specified in Plan. **WSA# 18584**: TCM, Psychological and Psychiatric services not provided as specified in Plan. **WSA# 8697:** SC services not provided as recommended **WSA# 247943:** Med reviews not provided as recommended **WSA# 12025:** TCM services not provided as recommended **CMH for Central Michigan** **WSA# 5736:** TCM, CLS services not provided as specified in Plan **WSA# 74939:** TCM, CLS services not provided as specified. RN services (not reflected in Plan) provided. **WSA# 4868:** Respite notes not provided to verify services. **Huron Behavioral Health** **WSA# 4762:**	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the 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. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

			SC/TCM services not provided as recommended **WSA# 33852:** Psychiatric services not provided as specified in Plan **<u>Lifeways</u>** **WSA# 5353:** TCM services not provided as specified in Plan **<u>Montcalm Care Network</u>** **WSA# 7072:** SC/TCM, CLS Respite services not provided as specified in Plan **<u>Newaygo County Mental Health</u>** **<u>Center:</u>** **WSA# 13568**: SC/TCM services (including full review of Plan with WSA and Guardian), and CLS services not provided as specified in Plan **<u>Saginaw County CMH Authority</u>** **WSA# 4685:** Unable to locate TCM notes to verify services. Periodic Reviews not completed as outlined in IPOS? **WSA# 55113:** SC/TCM services not provided as specified in Plan **WSA# 18936:** CLS, RD, RN services not provided as specified in Plan **<u>Shiawassee Health & Wellness</u>** **WSA# 10493:** Psychiatric, OPT, SC and CLS not provided as specified. **<u>The Right Door</u>** **WSA# 40806:** SC, CLS, Respite, OT not provided as specified in Plan. **<u>Tuscola Behavioral Health Systems</u>** **WSA# 5540:** PT(corrected from OT), RN not provided as specified in Plan.	**CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ By 11/30/22 for WSA # 74021, plan will be amended to include amount scope duration of recommended supports. ☒ Other: WSA # 73417 has CLS, per diem authorized in annual IPOS. Individual resides in an AFC. ☒ By 10/6/22 for WSA # 18584, plan will be amended to include amount scope duration of recommended supports. ☒ Other: Annual IPOS for WSA # 8697 was updated to include recommended scope and duration of supports on 5/2/22. ☒ Other: Annual IPOS for WSA # 247943 was updated to include recommended scope and duration of supports on 6/30/22.

				☒ By 11/30/22 for WSA # 12025, plan will be amended to include amount scope duration of recommended supports. **CMHCM** ☒ By 11/15/2022 the case holder will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity for WSA's #5736, #74939, #4868 **Huron** ☒ By 8/31/2022, plan will be amended for resolving/addressing service provision as recommended. ☒ By 8/31/2022, SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. **Lifeways** ☒ By 12/15/22, SC will provide

				rationale in the record for disparity between recommended and provided services for WSA# 5353, and steps to resolve that disparity. **MCN** ☒ By 11-30-22 CM will provide rationale in the record for disparity between recommended and provided services and take steps to resolve that disparity for WSA # 7072. **Newaygo** ☒ By 9/30/22, SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☒ By 9/30/22, The Case Manager will update the plan and document in progress notes the reason for services not being provided as authorized, in addition to a plan of improvement. The Client is in specialized residential and

				received CLS services 24/7/365. **SCCMH** ☒ By 9/30/22, plan will be amended for resolving/addressing service provision as recommended. (WSA# 55113, 18936) ☒ Other: (See response below) WSA# 18936: RD services are no longer being provided. IPOS effective on 6/5/2022 does not include a goal to reflect the need for this service. Moving forward, CLS and RN services will be provided per what is written in the IPOS. If they are unable to be provided at this rate, documentation will occur within the chart to indicate why there was a disparity between services recommended in the plan and what was actually provided. ☒ By11/30/2022, CM will provide rationale in the record for disparity between recommended

				and provided services, and steps to resolve that disparity. (WSA# 18936, 55113) **SHW** ☒ By 11/15/2022, plan will be amended for resolving/addressing service provision as recommended **The Right Door** ☒ By 11.26.2022 plan for WSA 40806 will be amended for resolving/addressing service provision as recommended for CSM, CLS, Respite and OT. **TBHS** ☒ Other: (See response below) #5540: Treatment plan monitoring was completed by the RN on 7/13/22 and by the PT on 7/29/22; both documents were uploaded into the medical record. Also, plan of service was amended to more accurately reflect current nursing needs based on acuity.

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN will coordinate a regional training using an external source for the implementation of Person Centered Planning, highlighting documentation of measurable goal and objectives, amount scope and duration.

				CEI ☒ By 11/30/22, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted **CMHCM** ☒ By 12/1/2022, staff training will be conducted by the Waiver review team, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **Huron** ☒ By 9/30/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **Lifeways** ☒ By 12/15/22, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to

				resolving disparity noted. **MCN** ☒ Other: (See response below) 1) By 11-30-22, additional training will be provided to the HSW team specific to intensity of services. 2) Effective 12-30-22 quarterly monitoring by IDD Community Services Managers and Quality Improvement staff of a random pull of records will be conducted for compliance. **Newaygo** ☒ By 9/7/22, the Adult Services Director and Associate Adult Services Director will educate Adult Services staff on the need to monitor service utilization, and providing documentation specific to resolving the disparity noted. **SCCMH**

				☒ By 11/30/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☒ Other: (See response below) By 11/30/2022 staff training will be conducted on the need to amend plans to reflect the correct amount of recommend services. **SHW** ☒ By 11/15/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **The Right Door** ☒ By 11.26.2022, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **TBHS**

				☒ Other: (See response below) By 11/01/2022, Staff will be re-educated on the revision/amend ment process during an upcoming staff meeting with documentation maintained in the form of meeting minutes. Supervision will review a random sample of HSW records on a quarterly basis throughout FY23 to ensure revisions are being made in a timely manner based on medical necessity and utilization . **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** **For CEI,** WSA# 73417, No individual remediation found. Please refer to original citation, within comment sheet provided, and submit corrective action for CEI's citation related to not providing two

				consecutive weeks of CLS progress notes (completed by AFC home staff) for services rendered during the review. For the remaining WSAs under CEI, more information is needed. How will amending the plan resolve the citations incurred (for not providing services as specified in the Plans). What will the amendments show*, related to services being provided* as recommended, that will remediate the citations? Will rationales be provided to address disparity between recommended services and provided service? Will amendments reflect what is being done to resolve the disparity? **For HBH**, singular language is used in individual remediation (Plan will be amended)., though two WSA's were

				cited. Please note whose plan will be amended by WSA#, so there is assurance that both WSAs are captured in the corrective action. **For Newaygo, WSA# 13568**, individual remediation does not appear to address the lack of Plan Review (steps to remediate). No individual remediation found for lack of CLS (community inclusion activities per the Plan of Service to occur 1x weekly). Please revise. **For SCCMHA**, no individual remediation found for WSA# 4685. **For TBHS,** no individual remediation found for PT services provided as specified in Plan. More than one review was at issue (please refer to comment sheet provided at end of review). Though an amendment was reportedly completed to address the

				need for RN service, no mention of PT services (on-going) found in remediation. Please revise. Regarding systemic remediation, please provide a specific target date for supervision reviewing a random sample of HSW records, that will fall within the 90-window following the approval of the CAP. **CMHSP/PHIP 2nd Response**: **CMHCM Individual Remediation;** By 12/15/2022 SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity for WSA's #5736, #74939, #4868 **CMHCM Systemic Remediation.** By 12/15/2022, staff training will be conducted, on the need to monitor service utilization and providing documentation

				specific to resolving disparity noted. **SCCMHA Individual Remediation:** Other: Proof docs of TCM Notes for services provided and Periodic Reviews completed have been obtained for WSA# 4685. Will be submitted no later than 11/30/2022. **Newaygo Individual Remediation:** During the initial review, evidence was not supplied by the CMH that the client (waiver #13568) received appropriate CLS services. However, CLS was provided other than the month of July due to the CLS worker leaving employment. NCMH has since provided the PCP review information that addressed how the Case Manager assisted the family to address that need, along with proof of the CLS provided.

				HBH Individual Remediation By 10/31/2022, plans for WSA 4762 and 33852 will be amended for resolving/addressing service provision as recommended. By 10/31/2022, SC will provide rationale in the record of WSA 4762 and 33852 for disparity between recommended and provided services, and steps to resolve that disparity. **TBHS Individual Remediation** #5540: Treatment plan monitoring was completed by the RN on 7/13/22 and by the PT on 7/29/22; both documents were uploaded into the medical record. Also, plan of service was amended to more accurately reflect current nursing needs based on acuity. #5540: By 10/31/22, plan will be amended for resolving/addressing service provision as recommended for PT.

				TBHS Systemic Remediation: Other: (See response below) By 11/01/2022, Staff will be re-educated on the revision/amendment process during an upcoming staff meeting with documentation maintained in the form of meeting minutes. Supervision will review a random sample of HSW records on a quarterly basis throughout FY23 to ensure revisions are being made in a timely manner based on medical necessity and utilization. The first supervisory review will be conducted by 12/31/22 **CEI Individual Remediation** WSA# 73417 CLS notes will be obtained from provider by 11/1/22 and be available to MDHHS during follow up visits to show services occurring as authorized. WSA 74021, 73417, 18584, 8697, 247943, 12025: By 11/30/22, Case managers

				will document review of authorized services in monthly service notes and will include in their note on rationale if services are not being provided as authorized (example of provider staff issues, family cancellations, etc.) and amend treatment plan as clinically needed. **CEI Systemic Remediation**: Training will be provided to the Case Managers related to interventions needed when services are not provided per the need and per the plan by 11/30/22. **MDHHS 2nd Response**: ☒ **Response accepted.** **For Newago:** **Response accepted with the expectation that a PCP review will be provided as evidence, as well as evidence of CLS services, (in the community, at least weekly, during the next**

				90 days), to confirm that individual remediation has taken place.
P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. (HSW PM D-5)	41	0		
D. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
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	1	0	Clinical charting tool very thorough.	

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.				
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	7	2	**REPEAT CITATION** **NA = 32** **Lifeways** **WSA# 5353:** Use of restrictive clothing to control behaviors, with no BTPRC involvement (all elements of) found within the record. **The Right Door** **WSA# 28567:** Lack of Special Consent for intrusive/restrictive interventions found in Plan.	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

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.				**CMHSP/PHIP Response**: **Individual Remediation:** **Lifeways** ☒ On 7/22/22, WSA #5353, had an expedited BTPRC review completed and approved for the restrictive clothing and a referral for a BTP assessment was recommended by BTPRC. ☒ By 12/15/22, BTP, functional behavior assessment will be completed for WSA #5353. ☒ By 12/15/22, WSA #5353 will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. ☒ By 12/15/22, the IPOS for WSA# 5353 will be amended to reflect recommendations within the BTP for restrictive measures.] **The Right Door**

				☒ WSA #_28567 does not have a BTP. 1) there are no restrictive/intrusive interventions in the IPOS 2) there is no BTP in place 3) there is no required special consent. Assessment incorrectly reflected use of wrist guards (historical by school 2 years ago), assessment was updated on 7.22.2022. **Systemic Remediation:** **MSHN** ☒ Through MSHN's regional BTPR Workgroup, our CMSHPs are working to explore integration of BTP modules and tracking systems into the EMR to help with consistency, timeliness, and implementation of required standards. -MSHN will monitor effectiveness of systemic remediation during monthly delegated managed care site reviews and ongoing through

				HSW Recertification reviews and HCBS final rule implementation efforts. -MSHN representatives will continue to gain clarification and assist with statewide communications related to Behavior Treatment Monitoring through the MDHHS BTP Workgroup Meeting. **Lifeways** ☒ By 12/15/22, staff training will be conducted, on the required steps for BTRC involvement. **The Right Door** ☒NA please see above **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>.** **The Right Door/TRD**: WSA 28567 is now disenrolled (as of 6/7/22),and so individual remediation is not possible. However, systemic remediation is

				expected. No systemic remediation found. Though TRD disputes the citation, no information was provided during the site review to give evidence of the above, and so citation stands. Please submit systemic remediation. **Lifeways:** An expedited review by BTPRC means (per technical requirements of your contract) that (a Behavior Treatment) ***Plan*** is reviewed and approved in a short time frame such as 24 or 48 hrs." Per CAP above, the assessment/BTP has not yet been done. Further, a five month lapse from the July date when BTPRC reviewed/approved of restrictive clothing (without the required documentation in place), and the timeframe proposed for the needed FBA/assessment, BTP and the remaining elements required under BTPRC (upon which such restrictions

				should be based) is excessive. Please revise with shorter timeframes, for all elements of BTPRC to be met. This should be considered an urgent matter, necessitating urgent response from Clinical staff to assess and confirm that restrictive interventions are needed. Please also address the need for special consent before any restrictive BTP is enacted. **CMHSP/PHIP 2nd Response**: **The Right Door - Individual** WSA #_28567 does not have a BTP. Staff reviewed the assessment and completed an updated assessment on 7/22/2022, identifying current needs. The IPOS was reviewed for restrictive or intrusive interventions. It was confirmed that during and since 2020 to current there were no restrictive or intrusive interventions requiring BTR.

				Evidence has been provided for submission to MDHHS during the 90 day follow up. **Systemic: The Right Door** The Right Door will provide training to HSW staff by 11.26.2022 to ensure that historical information is represented as such in assessments. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted**. No revised remediation found for Lifeways. **CMHSP/PHIP 3rd Response**: **Lifeways Remediation** We had the expedited review completed on 7/22/22 and BTC determined this continued to be an emergent need. We continue to recommend the use of this restrictive device and planned at that time to have

				a FBA/BTP completed during the next quarterly review on 10/21/22. However, due to capacity shortage of BTP authors there was a delay. We are contracting with a new BTP provider who is expediting the completion of the FBA and BTP by 11/22/22. If the FBA and BTP continues to recommend this restriction, then the BTP will be fully vetted BTC on 11/23/22, including the special consent. The treatment plan will be updated to align with treatment recommendations, as applicable, based upon BTC's review and recommendations.
G. WAIVER PARTICIPANT HEALTH AND WELFARE Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	41	0		

G.2 Individual served received health care appraisal. (Date/document confirming_____ _____)	40	1	**CMH for Central Michigan** **WSA# 4774**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ By 11/15/2022 WSA # 4774 will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal.

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ By 12/1/2022 training will be provided by the Waiver review team to Case management staff regarding this requirement. **MDHHS Response**: ☒ **Response accepted**

				CMHCM revision; **Individual remediation;** By 12/15/2022 WSA # 4774 will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. **CMHCM revision**; **Systemic remediation;** By 12/15/2022 training will be provided to CM staff regarding this requirement. **MDHHS 2nd Response**: ☒ **Response accepted with adjusted time frames noted above.**
Q. STAFF QUALIFICATIONS				
Q.2. HSW				
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).	50	7	**REPEAT CITATION** **A total of 57 Professional Staff were reviewed under the HSW.** **CMH for Central Michigan** *Lack of sufficient evidence of QIDP, or being supervised by QIDP, upon hire.* **WSA# 74939** Adam Bundy **WSA# 12160:** Justice Petty	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers meet credentialing

			WSA# 74939 Maria Nolen **WSA# 14217** Amanda Kibler **WSA# 14217:** Brianna Cass **WSA# 4774:** Steven Lundsted **<u>Newaygo County Mental Health Center</u>** *Lack of sufficient evidence of QIDP, or being supervised by QIDP, upon hire.* **WSA# 13568**: Candice Slizewski	standards, prior to providing HSW services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒Other WSA# 74939, Adam Bundy WSA# 12160:, Justice Petty WSA# 74939, Maria Nolen WSA# 14217, Amanda Kibler WSA# 14217:, Brianna Cass WSA# 4774:, Steven Lundsted Competency assessment forms for each of the employees listed above are currently in place which indicates the experience necessary to prove staff qualifications for

				QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. **Newaygo** ☒ By 9/30/2022, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of

				the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all new employees hiring on to CMHCM. • An MS Teams survey will be developed by the CMHCM HR department by 11/15/2022 questions that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. • The CMHCM competency

				assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **Newaygo** ☒ Other: Resumes will be updated at time of re-credentialing for staff who did not previously qualify for QIDP. The Human Resources Director/Contracts Manager will update NCMH's credentialing policy to include the resume updating. This will be sent out to staff by 12/30/2022. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found**

				☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CMHCM**: Regarding individual remediations, a "competency assessment form" showing QIDP eligibility, without the documentation that the HR reviewed to make that determination, is insufficient evidence. Primary source documentation is required during site reviews (ie, resume/updated resume that reflects the experience of working with the target population, job application, if it reflects population worked with, etc). Please revise. **CMHSP/PHIP 2nd Response**:

				CMHCM individual remediation. By 12/15/2022, primary source verification will be completed to verify QIDP eligibility. **CMHCM systemic remediation.** By 12/15/2022 Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. **MDHHS 2nd Response**: ☒ **Response accepted** with the expectation that primary source documentation will be obtained and provided to MDHHS at the time of the 90-Day review, giving evidence of cited staff being a QIDP or issupervised by a QIDP.

				Documented evidence of systemic remediation will also be expected in 90days.
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).	50	7	**REPEAT CITATION** **<u>CMH for Central Michigan</u>** *Lack of sufficient evidence of QIDP, or being supervised by QIDP, on-going.* **WSA# 74939:** Adam Bundy **WSA# 12160:** Justice Petty **WSA# 74939** Maria Nolen **WSA# 14217** Amanda Kibler **WSA# 14217:** Brianna Cass **WSA# 4774:** Steven Lundsted **<u>Newaygo County Mental Health Center</u>** *Lack of sufficient evidence of QIDP, or being supervised by QIDP, on-going.* **WSA# 13568**: Candice Slizewski	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers continue to meet credentialing standards on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ Other: (See response below) WSA# 74939:, Adam Bundy

				WSA# 12160, Justice Petty WSA# 74939, Maria Nolen WSA# 14217, Amanda Kibler WSA# 14217:, Brianna Cass WSA# 4774, Steven Lundsted Competency assessment forms for each of the above listed employees are currently in place which indicates the experience necessary to prove staff qualifications for QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. **Newaygo** ☒ By 9/30/2022, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review. **Systemic Remediation:** **MSHN** ☒ The CMHSP

				participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all

				new employees hiring on to CMHCM. • An MS Teams survey will be developed by the CMHCM HR department by 11/15/2022 questions that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. • The CMHCM competency assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **Newaygo** ☒ Other: Resumes will be updated at time of re-credentialing for staff who did not previously qualify for QIDP. The Human Resources Director/Contracts Manager will update NCMH's credentialing policy to include

				the resume updating. This will be sent out to staff by 12/30/2022. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CMHCM**: Regarding individual remediations, a "competency assessment form" showing QIDP eligibility, without the documentation that the HR reviewed to make that determination, is insufficient evidence. Primary source documentation is required (ie, resume/updated resume that reflects the experience of working with the

				target population, job application, if it reflects population worked with, etc). Please revise. **CMHSP/PHIP 2nd Response**: **CMHCM Individual remediation.** By 12/15/2022, primary source verification will be completed to verify QIDP eligibility. **CMHCM systemic remediation.** By 12/15/2022 Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. **MDHHS 2nd Response**: ☒ **Response accepted** with the expectation that primary source documentation will be obtained

				and provided to MDHHS at the time of the 90-Day review, giving evidence of cited staff being a QIDP or is supervised by a QIDP. Documented evidence of systemic remediation will also be expected in 90days.
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	344	49	**REPEAT CITATION** **A total of 393 Non-Professional/Aide level staff were reviewed under the HSW.** **<u>CMH for Central Michigan</u>** *Lack of sufficient evidence of Blood Borne Pathogen/BBP Training* **WSA# 17460:** Alex Pitroski Cheryl Coughlin Heather Rederick Heidi Getchell Michelle Frost Stephanie Sage Vickie Davidson **WSA# 17460, 7363:** Amanda Davis Breana Tatro Cheryl Martin Karen Findley Kelsey Straton Sandra Schanck **WSA# 7363:** Becky Overfield, June Fizhenry **WSA# 4868**: Susan Jones **WSA# 5736:** Lynn Dennert *Insufficient evidence/no evidence of being 18 years of age or*	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

demonstrate competence in basic first aid procedures.			*older.AND Lack of evidence of First Aid Training* **WSA# 17460, 7363:** *Karen Findley *Insufficient evidence of completing First Aid Training* **WSA# 8584:** Randie Hatchew **WSA# 4868:** Zaria Martin *Insufficient evidence of initial criminal background check, prior to hire.* **WSA# 14217:** Amber Warner **WSA# 74939:** Dylan Revell Troy Parsons **<u>Gratiot Integrated Health Network</u>** *Lack of sufficient evidence of Blood Borne Pathogen/BBP Training* **WSA# 13569:** Ashley Phenix Nicole Gilbert Scott Mayhew **<u>Huron Behavioral Health</u>** *Insufficient evidence of initial criminal background check, prior to hire.* **WSA# 4762** Kelcey Crawford, Ann Depcinski, Janet Schuster **<u>Saginaw County CMH Authority</u>** *Lack of evidence of completing First Aid Training and BBP Training* **WSA# 33223:** Jennifer Rieck-Martin *Evidence of name change needed/requested, not provided, to confirm credentialing evidence* **WSA# 33223:** Mary Fowler	**Individual Remediation:** **CMHCM** ☒ Documentation obtained for WSA #17460 staff AP, CC, HR, HG, SS, VD will be provided at the 90 day MDHHS audit follow-up by Provider Network. • Provider Network will obtain documentation for WSA #17460 staff MF and will provide at 90 day follow-up. • Provider Network will obtain documentation for WSA #17460, 7363 staff and will provide at 90 day follow-up. • Provider Network will obtain documentation for WSA #7363 staff and will provide at 90 day follow-up. • Documentation obtained for WSA #4868 staff SJ. Will be provided at 90 day

			Lack of evidence of completing First Aid Training **WSA# 6874:** Kaitlyn Madison **<u>Shiawassee Health & Wellness</u>** *Lack of evidence of being 18 or older* **WSA# 10493**: Amber Moore Bobbie Heier Dessa Perry Heather Albritton Heather Bigelow Jim McDonald Kari Freeman Kayla Ostipow Linda Bebiak Lorna Reyes-Monge Michael Marcotte Morgan Sowers Tina DeGarmo Zachary Crawford *Lack of evidence of Blood Borne Pathogen training* **WSA# 10493:** Kristyn King Sarah Hofacker **<u>Tuscola Behavioral Health Systems</u>** *Lack of evidence of initial background check being completed prior to hire* **WSA# 5540:** Bradley Thorton *Lack of evidence of Initial background check being completed prior to hire, and lack of evidence of being 18 years or older.* **WSA# 61994**: Sarah Fackler	MDHHS audit follow-up by Provider Network. • Documentation obtained for WSA #5736 staff LD. Will be provided at 90 day MDHHS audit follow-up by Provider Network. • Documentation obtained for evidence of age 18+ for WSA #17460, 7363 staff. Will be provided at 90 day MDHHS audit follow-up by Provider Network. • Provider Network will obtain documentation for WSA #8584 staff and will provide at 90 day follow-up. • Documentation obtained for WSA #4868 staff ZM. Will be provided at 90 day MDHHS audit follow-up by Provider Network.

				• Provider Network will obtain documentation for WSA #14217 staff and will provide at 90 day follow-up. • Provider Network will obtain documentation for WSA #74939 staff and will provide at 90 day follow-up. **GIHN** ☒ By 12/1/2022, cited staff for WSA 13569 will complete a bloodborne pathogens competency test issued by GIHN. **Huron** ☒ Other: (See response below) The cited staff for WSA #4762 have all completed criminal background checks. The dates of the most recent background checks are as follows: Kelcey Crawford = 10/7/2021, Ann Depcinski = 11/18/2021; Janet Schuster = 10/7/2021.

				SCCMH ☒ Other: (See response below) By 11/30/2022, cited staff for WSA# 33223 will have completed required trainings. By 11/30/2022, cited staff for WSA# 6874 will have completed required trainings. By 11/30/2022, for staff M.F. (related to WSA# 33223), proof of name change to confirm credentialing evidence will be obtained. **SHW** ☒ By 11/15/2022, cited staff for WSA #10493 will provide evidence of being 18 or older or evidence of training for Blood Borne Pathogens. **TBHS** ☒Per Provider an error was made on date of hire for WSA# 5540 B. Thorton – date of hire was 7/18/2018 I CHAT was ordered on 6/29/2018 – additional background check on

				5/4/2022. Documentation will be provided to support this error. ☒ Documentation to be provided that indicates WSA# 61994 S. Fackler date of hire was 4/13/21 – I chat completed 3/11/2021 MI Driver License DOB as 8/10/1989 **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care

				site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes. **CMHCM** ☒ By 11/15/22, CMHSP/PIHP Provider Network will meet with providers to review requirements related to staff credentialing. **GIHN** ☒ By 12/1/2022, GIHN will revise the bloodborne pathogens training (used with SD hired CLS/respite level aides) to include a competency test. **Huron** ☒ By 10/15/2022, CMHSP/PIHP will meet with provider to review

				requirements related to staff credentialing. ☒ Effective 10/1/2022 the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. **SCCMH** ☒ Effective 11/30/2022 the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. ☒ Other: (See response below) A plan of correction will be requested by the provider/staff/or supervisor of the staff person for when the staff person will be in compliance with training standards. The plan of correction will be monitored by the SCCMHA Auditing unit during annual audit reviews. **SHW** ☒ By 11/15/2022, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing.

				TBHS On 6/24/2022, TBHS met with providers to review requirements related to staff credentialing and background checks. By 12/1/22, TBHS Contracts Department will randomly select a staff sample to review quarterly for required background checks. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☒ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For GIHN**, Individual and systemic remediation: Evidence of training is required.

				Proposed competency tests to give evidence of training, without those tests being scored/signed or noted by someone (by full name/title) overseeing that training process, will not meet this requirement. That oversight element appears to be missing from both the individual and systemic remediation. Please revise. **For SHW,** regarding individual remediation, evidence of being 18 OR evidence of BBP training that is being proposed is not sufficient. Evidence of being 18 must be provided (for cited staff) AND evidence of completing BBP training, for those cited., must also be provided. Please revise. **For MSHN**, systemic remediations need to occur within 90 days of the approved CAP. The June ’23 is outside that 90-day

				window. Please revise. **CMHSP/PHIP 2nd Response**: **MSHN** By 1/14/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes. **SHW** **Individual:** By 11/15/2022 the cited staff will provide either evidence of being 18 or older or evidence of training on Blood Borne Pathogens (based on applicable identified finding). **GIHN** **Individual:** By 12/1/2022, cited staff for WSA 13569 will complete a bloodborne pathogens competency test issued by GIHN. Test will be scored and

				signed off on by the GIHN SD Training Coordinator or GIHN SD Coordinator. Scores of 80% or better will be deemed passing. **GIHN Systematic:** By 12/1/2022, GIHN will revise the bloodborne pathogens training (used with SD-hired CLS/respite level aides) to include a competency test. Future tests will be scored and signed off on by the GIHN SD Training Coordinator or GIHN SD Coordinator. Scores of 80% or better will be deemed passing. **MDHHS 2nd Response**: ☒ **Response accepted**
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*	348	45	**REPEAT CITATION** **<u>CMH for Central Michigan</u>** **WSA# 7363**: Becky Overfield Haylie Alexander **WSA# 8584:** Ray Smith Shannon Riggleman **WSA# 14217:** Amber Warner Connie Anderson	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all HSW providers meet the staff training requirements specific to

and family home). evidence: Training records: • *Has received training in the beneficiary's IPOS.*			Darlene McKay Desiree Hernandez-Garrcia Kari Castillo Krystal Kyser-Wale Matthew Stepp Paisley Beatty Tonya Cornelius **WSA# 4774:** Julie Kirby **WSA# 74939** Mackenzie Magill Madyson Williams **WSA# 4868:** Zaria Martin **Newaygo County Mental Health Center** **WSA# 13568**: Ashleigh Parker-Welborn, Bonnie Chase, Danielle Butler, Deborah Oakes, Jackie Toward, Theresa Coffee, Kymberlee Richardson, Stephanie Schopieray, Johnna Owens **Saginaw County CMH Authority** **WSA# 33223:** Bobrianna Wilson Tomasa Gonzales Willease Blacksher **WSA# 33223** Rebecca Harris **WSA# 18936:** Aaron Elijah Hernandez Ashley Ann Babcock Chelane Washington Danica L. Amador Gena Anne LaFleur Holly Jo Bigelow Nakella Shamara Williams **WSA# 54442:** Jimmy Thomas	beneficiary specific IPOS, prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ Other: (See response below) • Documentation obtained for WSA #7363 staff HA. Will be provided at 90 day MDHHS audit follow-up by Provider Network. • Will obtain documentation for WSA #7363 staff BO and will provide at 90 day follow-up. • Provider Network will obtain documentati

			RL Barney III Saterra Simmons **WSA# 55113:** Carla Wilson Kassandra Helfrecht Shirley Powell **WSA# 4685:** Atmeatria Williams **WSA# 13319:** Crystal Nicholls	on for WSA #8584 staff and will provide at 90 day follow-up. • Documentation obtained for WSA #14217 staff AW, CA, DM, KC, MS, TC. Will be provided at 90 day MDHHS audit follow-up by Provider Network. • Will obtain documentation for WSA #14217 staff DHG, KKW, PB and will provide at 90 day follow-up. • Provider Network will obtain documentation for WSA #4774 staff and will provide at 90 day follow-up. • Documentation obtained for WSA #74939 staff. Will be provided at 90 day MDHHS audit follow-up by Provider Network. • Documentation obtained for WSA #4868 staff

				ZM. Will be provided at 90 day MDHHS audit follow-up by Provider Network. **Newaygo** ☒ By 9/30/22, cited staff will receive required IPOS training specific to the beneficiary they are supporting. ☒ Other: The Case Manager will visit North Woods AFC to re-complete the IPOS training with staff cited. **SCCMH** ☒ By 11/30/2022, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will

				monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes. **CMHCM** ☒ By 11/15/22 CMHSP/PIHP Waiver review team will review with/train CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a

				timely manner (upon update/amending of IPOS), as well as the 4 elements required as evidence for training: • Date of Training • Content of Training (including date of IPOS) • Who was trained (legible names) • Who did the training (legible name/title) • **Newaygo** ☒ Effective 8/24/22, Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. ☒ Other: In future clinical records reviews, the Adult Services Director will request IPOS training proofs from the Case Manager for cases found in the sample without IPOS

				training documentation. In addition, for FY22, Quarter 3 record reviews, the Adult Services Director will request proofs of missing IPOS training for any client that was pulled in the clinical record review sample where there was no evidence of IPOS training. **SCCMH** ☒ By 11/30/2022, CMHSP/PIHP will review with/train CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS), as well as the 4 elements required as evidence for training: • Date of Training • Content of Training (including date of IPOS) • Who was trained (legible names)

				• Who did the training (legible name/title) **MDHHS Response**: ☒ **Response accepted**
H. HOME VISITS/TRAINING/INTERVIEWS				
H.3. HSW HOME VISIT				
Health and safety Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1; 4c CFR 438.208 Administrative rule Section 3(9) of Act 218 P.A. 1979, as amended Administrative Rule R 330.2802 Person-centered Planning Best Practice Guideline Attachment 3.4.1.1. to the MDHHS Contract AFP Section 2.7 Specialized Residential Settings (Administrative Rule R330.1806) Monitoring medications: R 330.1719 R 330.2813 R 330.7158	0	0	No home visits were conducted as a part of this Site Review. **Person Centered Planning Recipient Interviews were conducted across all three Waivers, as a part of the Full Site Review for MSHN/Region 5. A total of 26 interviews were conducted.** ***Strengths for MSHN, Region 5*** ▪ Overall historic satisfaction with the clinical providers (case management). ▪ Evidence of additional waiver services being provided (environmental modification). ▪ Continued satisfaction with telehealth options with families expressing support for this to continue. ▪ Overall satisfaction with intake experience. ▪ Knowledge of Independent Facilitation demonstrated. ▪ Overall knowledge of Self-Directed options. ▪ Satisfaction with Peer Supports (where available).	Any remediations expected out of feedback received during the recipient interviews are captured under the clinical performance measures, for the specific individual(s) recipient served. Further, this information is being provided to inform best practice and quality improvement measures within Region 5, going forward.

			Opportunities for System Improvement for MSHN, Region 5 ▪ Use of Independent Facilitation was not found. ▪ Concern noted with high turnover in clinical staff. ▪ Lack of knowledge and understanding of Waiver programs, purpose and services, what services are available and how to access. ▪ Difficulty in accessing Respite services across region. ▪ Lack of understanding of available services in general and how to access. ▪ Self-Directed Services: Inconsistent understanding/knowledge of SD options/models across waivers.	
<u>Non-Residential Visit</u> (HCBS and Health/Safety) Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1; 4c CFR 438.208 Administrative rule Section 3(9) of Act 218 P.A. 1979, as amended Administrative Rule R 330.2802 Person-centered Planning Best Practice Guideline Attachment 3.4.1.1. to the MDHHS Contract AFP Section 2.7 Specialized Residential Settings (Administrative Rule R330.1806)	0	0	No home visits were conducted as part of this Site Review	N/A

Serious Emotional Disturbance Wavier

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
E. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4. AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards	1	0	**See the HSW Report.**	
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents. 42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4. AFP Sections 2.5, 3.8, 3.1.8 Waiver Assurance for Participant Safeguards	1	0	**See the HSW Report.**	
A.1.3 Review and verify that the process is being implemented according to policy. Waiver Assurance for Participant Safeguards	1	0	**See the HSW Report.**	

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	**See the HSW Report.**	
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	1	0		

A.3.SEDW				
A.3.2 CMHSP has a process to prior authorize all services. (PM A-3)	1	0		
A.3.3 Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)	27	3	**Bay-Arenac Behavioral Health** **WSA# 178005** **Saginaw County CMH Authority** **WSA# 247682** **CMH for Central Michigan** **WSA# 76678**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that, claims are coded in accordance with MDHHS policies and procedures. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** ☒ By 9/30/22 will void regular Wraparound H2021 services for those individuals that were on the SED Waiver; doing an IPOS amendment to identify the correct SED Waiver wraparound service (H2022); submitting correct service. **SCCMH** ☒ By 9/30/2022 This concern was corrected in November 2021 when incorrect code stopped being used and correct code was authorized for use instead. **CMHCM** ☒ Other: (See response below) WSA #76678 was transitioned off the waiver on 8/31/2021 and the authorization for wraparound (H2022) expired on 8/24/2021. This cannot be remedied on an individual level. Please see systemic level remediation below.

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒ By 9/30/22, Wraparound program has been educated that individuals on the SED Waiver have a specific code for wraparound services. **SCCMH** ☒ By 11/30/2022, Supervisor will complete training with Wraparound staff to address correct code usage when requesting authorizations. **CMHCM** ☒ By 11/15/2022 staff training will take place by the CMHCM Waiver review team on required Wraparound services and authorizations while on SED Waiver. **MDHHS Response**: ☒ **Response accepted, with the expectation that those codes billed incorrectly (by SCCMHA and CMHCM) were pulled back and re-billed under the correct CPT code.** **CMHCM response;** This has been completed by CMHCM Finance Supervisor.

E. ELIGIBILITY (Medicaid Provider Manual, Mental Health/Substance Abuse)				
E.2. SEDW				
E.2.1 Level of Care evaluations are completed accurately. (evidence: sub-scores on CAFAS are consistent with notes and assessments in the record) (PM-B-3)	**26**	**4**	**CMH Authority of CEI Counties** **WSA# 71033** **CMH for Central Michigan** **WSA#s 71868, 176528** **Lifeways** **WSA# 229985**	Submit a plan for ensuring that Level of Care evaluations are completed accurately, and in a manner in which scores are consistent with notes/assessments in the record. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ This consumer recently closed services. **CMHCM** ☒ By 11/15/2022 the Level of Care evaluation will be completed for WSA # 71868, 176528, by the case holder with results of that evaluation incorporated into the plan of service if necessary via amendment. **Lifeways** ☒Other: WSA #229985 is no longer open to SEDW and is not actively receiving Community Mental Health services. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will

				monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** ☒ By 12/31/22, staff training on required frequency of Level of Care Evaluation will be completed. ☒ Other: During CAFAS / PECFAS Booster training, this requirement will be reviewed. (May 2023) **CMHCM** ☒ By 11/15/2022, staff training by the Waiver Review team on required elements of Level of Care Evaluation will be completed. **Lifeways** ☒ By 12/15/22, staff training on required elements of Level of Care Evaluation will be completed to all provider staff providing SEDW services. **MDHHS Response**: ☒ **Response accepted** **CMHCM revision**; **Individual remediation;** By 12/15/2022 the Level of Care evaluation will be completed for WSA # _71868, 176528, with results of that evaluation incorporated into the plan of service, if necessary, via amendment.. **Systemic remediation;** By 12/15/2022, staff training on required elements of Level of Care Evaluation will be completed **MDHHS 2nd Response**: ☒ **Response accepted with adjusted timeframes, above**

F. FREEDOM OF CHOICE				
F.3.1: Parent was informed of right to choose among qualified providers.	**30**	**0**		
F.3.2: Parent was informed of their right to choose among the various waiver services.	**30**	**0**		
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.3 SEDW				
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)	20	10	**REPEAT CITATION** **<u>CMH Authority of CEI Counties</u>** **WSA#s 235084, 176177:** Pre-Planning and Treatment Planning meetings held same day, without rationale/sufficient rationale in the record. **<u>CMH for Central Michigan</u>** **WSA# 71868** Child not present at Pre-Planning or Treatment Planning Meetings, with no rationale/sufficient rationale in the record. **<u>Lifeways</u>** **WSA#s 72696, 229985, 72886**: No evidence of Independent Facilitation being offered. (All Closed SEDW)	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that 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. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ WSA # 235084 has offered Self-Determination / Independent Facilitation, with documentation in the record by the 90-day f/u site review. A contact note added in the record by 9/16/22 to document family chose to complete treatment plan same day as pre planning checklist.

			<u>Saginaw County CMH Authority</u> **WSA#s 245896, 247682, 177971** No evidence of Pre-Planning activities found in record. **<u>The Right Door</u>** **WSA# 175545** Child not present at Pre-Planning or Treatment Planning Meetings. (Closed SEDW)	☒ WSA # 176177 Consumer is no longer open with CEICMH. **CMHCM** ☒ By 11/15/2022, pre-planning will occur to better inform the IPOS process, with evidence in the record by the 90-day f/u site review. **Lifeways** ☒ WSA #229985 is no longer open to SEDW and is not actively receiving Community Mental Health services. WSA #72696 and #72886 are not presently open to the SEDW **SCCMH** ☒ By 11/30/2022 pre-planning will occur to better inform IPOS process, with evidence in the record by the 90-day f/u site review. (WSA# 245896, 247682, 177971) **The Right Door** ☒ Clinician will hold an addendum for WSA #175545 by 11.26.2022 to ensure the youth's voice is a part of pre-planning and the creation of IPOS. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI**

				☒ By 12/31/22, training will be provided in department staff meeting and clinical program staff meetings on the requirement of pre-planning activities that must inform person-centered planning (i.e. Pre Planning Checklist to be completed IN ADVANCE of the treatment plan effective date). ☒ Effective 12/31/22 Wraparound Supervision will monitor a random selection of records quarterly to monitor for this requirement. ☒ Effective 12/31/22 QI will complete chart reviews quarterly and include this requirement. **CMHCM** ☒ By 11/15/2022 staff training will be provided by the Waiver review team on the requirement of pre-planning activities that must inform person-centered planning. **Lifeways** ☒ By 12/15/22, staff training will be provided on the requirement of pre-planning activities, including Independent Facilitation, that must inform person-centered planning. ☒ By 12/15/22, EMR will be adjusted to include Independent Facilitation, as a required fields in the pre-planning document. **SCCMH** ☒ By 11/30/2022 pre-planning will occur to better inform IPOS process, with evidence in the record by the 90-day f/u site review. (WSA# 245896, 247682, 177971) **The Right Door** ☒ By 11.26.2022, staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. **MDHHS Response**: ☐ **Response accepted**

				☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ **Other:** **For CMHCM,** individual remediation for WSA# 71868: Citation was for the child served being absent from pre-planning/IPOS plan development activities. Remediation does not appear to address this specifically. Is pre-planning being completed, with parent *and child*, to offer the opportunity to update the Plan or obtain a new Plan, informed by the presence of *both the child and family* served? Please advise/revise. **For SCCMHA**, WSA# 245896 is now disenrolled. For the remaining two, Individual remediations: Will recipients be offered the opportunity for a new IPOS, given the current plans were not informed by pre-planning activities? Please advise/revise. **CMHSP/PHIP 2nd Response**: **SCCMHA** ☒ For WSA#s 247682, 177971: pre-planning will occur by 11/30/2022 to better inform IPOS process, with evidence in the record by the 90-day f/u site review. Recipients will be offered the opportunity for a new IPOS given the originally reviewed plans were not informed by pre-planning activities. **CMHCM individual remediation**; Clinician will hold an addendum for WSA #71868 by 12/15/2022 to ensure the youth's voice and attendance is a part of pre-planning and the creation of IPOS and offer updates to plan if child and family desire. **CMHCM systemic;**

				By 12/15/2022 staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. **MDHHS 2nd Response**: ☒ **Response accepted**
P.3.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	27	3	**REPEAT CITATION** **<u>CMH for Central Michigan</u>** **WSA# 71868: Assessed need for CLS and Respite not resolved within the Plan.** **<u>Lifeways</u>** **WSA# 229985: RN services reflected in the Plan, without establishment of medical necessity for those services within the PSA or elsewhere. (Closed SEDW)** **<u>Saginaw County CMH Authority</u>** **WSA# 177971:** Family therapy requested and TAY groups reflected as needed, neither resolved within the Plan.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered plan addresses all service needs reflected in the assessments. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ A review of progress will be completed in a progress note by 11/15/2022 for WSA #71868 by the case holder to inquire about the current medical necessity for these services and a follow-up addendum will be completed if necessary by 11/15/2022. **Lifeways** ☒ WSA #229985 is no longer open to SEDW and is not actively receiving Community Mental Health services. **SCCMH** ☒ As of 8/21/22 Wraparound Plan has been updated to remove Family Therapy services and TAY Group services. Family Therapy services and TAY Group services were recommended but not clinically determined as necessary.

				By 9/30/2022 advance notice will be sent to the consumer to indicate these services will no longer be provided. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ By 11/15/2022 staff training will be conducted by the Waiver review team focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. **Lifeways** ☒ By 12/15/22, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, including ensuring that medical necessity has been determined for treatment needs, and documented in the IPOS. **SCCMH** ☒ By 11/30/2022, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. ☒ By 11/30/2022, staff will be trained on the necessity of sending an Advance Notice of Benefit Determination when services are being changed outside of the regular Person-Centered Planning process

				MDHHS Response: ☒ **Response accepted** **CMHCM Revision;** I**ndividual remediation**; A review of progress will be completed in a progress note by 12/15/2022 for WSA #71868 to inquire about the current medical necessity for these services and follow up addendum will be completed if necessary by 12/15/2022. **CMHCM systemic;** By 12/15/2022 staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. **MDHHS 2nd Response**: ☒ **Response accepted with adjusted timeframes noted above.**
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)	20	10	**REPEAT CITATION** **Bay-Arenac Behavioral Health** **WSA# 178005:** No coordination of care found with primary care physician. **CMH Authority for CEI Counties** **WSA# 235084:** Request for Psychiatric services not responded to in a timely manner (wait listed for 4 mths). **WSA# 177786:** Coordination Of Care with Primary Care Physician did not include psychotropic meds prescribed by CMH psychiatrist. **(Closed SEDW)** **WSA# 71033:**	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care provider. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** ☒ By 9/30/22 the following will be completed/ reflected in the record: - Psychiatric Eval - Coordination of Care

			Coordination Of Care with Primary Care Physician not found. (Closed SEDW) **WSA# 240610**: Coordination Of Care with PCP not found for period of time on SEDW/2021. (Closed SEDW) **<u>CMH for Central Michigan</u>** **WSA# 76678:** Coordination Of Care with Primary Care Physician and Crisis Plan not found. (Closed SEDW) **WSA#s 71868, 176528:** No evidence of crisis planning being accepted or declined by parent., found **<u>Lifeways</u>** **WSA# 177475**: Coordination Of Care with Primary Care Physician not found. **<u>The Right Door</u>** **WSA# 177928**: Coordination Of Care with Primary Care Physician not found. (Closed SEDW)	- Medication consent reflecting all meds - Resolution of the health and safety matter noted below. **CEI** ☒ By 10/31/22 the following will be completed/ reflected in the record: Coordination of Care (177786, 71033, 240610) ☒ By (Date) 11/15/22 the following will be completed/ reflected in the record: Psych Eval and Coord of Care letter (235084) **CMHCM** ☒ By 11/15/2022, the following will be completed/ reflected in the record by the case holder: - Coordination of Care for WSA #76678 - Crisis plan will be offered and response documented in progress note for WSA #71868 and #176528 **Lifeways** ☒ WSA #177475 is no longer open to SEDW, **The Right Door** ☒ By 11.26.2022 the following will be completed/ reflected in the record: - Coordination of Care with Primary Care Physician **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023.

				BABH ☒ By 9/30/22, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **CEI** ☒ By 12/31/22, additional training will be provided to the staff at large and in program staff meetings regarding the required elements of coordination of care, including list of medications when applicable. ☒ Effective 12/31/22 QI will complete chart reviews quarterly and include this requirement. **CMHCM** ☒ By 11/15/2022, additional training will be provided to the staff at large by the Waiver Review team regarding the required elements of offering and documenting coordination of care with primary care physician if a valid consent is present. ☒ Discussion to take place by 11/15/22 with EMR vendor to revise the offer of crisis plan to include whether consumer accepted or declined the crisis plan. **Lifeways** ☒ By 12/15/22, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **The Right Door** ☒ By 11.26.2022, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents.

				MDHHS Response: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) **For CEI,** WSA# 235084, no remediation found to address the requirement to respond to requests for services (in this case, psychiatric) in a timely manner. If this is a capacity issue, what is CEI doing to address/remediate this matter? Please revise. **CMHSP/PHIP 2nd Response**: **CMHCM individual remediation.** "By 12/15/2022, the following will be completed/ reflected in the record: Coordination of Care for WSA #76678" By 12/15/2022, the following will be completed/ reflected in the record: Crisis plan will be offered and response documented in progress note for WSA #71868 " **CMHCM systemic remediation.** "By 12/15/2022, additional training will be provided to the staff at large regarding the required elements of offering and documenting coordination of care with primary care physician if a valid consent is present. Discussion to take place by 12/15/22 with EMR vendor to revise the offer of crisis plan to include whether consumer accepted or declined to crisis plan. "

				CEI WSA# 235084 - Capacity issue in the CEI med clinic. CEI is in the process of hiring staff needed in the medication clinic and a Resident has started as of 9/6/22. Staff training to occur by 12/31/22 on requirements of follow up when services are not able to be provided timely. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** Individual remediation around timely provision of needed services is not yet found. When will this individual receive psychiatric services support under CEII (by what date)? Regarding systemic remediation, what specific steps will CEI (and or PIHP) take to address network capacity issues, while recruitment is going on? Will CEI or MSHN administrative staff be making efforts to contract this service with neighboring CMH's /PIHP's (utilizing telehealth) until CMH positions are filled? How will the *process* change to ensure capacity to provide on-going services, going forward? **CMHSP/PHIP 3rd Response**: CEI: **Individual:** CEI: individual has been offered 4 appointments and have cancelled each time. At WA meeting on 10/27/22 Family confirmed they do not want to move forward with medication clinic services with CMH and are using pediatrician to receive medications.

				Systemic: Positions have now been filled as of 10/1/22 and have added on more telehealth options with contracted services to ensure having capacity on-going. Supervisors will monitor staffing levels on-going by monitoring caseload sizes and open positions. Supervisors will quarterly monitor authorized services and service utilization and tracking if services begin with 14 days of authorization.
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)	6	24	**REPEAT CITATION** **Bay-Arenac Behavioral Health** **WSA# 178005:** Lack of amt scope duration of services within Plan. **CMH Authority of CEI Counties** **WSA# 177786:** Lack of measurable objectives, lack of prior authorizations for PDP and lack of clarification of respite supports in Plan. (Closed SEDW) **WSA# 235084:** Lack of amt scope duration of WA and RN services, lack of clarify in Plan for changes to service levels, and lack of WA Plan(s) **WSA# 71359:** Lack of measurable objectives. (Closed SEDW) **WSA# 240610:** Lack of amt scope duration of respite services in Plan. (Closed SEDW) **WSA# 176177:** Lack of amt scope duration of respite	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **MSHN (Individual and Systemic)** MSHN has sent a letter (attached) in response to the following citation: *Lack of specific amount, scope and duration (ranges used instead)* to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and

			services in Plan. (Closed SEDW) **WSA# 240168:** Med review amount not specified In the Plan. (Closed SEDW) **<u>CMH for Central Michigan</u>** **WSA# 177942:** Range language used for Wraparound, Home-Based Therapy, Respite and Med Reviews. (Closed SEDW) **WSA# 76678**: Range language used for Wraparound and Therapy Services. (Closed SEDW) **WSA#s 177942, 76678:** Range language embedded in EMR documents, indicating ranges of service can be used/provided. (Both Closed SEDW) **WSA# 176528:** Lack of amt scope duration of services (ranges used instead). and for a time periods within the last 12 months, services were provided without a support plan in place, and without prior authorizations. Wraparound services were also cancelled due to lack of prior authorizations. **WSA# 71868:** Lack of measurable objectives, lack of amt scope duration of services within	efficient approach to providing care to vulnerable individuals in our system. MSHN Feels that the use of ranges is more aligned with the recovery model of care. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appear overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. Additional action will be identified once a response is received from MDHHS. **Individual Remediation:** **BABH** ☒ By 9/5/22 plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. **CEI** ☒ WSA # 177786. Completed as of 6/14/22- plan was amended for resolving lack of measurable goals/ objectives/ timeframes. ☒ WSA #177786. Completed as of August '22- the plan was amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). Family need is for CLS and Behavioral Supports and these have been authorized. ☒ WSA# 235084: By 10/31/22 plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☒ WSA# 71359. Completed as of 6/13/22- plan was amended for resolving lack of measurable goals/ objectives/ timeframes.

			the Plan and providing both Wraparound Coordination and TCM services at the same time. **<u>Lifeways</u>** **WSA#s 177475, 72696**: Not all goal objectives are measurable.(Closed SEDW) **WSA# 229985:** Amt scope duration of services not found. (Closed SEDW) **WSA# 72886:** Amt scope duration of Peer Support Services and Home-Based Services not found, and lack of measurable objectives. (Closed SEDW) **<u>Montcalm Care Network:</u>** **WSA# 240999** Respite services not identified in IPOS as to specific amt scope duration frequency. **<u>Saginaw County CMH Authority</u>** **WSA#s 247682, 245896, 177971:** Lack of amt scope duration of services within the Plan (ranges used instead). (Closed to SEDW, 246896) **WSA# 73007:** Range language used for Wraparound, therapy, Respite and Med Reviews. **Citations from parent interview:**	☒ WSA# 240610. Treatment plan completed July '22 to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). CLS was authorized and provided. ☒ WSA# 176177. Completed as of 6/23/21 - plan was amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). CLS was authorized and provided. Internal training is being done to help eliminate confusion between these 2 different services (respite vs CLS). ☒ WSA# 240168. Completed as of 7/19/21- plan was amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). (7/19/21 addendum documents that family will meet with Med Clinic as scheduled and intervention defines as scheduled as 6 units quarterly. Authorized in treatment plan as 6 units quarterly.) **CMHCM** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. **Lifeways** ☒ WSA #229985 is no longer open to SEDW and is not actively receiving Community Mental Health services. WSA #72696, #177475 and #72886 are not presently open to the SEDW. **MCN** ☒ By 11-30-22 the IPOS for WSA # 240999 will be amended to ensure amount, scope duration of Respite services is reflected.

			CLS/Respite removed from Plan without change in medical necessity; services were reduced, overall, with services stopping at the time of the IPOS planning process; Therapy appts cancelled by Clinician; parent/WSA advised they had been on Waiver "too long", and due process (around case closure) was not completed on a timely basis. (Closed SEDW) **WSA# 75964:** Range language used for Wraparound, Therapy, Respite, Med Reviews and CLS. (Closed SEDW) **WSA# 71348:** Range language used for Wraparound, Therapy, respite, and Med Reviews. (Closed SEDW) **<u>The Right Door</u>** **WSA# 76138:** Lack of amt scope duration of services specified in the Plan, and Psychosocial Assessment being completed after treatment planning meeting. (Closed SEDW) **WSA# 175545:** Lack of amt scope duration of services specified in the Plan. (Closed SEDW)	**SCCMH** ☒ WSA#s 247682, 245896, 177971, 73007, 75964, 71348: Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. For WSA# 73007, this case has since been closed. No additional individual remediation can take place to correct concerns noted during the parent interview. **The Right Door** ☒ 76138 is closed to the waiver – individual remediation is not possible. Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN QIC will develop a QI Team to review the

				PCP process steps to assess for efficiencies and value. Actions will be taken based on the results of the QI team. **BABH** ☒ Wraparound facilitators were informed on 8/29/22 that outcomes need to be measured monthly by putting outcomes in a wraparound progress note. The wraparound plan of service will be reviewed quarterly and taken to the wraparound community team. This will be further discussed on 9/27/22 at wraparound group supervision. Please refer to the MSHN action to address the *Lack of specific amount, scope and duration (ranges used instead)* as outlined in the *Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report* sent by MSHN to MDHHS on 8/17/2022 **CEI** ☒ By 12/31/22, staff training at large will be conducted on developing measurable goals/ securing prior authorizations. This was completed on 8/17/22. ☒Effective 12/31/22 Wraparound Supervision will monitor a random selection of records quarterly to monitor for this requirement. ☒ By 12/31/22, staff training at large will be conducted on difference between Respite and CLS. **CMHCM** ☒ Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022.

				Lifeways ☒ By 12/15/22, staff training will be conducted on developing measurable goals/ securing prior authorizations, including amount, scope and duration of medically necessary services. **MCN** ☒ By 11-30-22 additional training will be provided to the SEDW team specific to amount, scope, duration. Effective 12-30-22 quarterly monitoring by Children's Services Managers and Quality Improvement staff of a random pull of records will be conducted for compliance. **SCCMH** ☒ WSA#s 247682, 245896, 177971, 73007, 75964, 71348: Please refer to the MSHN action to address the Lack of specific amount, scope and duration (ranges used instead) as outlined in the Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report sent by MSHN to MDHHS on 8/17/2022. By 11/30/2022, staff will be trained on the necessity of sending an Advance Notice of Benefit Determination when services are being changed outside of the regular Person-Centered Planning process. **The Right Door** ☒ Will train staff on the importance of providing training on assessment occurring prior to Person centered planning and creation of IPOS by 11.26.2022. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –**

				No individual remediation/systemic remediation found. **For BABH**: Individual remediation does not address citation (for lack of amt scope duration of services within Plan). Please revise. Also, no systemic remediation found. **For CEI:** all records except WSA# 235084 are now closed to the SEDW. For WSA 235084, individual and systemic remediations do not appear to address citations. Please revise. **For CMHCM,** WSA#s 176528 and 71868: No individual or systemic remediations found. (The other WSAs are now closed and cannot be remediated, individually.) **Lifeways**: Systemic remediations do not appear to address the requirement to include specific amt scope duration of services within the Plan. Please revise. **SCCMHA**: WSA#s 247682, 177971: No individual or systemic remediations found. WSA# 73007, Insufficient systemic remediation found. Several areas cited, only sufficient advance notice/due process being addressed in remediation. Please revise. **The Right Door:** Insufficient systemic remediation, addressing all areas of citation. Please revise. **CMHSP/PHIP 2nd Response**: **MSHN Systemic Remediation** Mid-State Health Network (MSHN) acknowledges receipt of the email from the Michigan Department of Health and Human Services (MDHHS) as to feedback to MSHN regarding the need to reflect the specific amount, scope, duration, and frequency of services deemed medically necessary in the

				individual plan of service (IPOS). MSHN fully intends on following the MDHHS/PIHP Contract, the Michigan Medicaid Provider Manual (MMPM), and related guidance in implementing the required documentation practices in representing the service amount elements as codified. MSHN, however, is unable to identify a standard that indicates that a specific service amount must be identified and represented in a singular number of units. This is of concern as any amount of service provided less than is noted in the IPOS, for any reason, will trigger an adverse benefit determination notice. Individual service patterns often vary and require more or less units of service based on the needs at the moment of the person served. The expectation of a rigid specific amount does not allow for the flexible, recovery-oriented means of service delivery. MSHN wishes to formally appeal the MDHHS decision not to accept reasonable ranges as an alternative to the use of a specific service amount. **BABH Individual Remediation:** By 12/1/22, plan for WSA#178005 will be updated to include more defined amount, scope, and duration of services. **BABH Systematic Remediation:** By 12/1/22, BABH staff will be trained on how to include goals and objectives with more defined amount, scope, and duration. Quality of Care Record Reviews will be completed quarterly to review a sample of records. **CMHCM individual remediation**; By 12/15/22, WSA #177942, plan will be amended to include exact amount scope duration of recommended supports.

				By 12/15/22, WSA #76678, plan will be amended to include exact amount scope duration of recommended supports By 12/15/22, WSA #174942, plan will be amended to include exact amount scope duration of recommended supports By 12/15/22, WSA #76678, plan will be amended to include exact amount scope duration of recommended supports By 12/15/22, WSA #176528, plan will be amended to include exact amount scope duration of recommended supports **CMHCM systemic remediation;** . " By 12/15/2022, staff training will be conducted on the requirement of including specific amount, scope, and duration of services in the plan and discontinuing use of ranges when authorizing services. Additionally, by 12/15/22, a UM monitoring section will be added to the IPOS Review of Progress document to ensure services are delivered as authorized and medically necessary. Finally, the CMHCM EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022. **CEI Individual** WSA 235084, By 11/30/22 plan will be updated to reflect specific amount, scope and duration for all services in the plan. By 11/30/22 notes in the record will be added to show rationale for service level changes. The Wrapround plan has been completed and can be provided during the follow up visit **CEI Systemic** By 12/31/22 staff training will occur on amount, scope and duration of services and including rationale in record for service level changes.

				<u>SCCMHA</u> Individual: By 11/30/2022, the plans for WSA#s 247682, 177971 will be updated to reflect specific amount, scope, and duration for all services that are referenced within the plan. **SCCMHA Systemic:** By 11/30/2022, staff will receive training on appropriate documentation of services within an IPOS. Staff will be trained to no longer use ranges when documenting the amount, scope, and duration of services. Rather, staff will be trained to include specific amounts of amount, scope, and duration for each service listed within the plan. By 11/30/2022, staff will be trained on the necessity of sending an Advance Notice of Benefit Determination when services are being changed outside of the regular Person-Centered Planning process. In addition, staff will be trained that services should not be reduced or stopped when medical necessity is still apparent and consumer/family are still interested in receiving the services. **The Right Door Systemic:** Will train staff on ensuring that the amount, scope and duration is in the actual plan language in the goals section and not just in the authorizations section by 11.26.2022. Additionally, by 12/31/22, a UM monitoring section will be added to the Clinical Record Review module to ensure services are delivered as authorized and medically necessary. Finally, The Right Door EMR will be reviewed with PCE to ensure that all relevant compliance standards changes are completed by 12/31/2022. **LifeWays:**

				By 12/15/22, staff training will be conducted on developing measurable goals/ securing prior authorizations, including amount, scope and duration of medically necessary services; training will ensure that amount, scope and duration of services in the Treatment Plan with Goals section versus as captured in the authorization section. **MDHHS Response**: ☒ **Response not accepted.** **For MSHN:** The request to appeal the decision by MDHHS not to allow ranges is under review. Outcome pending. **For CEI:** Regarding individual remediation for 235084. It is the *Plan* that must provide clarity regarding levels of service that are medically necessary, not just notes in the record. Please revise. Please also note that WA Plans, once completed, must be updated at least quarterly. More than one WA plan will need to be seen at the 90-day review. Please revise. **CMHSP/PHIP 3rd Response**: **CEI:** WSA 235084, By 11/30/22 plan will be updated to reflect specific amount, scope and duration for all services in the plan. Any change in service amounts will be noted in plan addendum with reasoning around changes.
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.6. SEDW				
P.6.1 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM D-7)	16	14	REPEAT CITATION **Bay-Arenac Behavioral Health** **WSA# 178005**: Home-Based services not	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring services and supports are provided as

			occurring as specified in Plan. **<u>CMH Authority of CEI Counties</u>** **WSA# 235084:** Home-Based services not occurring as specified in the Plan. **WSA# 71359:** Wraparound, Respite services not occurring as specified in Plan. (Closed SEDW) **WSA# 71033**: Home-Based services not occurring as specified in Plan. (Closed SEDW) **WSA# 240610:** Wraparound, Home-Based and CLS services not occurring as specified in Plan. (Closed SEDW) **<u>CMH for Central Michigan</u>** **WSA# 176528:** Wraparound, Home-Based Services not occurring as specified in Plan. **WSA# 71868**: Wraparound and Home-Based Services not occurring as specified in the plan. **<u>Lifeways:</u>** **WSA# 229985:** Wraparound, Home-Based services not occurring as specified in Plan. (Closed SEDW) **WSA# 72886:** Parent Support Partner, Peer	specified in the IPOS including type, amount, scope, duration and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** By 9/30/22, Staff will be reminded about adhering to the amount, scope, and duration of Home-Based services written in the plan. **CEI** ☒ By 9/16/22, therapist will provide rationale in the record for disparity between recommended and provided services. (235084) ☒ Other: (71359) This family's SED Waiver closed with Wraparound in October '21. Systemic Remediation to address citation for 71033 due to this case recently closing. (240610) Wraparound increased temporarily to respond to family crisis; family's request was not for this temporary increase to continue. Please see systemic remediation for June CLS auth not being met (staff is no longer with agency). **CMHCM** ☒ By 11/15/22, the Wraparound Coordinator will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity for WSA #176528 and #71868. **Lifeways** ☒ Other: (See response below) WSA #229985 is no longer open to SEDW and is not actively receiving Community Mental Health services.

			Support Services, Wraparound and Psychiatric Services not occurring as specified in Plan. (Closed SEDW) **<u>Saginaw County CMH Authority</u>** **WSA# 247682:** Wraparound, Dietary, Parent Support Partner and Peer Support Services not occurring as specified in Plan. **WSA# 245896:** Wraparound, Psychiatric services not occurring as specified in Plan. (Closed SEDW) **WSA# 177971:** DBT Group and Respite services not occurring as specified in Plan. **<u>The Right Door</u>** **WSA# 76138:** Wraparound, Respite Therapy, Psychiatry and RN services not occurring as specified in Plan. (Closed SEDW) **WSA# 175545:** Wraparound, Home-Based and RN services not occurring as specified in Plan. (Closed SEDW)	**SCCMH** ☒ By 11/30/2022 plan will be amended for resolving lack of service provision as recommended. **The Right Door** ☒ Both WSA 76138 and 175545 are closed to the SED Waiver, individual remediation cannot be completed. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN will coordinate a regional training using an external source for the implementation of Person Centered Planning, highlighting documentation of measurable goal and objectives, amount scope and duration. **BABH** ☒ By 9/30/22, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **CEI** ☒ By Date 8/19/22, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted.

				☒ Other: Ongoing quarterly monitoring of scope, duration, and frequency through quarterly chart reviews and supervision. **CMHCM** ☒ By 11/15/2022, staff training will be conducted by the Waiver review team on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **Lifeways** ☒ By 12/15/22, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **SCCMH** ☒ By 11/30/2022, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **The Right Door** ☒ By 11/26/2022 staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** **BABH:** Insufficient Individual remediation found (appearing to be systemic remediation, rather than individual remediation). How else will individual remediation occur, for the WSA, who did not receive the services recommended, (i.e., will services be tracked on a monthly basis, by the case holder and/or clinical service providers, who will document rationale for those services not provided as

				recommended, and address any barriers to services when appropriate, as evidenced in monthly progress notes over the next 90 days)? Please revise. **SCCMHA.** Re individual remediation, three WSA's cited, two remain open, and remediation is provided in singular language (suggesting only one plan will be amended to resolve disparity). Please clarify what plans will be amended (by WSA#) in the individual remediations. **CMHSP/PHIP 2nd Response** **CMHCM revision;** **Individual remediation;** By 12/15/22, Wraparound Coordinator will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity for WSA #176528 and #71868. **CMHCM systemic remediation;** By 12/15/2022, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **BABH Individual Remediation:** BABH supervisor will run monthly reports for 3 months for WSA#178005 to ensure consumer is receiving home-based services as identified in the plan. If there is a disparity between the recommended services and what is provided, staff will document rationale in the record. **SCCMHA** ☒ By 11/30/2022 plans for WSA#s 247682 and 177971 will be amended for resolving lack of service provision as recommended. **MDHHS 2nd Response**: ☒ **Response accepted**

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)	1	0	NA=29	
P.6.4 The IPOS was updated at least annually	22	2	NA=6 **Montcalm Care Network** **WSA# 240999** **CMH for Central Michigan** **WSA# 176528**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that IPOS is updated at least annually. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **MCN** ☒By11-30-22_clinician will ensure a current IPOS for WSA #240999. **CMHCM** ☒ By 11/15/2022 a review of progress and, if necessary, addendum will be completed for WSA #176528 by the case holder to ensure the IPOS is up to date. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and

				effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **MCN** ☒ By 11-30-22 additional training will be provided to the SEDW team specific to IPOS being completed with 365 days. Effective 12-30-22, IPOS Annuals Due Reports will be reviewed monthly at Managers meeting to ensure compliance. **CMHCM** ☒ By 11/15/2022, staff training will be conducted by the Waiver review team, on the need to ensure IPOS is updated at least annually. **MDHHS Response**: ☒ **Response accepted** **CMHCM revision**; Individual remediation; By 12/15/2022 a review of progress and, if necessary, addendum will be completed for WSA #176528 to ensure IPOS is up to date. **Systemic remediation;** By 12/15/2022, staff training will be conducted, on the need to ensure IPOS is updated at least annually **MDHHS 2nd Response**: ☒ **Response accepted with adjusted timeline noted, above**
P.6.5 The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's	20	10	**REPEAT CITATION** **Bay-Arenac Behavioral Health** **WSA# 178005:** Plan not updated following use of	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the IPOS is reviewed both at intervals

needs (evidence: IPOS is updated if assessments/ quarterly reviews / progress notes indicate there are changes in the condition). (PM D-6)			crisis stabilization services or psychiatric hospitalization **<u>CMH Authority of CEI Counties</u>** **WSA# 240610:** Lack of amendment following crisis stabilizations services that resulted in higher service needs. (Closed SEDW) **WSA# 177530**: Satisfaction not addressed in Review completed. (Closed SEDW) **<u>CMH for Central Michigan</u>** **WSA#s 176528, 71868:** Plan(s) not reviewed quarterly, as specified in the Plan(s). **<u>Saginaw County CMH Authority</u>** **WSA#s 247682, 245896:** Lack of reviews specified in the plan, and lack of a full review (with all required elements, including assessment of satisfaction of WSA and guardian, with supports/services/progress). (WSA# 245896 Closed SEDW) **WSA#s 73007, 75964, 71348:** Lack of reviews specified in the Plan. (All Closed SEDW)	specified in the IPOS and when there were changes to the waiver participant's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **BABH** ☒By 9/30/2022 the IPOS will be reviewed to determine if any updates need to be made to reflect the current situation. **CEI** ☒ WSA# 240610. Current plan indicates Wraparound authorized at 2 meetings monthly. Prior increase was temporary due to sudden need for stabilization and was not requested by the family to continue. It was in response to family crisis. ☒ WSA# 177530. Satisfaction documented in service notes (dates 5/12/22, 5/19/22, 5/22/22). **CMHCM** ☒ By 11/15/2022, the IPOS will be formally reviewed, with adjustment (as needed) by the case holder to the recommended dates for the remaining reviews for WSA #176528 and #71868. **SCCMH** ☒ By 11/30/2022, the IPOS will be formally reviewed, with adjustment (as needed) to the recommended dates for the remaining reviews. (WSA# 247682, 245896, 73007, 75964, 71348) **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and

				systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **BABH** ☒ By 9/30/22, staff training will be conducted, on the need to ensure that the IPOS is reviewed / amended as recommended / needed. **CEI** ☒ Other: (See response below) We had prior TA on this that if a change was temporary, authorization document and documentation in the notes was sufficient. Wraparound supervisor will continue to monitor the need to IPOS to be amended due to changes of family need and will monitor for documentation on short term needs. **CMHCM** ☒ By 11/15/2022, staff training will be conducted by the Waiver review team, on the need to ensure that the IPOS is reviewed / amended as recommended / needed. **SCCMH** ☒ By 11/30/2022, staff training will be conducted, on the need to ensure that the IPOS is reviewed / amended as recommended / needed. To address this concern, staff have been documenting within the Wraparound Progress Notes at least monthly that a review of satisfaction with supports/services/programs is

				occurring with consumers and their family. By 11/30/2022, staff will be completing Session Rating Scales with consumer/family at least monthly. A copy of the completed scale will be attached to the progress note for the applicable session for inclusion in the EHR. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted.** **CEI**: Insufficient systemic remediation. (Individual remediation not possible on both cases, now closed SEDW). Though CEI disputes the citations, per their comments, their input was reviewed during the site review, and a determination was made (to cite) that now requires remediation. How will assessment of satisfaction in reviews (required over and above what is documented in service notes), and the expectation to amend the plan, when levels of services change due to increased/decreased needs of the WSA/family, be addressed going forward/systemically? Additional staff training? If so, by when? More information needed then provided, on monitoring by supervisor. By what date will supervisor begin monitoring of Plans (timeline) and how will this be done (random monthly or quarterly draw)? To clarify, changes to the level of services require amended plan. **CMHSP/PHIP 2nd Response**:

				CMHCM revision. **CMHCM Individual remediation.** By 12/15/2022, the IPOS will be formally reviewed, with adjustment (as needed) to the recommended dates for the remaining reviews for WSA #176528 and #71868 **CMHCM Systemic remediation.** By 12/15/2022, staff training will be conducted, on the need to ensure that the IPOS is reviewed / amended as recommended / needed. **CEI** **Systemic** By12/31/22 Staff training will occur on the need to obtain satisfaction of the plan and ensure that IPOS is reviewed/amended as recommended/needed.By 12/31/22 supervisory staff will quarterly monitor SEDW to monitor the IPOS to be amended due to changes of family need and will monitor for documentation on short term needs and review for documentation of satisfaction **MDHHS 2nd Response**: ☒ **Response accepted**
F. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.1.The BTPRC process includes all the following elements as required by the Technical Requirement for	1	0	Please see HSW Report	

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.				

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	NA	NA	NA=30	

restrictive techniques at least quarterly.				
G. WAIVER PARTICIPANT HEALTH AND WELFARE				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	29	1	**Saginaw County CMH Authority** **WSA# 177971**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual is provided information/education on how to report abuse/neglect/exploitation and other critical incidents. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **SCCMH** ☒ By 11/30/2022, WSA #177971 will be provided information/education on how to report abuse/neglect/exploitation and other critical incidents, as evidenced in the record by _signed copy of proof document showing provision of information/education__. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed

				care site reviews for each CMHSP to occur in 2023. **SCCMH** ☒ By 11/30/2022, training will be provided to CM staff regarding this requirement. **MDHHS Response**: ☒ **Response accepted**
G.2 Individual served received health care appraisal. (Date/document confirming_____ _____)	28	2	**REPEAT CITATION** **CMH Authority of CEI Counties** **WSA# 235084** **Lifeways** **WSA# 177475** **(Closed SEDW)**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CEI** ☒ By 10/31/22, WSA # 235084 will receive a health care appraisal in line with requirement and acceptable options for meeting this requirement. **Lifeways** ☒ WSA #277475 is not presently open to the SEDW. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the

				required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CEI** ☒ By 12/31/22 training will be provided to staff at large regarding this requirement. ☒ Effective 12/31/22 Supervisory staff will monitor this requirement at least quarterly, from a random sample. ☒ Effective 12/31/22 QI will complete chart reviews quarterly and include this requirement. **Lifeways** ☒ By 12/15/22, training will be provided to CM staff regarding this requirement **MDHHS Response**: ☒ **Response accepted**
Q. STAFF QUALIFICATIONS				
Q.3 SEDW				
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)	~~65~~ 68	~~7~~ 4	**REPEAT CITATION** **A total of 72 professional staff were reviewed under the SEDW** **CMH for Central Michigan** *Insufficient evidence of being a CMHP upon hire, or being supervised by a CMHP (if not CMHP)* **WSA# 76678: (Closed SEDW)** Lori Golden	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound facilitators are credentialed prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

			Insufficient evidence of being a CMHP **WSA# 76678:** Mary Diepstra **Montcalm Care Network** *Lack of evidence of initial background check being completed prior to hire.* **WSA# 240999:** Samantha Kennedy ~~**Saginaw County CMH Authority**~~ ~~*Lack of evidence of initial 3-day new WA Facilitator's Training.*~~ ~~**WSA# 247682:**~~ ~~Elise Hodkins~~ ~~**WSA# 75964:**~~ ~~Lucia Vargas~~ ~~**WSA#s 177971, 247682**~~: ~~Brian Shelter~~ **The Right Door** *Lack of evidence of initial 3-day new WA Facilitator's Training.* **WSA#s 76138, 177928, 175545:** Kali Teater	**Individual Remediation:** **CMHCM** ☒ Mary Diepstra and Lori Golden Competency assessment forms for each of the employees are currently in place which indicates the experience necessary to prove staff qualifications for QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. **MCN** ☒ Case cannot be remedied individually: initial hiring of provider occurred in 2018 and credentialing fully completed in 2019. Evidence of credentialing of this provider is available in HR/Provider Network department records. See systemic remediation. **SCCMH** ☒ WSA# 247682, 75964, 177971: Each of the staff listed as not having the 3-day new WA Facilitator's Training are not providing services as a WA Facilitator. Each of the staff listed provide services as part of the Central Access and Intake Department and assist consumers with services prior to assignment in a specific clinical department. These staff will continue to complete the 24-hour child specific training annually and will have completed their trainings for 2022 by 12/31/2022. **The Right Door** ☒ Training was completed in 2015, evidence provided to MSHN with the CAP, and will be provided to MDHHS during the follow up review. **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to

				address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. **CMHCM** ☒ The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all new employees hiring on to CMHCM. • An MS Teams survey will be developed by the CMHCM HR department by 11/15/2022 questions that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. • The CMHCM competency assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **MCN** ☒ A tool and process has been developed since the above 2018/2019 citation to assure CMHP credentialing of newly hired/assigned staff prior to service delivery. This includes a process for requesting Temporary Privileges when immediate service delivery is in the best interest of the consumer(s). Evidence of credentialing of individual

				providers are available in HR/Provider Network department records, and related tool and procedures are available in department forms and processes. **SCCMH** ☒ By 11/30/2022, staff will receive reminders regarding the importance of completing the required 24-hour child specific training annually. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **For CMHCM**: Regarding individual remediations, a "competency assessment form" showing QIDP eligibility, without the documentation that the HR reviewed to make that determination, is insufficient evidence. Primary source documentation is required (ie, resume/updated resume that reflects the experience of working with the target population, job application, if it reflects population worked with, etc). Please revise. **For MCN**, regarding systemic remediation, more information is needed. Beyond changing policy/procedure (at some point in the past), what is MCN doing/planning to do to ensure that policy/procedures are being followed at the systems level, as a result of this citation? What specifically will

				MCN provide at the 90-day review to give evidence that this matter (of ensuring background checks prior to delivering services) has been sufficiently remediated? ***For SCCMHA, citations under this PM for the three staff noted have been removed, as entered in error. No remediations (individual or systemic) are needed. Staff totals (numbers) has been adjusted accordingly.*** **CMHSP/PHIP 2nd Response**: **CMHCM individual remediation;** By 12/15/2022 primary source verification will be completed to verify QIDP eligibility. **CMHCM Systemic remediation;** By 12/15/22 Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. **MCN systemic remediation:** By 11/30/22, MCN will further detail/refine its process by which staff responsible for contract approvals notify the Provider Network specialist of incoming contracted providers, including targeted start date of the provider, so that initial background checks and temporary privileging activities are completed prior to start date. This process will be added to MCN procedure 7152A Credentialing and Privileging. MCN has evidence

				of practice being used for timely credentialing and privileging of an Occupational Therapist in February 2022. **MDHHS 2nd Response**: ☒ **Response accepted** **For CMHCM, accepted with the expectation that primary source documentation will be provided at the 90 day review that will give evidence of CMHP (of cited staff) or supervision by a CMHP. Documented evidence of review/updates of current processes will also be expected.**
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)	64	8	**REPEAT CITATION** **<u>CMH for Central Michigan</u>** *Insufficient evidence of 3-Day WA New Facilitator's training and 2 MDHHS trainings per year.* **WSA#s 71868, 76678, 177942, 176528:** Jennifer Schaefer *Insufficient evidence of 24 hr/yr child specific training.* **WSA# 76678:** Delores Mayen *Insufficient evidence of being a CMHP, or being supervised by a CMHP (on-going)* **WSA# 76678:** Lori Golden *Insufficient evidence of being a CMHP, on-going.* **WSA# 76678:** Mary Diepstra **<u>Saginaw County CMH Authority</u>**	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound facilitators are credentialed on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **CMHCM** ☒ Lori Golden and Mary Diepstra's Competency assessment forms are currently in place which indicates the experience necessary to prove staff qualifications for QIDP/CMHP that were previously cited. Evidence of this can be provided by the HR department at the 90 day review by MDHHS. WSA#s 71868, 76678, 177942, 176528:

			Lack of 24 hrs/year child specific training. **WAS# 71348: Cathy Williams** **WSA# 247682: Elise Hodkins** **WSA#s 73007, 177971, 247682, 245896: Tanual Gaskew-Collins** **<u>The Right Door</u>** *Lack of sufficient evidence of 24 hr/yr child specific training* **WSA# 175545:** Jennifer Mcvay	Jennifer Schaefer proof of completion of the wraparound training in 2021 is in place. Evidence of this can be provided by the HR department at the 90-day review by MDHHS. WSA# 76678: Delores Mayen At time of staff employment termination June 2022, required Children's training hours were not completed, individual level remediation is not possible. **SCCMH** ☒ Within 90 days of CAP approval, evidence of at least six hours of the required 24 hours / year annual child specific training will be provided for staff cited for lack of this requirement. ☒ By 11/30/2022, evidence of at least six hours of the required 24 hours / year annual child specific training will be provided for staff cited for lack of this requirement. **The Right Door** ☒WSA# 175545 Evidence provided for 24 hours of IMH training along with RELIAS log of additional CDT training **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023.

				CMHCM ☒ The CMHCM hiring application was updated on 9/1/2022 by the HR department which incorporated a question that requests the years of experience an individual has within each population to ensure this area of need for credentialing for QIDP, CMHP. This will ensure that this is being tracked for all new employees hiring on to CMHCM. An MS Teams survey will be developed by the CMHCM HR department by 11/15/2022 questions that identify years of experience each staff have accumulated for ongoing credentialing and working with populations to save within HR personnel files. The CMHCM competency assessment form will be further evaluated by the HR department by 11/15/2022 to determine additional fields (if necessary) for tracking of credentialing and monitoring of ongoing credentialing. **Children's training** CMHCM has a tracking system in place for active staff serving children who are required to complete 24 hours of child-related training per year. A quarterly report is run to track progress, and an end-of-year report is run to measure compliance, and is reported to HR as such. No corrective action is needed for this incident. Wraparound training In September of 2021, CMHCM created a requirements tracker in the online training platform for the Wraparound training requirement. Any new wraparound employees is assigned this tracker so they will receive reminders to complete the training within 90 days of hire. On September 6, 2022, a Wraparound filter in the online training platform

				was added so that reports can be run annually to verify compliance of initial and ongoing Wraparound trainings **SCCMH** ☒ By 11/30/2022, the SCCMHA Continuing Education Department will develop a tool to assure monitoring of the required 24 hours / year annual child specific training for all staff needing to meet this requirement. Tool will be used to assist staff with monitoring total number of completed trainings and used as reminder system for staff to ensure trainings are completed by the end of each year. A plan of correction will be requested by the provider/staff/or supervisor of the staff person for when the staff person will be in compliance with training standards. The plan of correction will be monitored by the SCCMHA Auditing unit during annual audit reviews. **The Right Door** ☒ Other: (See response below) Disagree – provided 24 hours of IMH training along with RELIAS log of additional CDT training **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **For CMHCM**: Please see comments under Q.3.1, regarding evidence of CMHP on-going. Regarding 24 hr child specific training, no systemic remediation found, as a result of this new citation (that the current system in

				place at CMHCM did not prevent). What will CMHCM do differently, going forward, to systemically prevent this citation from occurring in the future. **The Right Door/TRD** No individual or systemic remediation found, only that "evidence provided" and "disagree". Please note that evidence provided was reviewed and found insufficient in meeting the 24 hr ***per year*** child specific training. What will TRD do to remediate, going forward, both individually and systemically? **CMHSP/PHIP 2nd Response** **CMHCM individual remediation.** By 12/15/2022, primary source verification will be completed to verify CMHP eligibility. By 12/15/2022, primary source verification will be completed to verify CMHP eligibility. No individual remediation can occur for this citation given this staff person is no longer employed by the agency. By 12/15/2022 primary source verification will be completed to verify CMHP eligibility. No individual remediation can occur for this citation given we are in a new calendar year for the 24 hour children's training requirement. **CMCMH Systemic remediation.** By 12/15/22 Human Resources will review and update current processes to ensure primary source verification and Human Resources review and approval is in place for all credential verifications, both at hire and ongoing. Human Resources will also review and update current children's training tracking requirements to ensure compliance. **Individual: The Right Door** WSA# 175545 Evidence will be

				provided for 24 hours for Jennifer at the 90 day follow up. This includes her IMH training hours, supervision notes and RELIAS log of additional CDT training. **Systemic: The Right Door** Other: (See response below) The Right Door will update their CDT procedure by 11.26.2022 with TA from MSHN on what counts for CDT hours. The Right Door will ensue that trainings that do not clearly state children, adolescent, minor, etc in the training has an accompanied agenda, mins or training materials available for review. This will be reviewed with those involved in tracking this process by 11/26/2022. **MDHHS 2nd Response**: ☒ **Response accepted with documented evidence of the above.**
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, CPR, and that staff is employed by or on contract with the CMHSP. (PM C-3) 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	28	2	**REPEAT CITATION** **A total of 30 Aide level staff were reviewed under the SEDW.** **<u>Saginaw County CMH Authority</u>** *Lack of evidence of initial background check being completed prior to hire* **WSA# 71348: Cody Richards** *Lack of evidence of on-going background checks.* **WSA# 71348:** Lindie Mckenzie	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **SCCMH** ☒ By 11/30/2022, cited staff for WSA #_71348_ will secure a criminal background check **Systemic Remediation:** **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to

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.				address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes **SCCMH** ☒ By 11/30/2022, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. ☒ A plan of correction will be requested by the provider/staff/or supervisor of the staff person for when the staff person will be in compliance with training standards. The plan of correction will be monitored by the SCCMHA Auditing unit during annual audit reviews. **MDHHS Response**: ☐ **Response accepted** ☒ **<u>Response not accepted</u>. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **For MSHN**, systemic remediations need to occur within 90 days of the CAP

				being approved. A June 2023 target date for the development of training guidelines is outside that window. Please revise. **CMHSP/PHIP 2nd Response** **MSHN** **Systemic Remediation** By 1/14/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes **MDHHS 2nd Response**: ☒ **Response accepted**
Q.3.4 All SEDW providers meet training requirements including training of CLS 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)	14	16	**REPEAT CITATION** **Saginaw County CMH Authority** **WSA# 71348:** Cody Richards, Elizabeth Wells, Emma Shustek, Germaine King, Jenna Singleton, Lindie Mckenzie, Madisyn Turner, Melissa Collins, Michael Arnold, Michiela Boone, Samantha Schroeder, Sarah Carpenter, Shawnita Arder **WSA# 75964:** Ericka Jackson Mark Bryant Sr. **The Right Door** **WSA# 76138:** Angela Miller	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that all SEDW providers meet training requirements including training of CLS staff on the implementation of the IPOS by the appropriate professional. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: **Individual Remediation:** **SCCMH** ☒ By 11/30/2022, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **The Right Door** ☒ WSA 76138 is closed to SEDW, individual remediation cannot occur.

				Systemic Remediation: **MSHN** ☒ The CMHSP participants have developed an individual and systemic remediation plan to address each citation for the standards. MSHN will monitor each remediation plan submitted by the CMHSP through the submission of evidence by the required due date. MSHN will monitor the standard and effectiveness of the systemic remediation plan by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2023. ☒ By 6/1/2023 MSHN in collaboration with the CMHSPs will develop guidelines for training documentation. The MSHN training grid will be reviewed and modified if needed to ensure trainings include the required timeframes **SCCMH** ☒ By 11/30/2022, CMHSP/PIHP will review with/train CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS), as well as the 4 elements required as evidence for training: • Date of Training • Content of Training (including date of IPOS) • Who was trained (legible names) • Who did the training (legible name/title) **The Right Door** ☒ As a part of our respite placements, respite providers will meet the family/person served and be trained on the IPOS. The foster care worker and supervisor reviews each packet for

				completion and compliance. This process is already in place. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found** ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) **The Right Door/TRD**: No systemic remediation found as a result of this citation. A system already in place did not prevent this citation from occurring. Going forward, what will TRD do differently (with timelines, that can be confirmed at the 90-day review) to ensure this is remediated, going forward. **For MSHN**, please see comments under Q.3.3. **CMHSP/PHIP 2nd Response:** **The Right Door** Training on this requirement will be provided to all SEDW staff by 11/26/2022. **MDHHS 2nd Response**: ☒ **Response accepted** **For MSHN, MDHHS accepts the adjusted time frame noted under Q.3.3 for meeting this requirement for systemic remediation as well.**
H. HOME VISITS/TRAINING/INTERVIEWS				

H.2. SEDW HOME VISIT				
H.2.1 The current IPOS is in the home and the parent /guardian and staff have access to it. (evidence: a copy of the plan is in the home)	0	0	NA There were no SED-W Home Visits/Interviews as a part of this review. For Recipient Interviews, conducted under all three Waivers, please see the HSW Report.	N/A
H.2.2 The parent is offered a formal opportunity to express his/her level of satisfaction with the SEDW. (evidence: as reported to the surveyor by the parent and documented by the surveyor's notes)				
H.2.3 Protocols for managing individual health and safety issues are identified in the IPOS and implemented by staff and parents. Evidence: 1. Crisis and Safety Plans are current, accessible and – per report of the child/youth, parent and staff - responsive to need 2. Staff and parents know what the protocol is, where it is, and how to implement it				

Consumer Satisfaction Survey

Summary

This year, CEI distributed 4,748 total surveys with an overall rate of return of 16.3%. See the breakdown for each of the four programs below, compared to 2020 when possible:

Survey Response by Program					
	Distributed (2022)	Returned (2022)	% Returned (2022)	Distributed (2020)	% Competed (2020)
AMHS	2,153	394	18.3%	1,998	13.1%
Families Forward	1,180	112	9.5%	970	9.4%
CSDD Adults	961	217	22.6%	--	--
CSDD Youth	454	51	11.2%	--	--
TOTAL	**4,748**	**774**	**16.3%**	**2,968**	**11.9%**

The purpose of this survey is to fulfill this portion of our MSHN contract and to help CMHA-CEI (1) gauge the level of satisfaction among its consumers who were receiving services and (2) determine ways it could improve its practices to better serve its consumers. The results of the survey help to measure the quality of CEI services. This evaluation report summarizes the levels of satisfaction with the CMH service system.

Adult consumers participating in AMHS and CSDD Adult programs completed the MHSIP thirty-six-question survey. This survey template provided by MSHN used a six-point Likert scale with the following options: Strongly Agree (1), Agree (2), Neutral (3), Disagree (4), Strongly Disagree (5), and Not Applicable (9).

Child consumers participating in Families Forward and CSSD Youth programs, or their families if the consumer was younger than 13, completed the YSSF twenty-six-question survey. This survey template provided by MSHN used a five-point Likert scale with the following options: Strongly Agree (5), Agree (4), Neutral (3), Disagree (2), and Strongly Disagree (1). Please note that this numerical order is flipped when compared to the MHSIP survey administered to the adult-focused programs.

Results from AMHS and Families Forward programs are reported to MSHN for the annual analysis and report which provides CEI with year-over-year regional comparisons and subscale ratings for those services. Although consumers from CSDD programs were previously surveyed in FY19, that data is unfortunately not able to be directly compared to the current FY22 data as different survey questions were asked.

Additionally, ITRS programs distributed the SUD consumer satisfaction survey in FY22. Ninety-seven total consumers representing four ITRS programs were surveyed on the quality of the care they received using a series of fifteen questions across six subscales. This survey used a five-point Likert scale with the following options: Strongly Agree (5), Agree (4), Neutral (3), Disagree (2), and Strongly Disagree (1).

Procedure

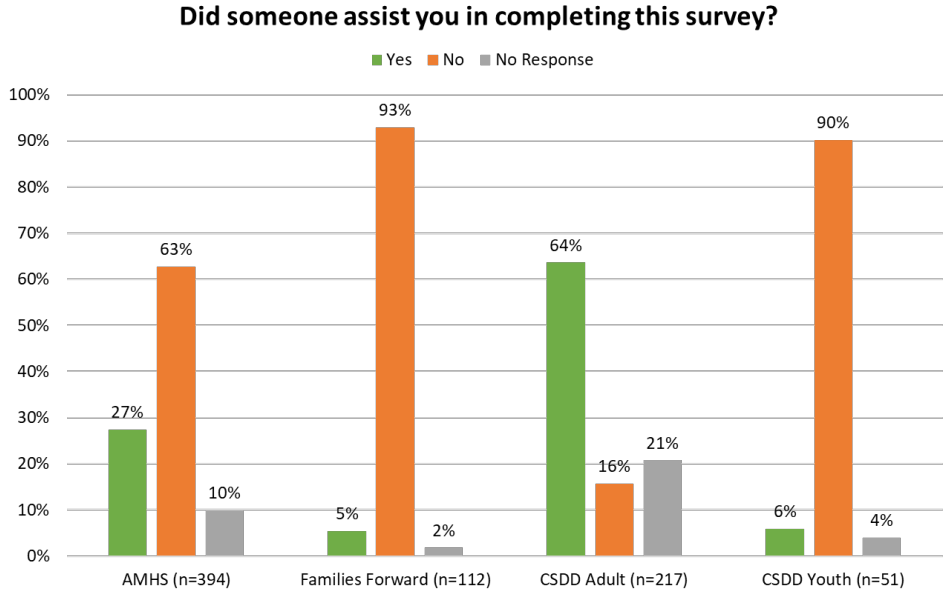
Surveys were handed out to consumers who received services from AMHS, Families Forward, or CSDD programs between 7/18/22 and 8/14/22. Response methods included mail, phone, face-to-face, and electronic submission. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The survey respondents were anonymous, although consumers were given the option to identify themselves if they wished to be contacted at a later date for follow-up.

Findings

Across all programs, the difference between the highest and lowest-performing questions was relatively small. This indicates that consumers are generally satisfied with CEI services. However, year-over-year, questions on the quality of staff and services have often scored slightly higher than those regarding treatment outcomes.

Across all programs, the most common survey response method was face-to-face.

CSDD Adult was the only program surveyed where a majority of consumers received assistance completing the survey. This proportion was also relatively high for AMHS.



Analysis of Findings

AMHS – Lower numerical score indicates greater satisfaction.

- The average score of all responses was 1.69.
- Top three positive responses:
  1. I like the services that I received (1.43)
  7. Services were available at times that were good for me. (1.47)
  10. Staff believed that I could grow, change and recover. (1.47)
- Lowest three negative responses:
  26. I do better in school and/or work. (1.97)
  28. My symptoms are not bothering me as much. (1.96)
  35. I feel I belong in my community. (1.96)
- Performance across the seven MHSIP subscales (calculated by MSHN):
  - Subscales measure consumer perceptions of: General Satisfaction, Participation in Treatment Planning, Quality and Appropriateness, Access, Social Connectedness, Functioning, and Outcome of Services.
  - Scored best: Quality and Appropriateness
  - Scored worst: Outcome of Services and Social Connectedness
  - All subscale ratings increased since FY20 except for Social Connectedness, which decreased.
  - Depending on the individual subscale, CEI scored near average or above average when compared to other CMH agencies in the region.

Families Forward – Higher numerical score indicates greater satisfaction.

- The average score of all responses was 4.33.
- Top three positive responses:
  12. Staff treated me with respect. (4.85)
  14. Staff spoke with me in a way that I understood. (4.83)
  13. Staff respected my family's religious/spiritual beliefs. (4.73)
- Lowest three negative responses:
  19. My child is doing better in school and/or work. (3.56)
  20. My child is better able to cope when things go wrong. (3.64)
  18. My child gets along better with friends and other people. (3.72)
- Performance across the seven YSSF subscales (calculated by MSHN):
  - Subscales measure consumer perceptions of: Cultural Sensitivity, Participation in Treatment, Access, Appropriateness, Social Connectedness, Social Functioning, and Outcomes.
  - Scored best: Cultural Sensitivity
  - Scored worst: Outcomes and Social Functioning

- All subscale ratings increased since FY20 except for Participation in Treatment, which decreased.
- Depending on the individual subscale, CEI scored near average or above average when compared to other CMH agencies in the region.

CSDD Adult – Lower numerical score indicates greater satisfaction.

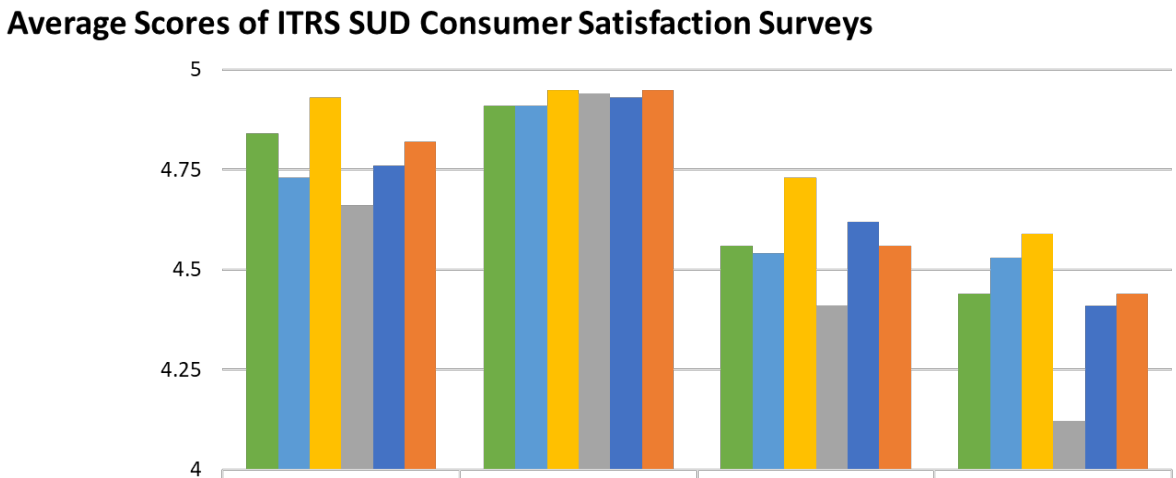
- The average score of all responses was 1.88.
- Top three positive responses:
  11. I felt comfortable asking questions about my treatment, services and medication. (1.60)
  5. Staff were willing to see me as often as I felt it was necessary. (1.64)
  7. Services were available at times that were good for me. (1.65)
- Lowest three negative responses:
  26. I do better in school and/or work. (2.29)
  23. I am better able to deal with crisis. (2.23)
  31. I am better able to handle things when they go wrong. (2.22)

CSDD Youth – Higher numerical score indicates greater satisfaction.

- The average score of all responses was 4.20.
- Top three positive responses:
  14. Staff spoke with me in a way that I understood. (4.69)
  12. Staff treated me with respect. (4.65)
  6. I participated in my child's treatment/services. (4.60)
- Lowest three negative responses:
  20. My child is better able to cope when things go wrong. (3.59)
  16. My child is better at handling daily life. (3.72)
  19. My child is doing better in school and/or work. (3.75)

ITRS – Higher numerical score indicates greater satisfaction.

- The average satisfaction score across all subscales and programs was 4.68.
- Short chart y-axis to highlight differences as each program scored relatively well.
- Overall, The Recovery Center scored best and House of Commons scored worst.
- The highest-rated subscale, generally, was Cultural/Ethnic Background with an average score of 4.80.
- The lowest-rated subscale, generally, was Appropriateness/Choice with Services with an average score of 4.53.



	ITRS Outpatient (n=31)	The Recovery Center (n=22)	CATS (n=27)	House of Commons (n=17)
Welcoming Environment	4.84	4.91	4.56	4.44
Information on Recipient Rights	4.73	4.91	4.54	4.53
Cultural/Ethnic Background	4.93	4.95	4.73	4.59
Appropriateness and Choice with Services	4.66	4.94	4.41	4.12
Treatment Planning/Progress Towards Goals	4.76	4.93	4.62	4.41
Coordination of Care/Referrals to Other Resources	4.82	4.95	4.56	4.44

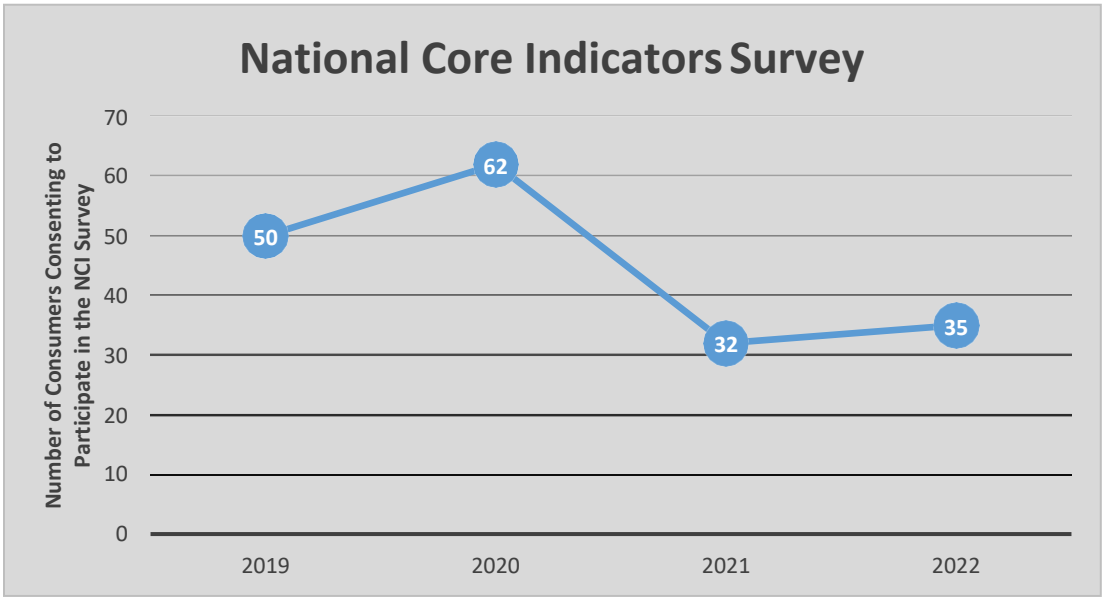
Consumer Concerns

CEI shared this analysis with its Consumer Advisory Council and received valuable stakeholder feedback. Consumers present at the meeting overwhelmingly believed that the surveys should have fewer questions that are also easier to understand, fewer restrictions on clinician or peer assistance, easier electronic access, and be distributed to as many CEI locations as possible. Given the highly standardized nature of the MSHN template and requirements for regional reporting, CEI is considering the development of a second survey that can be administered internally in addition to the MSHN surveys with this feedback in mind.

National Core Indicators Survey

The NCI Survey is a collaboration between participating states, Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. Information about specific 'core indicators' are gathered to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The NCI survey aims to assess family and adult consumer perceptions of and satisfaction with their community mental health system and services.
Consumers are selected at random and asked if they would like to participate in the in person survey. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritize quality improvement initiatives.

During the 2021-2022 survey, there were 32 total consumers who consented to participate in the survey. This was a decrease from the number of consents obtained in the 2020-2021 survey. During the 2022-2023 survey, a total of 35 consumers consented to participate in the survey. This was a slight increase, but still lower than previous years.



Quality Improvement and Performance Measurement Report for CARF Accredited CMHA-CEI Programs

CMHA-CEI is nationally accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF). The agency's most recent survey for reaccreditation took place virtually in August 2020, which granted it a 3-year accreditation through June 2023.

An application to renew accreditation was completed in December 2022 and a survey will take place in the spring or summer of 2023. CMHA-CEI will seek to continue accreditation for all administrative units (General Administration, Properties & Facilities, Human Resources, Finance/Contracts, Quality, Customer Service, and Recipient Rights), as well as 19 clinical programs in Adult Mental Health Services, Families Forward, Community Services for the Developmentally Disabled, and Integrated Treatment and Recovery Services.

CMHA-CEI Department	CMHA-CEI Program	CARF Core Program
Adult Mental Health Services (AMHS)	ACT - Cedar	Assertive Community Treatment (ACT)
Adult Mental Health Services (AMHS)	ACT – Louisa	Assertive Community Treatment (ACT)
Adult Mental Health Services (AMHS)	Team I Case Management	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Team II Case Management	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Team III Case Management	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Outreach Case Management	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Older Adult Services	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Eaton County Counseling Center	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Clinton County Counseling Center	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Mason Rural Outreach Program	Case Management – Mental Health
Adult Mental Health Services (AMHS)	Waverly Wellness	Case Management – Mental Health
Families Forward	Parent Young Child (PYC)	Intensive Family Based Services – Early Intervention
Families Forward	Parent Infant Program (PIP)	Intensive Family Based Services – Early Intervention
Families Forward	Family Guidance Services	Intensive Family Based Services – Home Based

Community Services for the Developmentally Disabled (CSDD)	Life Consultation	Case Management – Psychosocial Rehab - Adults
Community Services for the Developmentally Disabled (CSDD)	Family Support Case Management	Case Management – Psychosocial Rehab - Children
Integrative Treatment and Recovery Services (ITRS)	ITRS Outpatient	Outpatient Treatment Alcohol and other drugs – Adults
Integrative Treatment and Recovery Services (ITRS)	Corrections and Treatment Services (CATS)	Outpatient Treatment Alcohol and other drugs – Criminal Justice
Integrative Treatment and Recovery Services (ITRS)	House of Commons (HOC)	Residential Treatment Alcohol and other drugs – Criminal Justice
Integrative Treatment and Recovery Services (ITRS)	The Recovery Center (TRC)	Detoxification/Withdrawal Support Treatment Alcohol and other drugs – Adults

The QI Team are charged with facilitating and preparing each unit for the audit. Part of audit preparation includes submitting annual efficiency measures and outcomes data from CARF accredited programs in the form of a Quality Improvement and Performance Measurement Plan. The plan is composed of a data from performance indicators, satisfaction surveys, incident reports, and other internal QI initiatives.

Outcomes Management: Performance Indicator Report

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly, and quarterly reports are compiled and submitted to the PIHP for analysis and regional benchmarking and to MDHHS. In the event that CMHA-CEI performance is below the identified goal, the QI team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval.

Changes in PI reporting standards were adopted beginning FY 20 Q3, which removed exceptions and exclusions for Indicators 2 and 3, while also eliminating the 95% standard for those indicators.

Indicator #1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%

Indicator #2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95% for Q1 and Q2, no standard.

Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. Standard = 95% for Q1 and Q2, no standard.

Indicator #4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%

Indicator 5#: The percentage of Face-to Face Assessment with Professionals that result in decisions to deny CMHSP services (only submitted for full population)

Indicator #10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

FY22 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4
1 - Total	**96%**	**96%**	**96%**	**96.04%**
1 - Children	92%	95%	97%	93.77%
1 - Adults	97%	97%	96%	97.1%
2a - Total	**51%**	**49%**	**54%**	**50.98%**
2a – IDD-C	31%	11%	26%	8.33%
2a – IDD-A	61%	20%	38%	60%
2a – MI-C	61%	68%	77%	62.9%
2a – MI-A	47%	44%	46%	50%
3 - Total	**46%**	**50%**	**49%**	**56.17%**
3 – IDD-C	63%	64%	73%	81.69%
3 – IDD-A	23%	38%	36%	21.43%
3 – MI-C	41%	41%	37%	50.26%
3 – MI-A	47%	58%	54%	55.56%
4a - Total	**100%**	**98%**	**98%**	**98.48%**
4a - Children	--	100%	100%	100%
4a - Adult	100%	9%	97%	98.04%
10 - Total	**10%**	**10%**	**12%**	**7.72%**
10 - Children	9%	6%	8%	12.5%
10 - Adults	11%	10%	13%	6.85%

FY22 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4
1 - Total	**94%**	**95.5%**	**96%**	**96%**
1 - Children	91%	94%	96%	94%
1 - Adults	97%	97%	96%	95%
2a - Total	**49%**	**37%**	**53%**	**49%**
2a – IDD-C	26%	8%	18%	5%
2a – IDD-A	67%	18%	39%	63%
2a – MI-C	59%	67%	75%	59%
2a – MI-A	45%	28%	46%	49%
3 - Total	**47%**	**50%**	**49%**	**55%**
3 – IDD-C	62%	64%	70%	81%
3 – IDD-A	33%	40%	40%	35%
3 – MI-C	44%	42%	40%	52%
3 – MI-A	47%	57%	54%	54%
4a - Total	**96%**	**99%**	**98.5%**	**98%**
4a - Children	95%	100%	100%	100%
4a - Adult	97%	98%	97%	97%
5 - Total	**14%**	**10%**	**7%**	**12%**
10 - Total	**9%**	**10%**	**12%**	**10%**
10 - Children	3%	6%	9%	11%
10 - Adults	11%	10%	12%	10

FY21 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4
1 - Total	**98.49%**	**96.8%**	**98.25%**	**97.74%**
1 - Children	98.6%	96.21%	98.79%	97.33%
1 - Adults	98.44%	97.05%	98.05%	97.89%
2a - Total	**51.44%**	**57.37%**	**50%**	**54.46%**
2a – IDD-C	41.86%	46.81%	44.44%	37.84%
2a – IDD-A	41.86%	37.04%	42.1%%	50%
2a – MI-C	70.13%	72.01%	64.38%	68.27%
2a – MI-A	43.36%	52.04%	44.13%	43.94%
3 - Total	**59.9%**	**59.05%**	**56.86%**	**56.58%**
3 – IDD-C	65.63%	68.09%	72.73%	67.19%
3 – IDD-A	13.33%	7.69%	36.84%	22.22%
3 – MI-C	45.32%	49.77%	47.03%	53.5%
3 – MI-A	73.54%	67.54%	63.06%	58.8%
4a - Total	**96.47%**	**81.82%**	**96%**	**96.53%**
4a - Children	100%	100%	100%	100%
4a - Adult	95.65%	80%	95.27%	95.73%
10 - Total	**13.64%**	**12.06%**	**7.34%**	**13.19%**
10 - Children	6.67%	17.24%	0%	20.69%
10 - Adults	14.74%	11.4%	7.34%	13.19%

FY21 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4
1 - Total	**98%**	**97%**	**98%**	**98%**
1 - Children	99%	96%	98%	97%
1 - Adults	99%	97%	98%	98%
2a - Total	**40%**	**48%**	**40%**	**40%**
2a – IDD-C	29%	44%	38%	31%
2a – IDD-A	32%	29%	29%	43%
2a – MI-C	67%	69%	61%	65%
2a – MI-A	32%	40%	33%	30%
3 - Total	**63%**	**59%**	**57%**	**57%**
3 – IDD-C	48%	67%	73%	66%

3 – IDD-A	78%	11%	33%	25%
3 – MI-C	62%	52%	49%	55%
3 – MI-A	63%	65%	63%	59%
4a - Total	**94%**	**93%**	**95%**	**76%**
4a - Children	96%	100%	100%	100%
4a - Adult	93%	92%	95%	97%
5 - Total	**5%**	**5%**	**4%**	**9%**
10 - Total	**14%**	**12%**	**7%**	**13%**
10 - Children	4%	16%	0%	21%
10 - Adults	16%	11%	8%	12%

FY20 Performance Indicator Results: Medicaid Only (Combined Demographics)**

Indicator	Q1	Q2	Q3	Q4
PI 1	97.23%	96.96%	98.29%	97.39%
PI 2	96.76%	97.32%	68.70%	68.07%
PI 3	95.56%	96.44%	64.84%	68.93%
PI 4	94.62	93.59%	95.63%	100%
PI 10	9.83%	8.25%	19.05%	15.32%

FY20 Performance Indicator Results: Full Population (Combined Demographics)**

Indicator	Q1	Q2	Q3	Q4
PI 1	97.86%	97.00%	98.32%	97.46%
PI 2	96.42%	97.43%	70.42%	54.65%
PI 3	96.14%	96.39%	63.73%	68.89%
PI 4	93.51%	94.94%	93.53%	98.81%
PI 10	9.02%	8.12%	18.21%	14.62%

** Changes in PI reporting standards were adopted beginning FY 20 Q3, which removed exceptions and exclusions for Indicators 2 and 3, while also eliminating the 95% standard for those indicators.

CMHA-CEI Integrated Treatment & Recovery Services

Efficiency Objective:	FY 2019-2020											
	Oct-Dec 2019			Jan-Mar 2020			April-June 2020			July-Sept 2020		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) 85% of all open clients will have a completed Quarterly Review on or before the scheduled due date, i.e. every 90 days. **(Clinton County Counseling Center- SUD)**	28	27	96%	31	29	94%	31	30	97%	25	25	100%
2) 95% of all open clients funded by MSHN & OCC will have a completed Treatment Plan within 14 days of admission. **(House of Commons)**	63	59	94%	41	40	96%	29	29	100%	33	33	100%
3) 95% of all clients will be seen individually every 30 days. **(CATS Program)**	95	93	98%	363	361	99%	254	253	99%	248	243	98%
4) 75% of clients who schedule an intake appointment will show up. **(The Recovery Center)**	125	103	82%	127	114	90%	105	85	81%	152	79	53%

Efficiency Objective:	FY 2020-2021											
	Oct-Dec 2020			Jan-Mar 2021			April-June 2021			July-Sept 2021		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) 85% of all open clients will have a completed Quarterly Review on or before the scheduled due date, i.e. every 90 days. **(Clinton County Counseling Center-SUD)**	25	22	88%	24	24	100%	17	15	88%	18	18	100%
2) 95% of all open clients funded by MSHN & OCC will have a completed Treatment Plan within 14 days of admission. **(House of Commons)**	22	22	100%	29	29	100%	26	26	100%	27	27	100%
3) 95% of all clients will be seen individually every 30 days. **(CATS Program)**	161	110	68.32% COVID19	197	192	97.46%	188	184	97.87%	253	249	98.42%
4) 75% of clients who schedule an intake appointment will show up. **(The Recovery Center)**	122	120	98.36%	141	127	90%	134	116	87%	106	76	80.56%

Efficiency Objective:	FY 2021-2022											
	Oct-Dec 2021			Jan-Mar 2022			April-June 2022			July-Sept 2022		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) Increase percentage of all clients will have attended at least four sessions. **(ITRS Outpatient Clinton & Ingham)**	78	46	59%			57%			79%	--	--	--
2) 95% of clients will have a Primary Care Physician by discharge. **(House of Commons)**	32	22	69%	26	19	73%	37	24	64.86%	--	--	--
3) 90% of clients will have a Primary Care Physician by discharge. **(CATS Program)**	68	82	83%	135	165	82%	237	172	72.57%	--	--	--
4) 80% of clients will successfully discharge. **(The Recovery Center)**	85	62	73%	80	42	53%	92	46	50.08%	--	--	--

*COVID restrictions prevented face-to-face sessions with CATS clients in ICJ, effective 12/1/21 to end of reporting period (and continuing into next quarter).

Consumer Satisfaction for Mental Health Case Management, Family Based Services, and Psychosocial Rehab Case Management

As part of the CMHA-CEI quality improvement efforts, a consumer satisfaction survey is administered annually to persons who are receiving services. The purpose of this survey is to help the agency gauge the level of satisfaction among consumers who are currently receiving services and determine ways to improve practices to better service consumers. The results of the survey help to measure the quality of CMHA-CEI services and the evaluation report summarizes the levels of satisfaction consumers have with their services. CARF Programs included in this survey for FY2022 were ACT, Case Management, Family Guidance Services, Parent Infant Program, Parent Young Child, Life Consultation, and Family Support Case Management

In 2021 and 2022, the Youth Services Survey (YSS) and Mental Health Statistics Improvement Program (MHSIP) survey were administered to a random selection of CMHA-CEI Consumers. While the CMHSPs in the region are responsible for administering the survey, the PIHP collects and maintain the data and survey findings.

Department	Distributed (2022)	Returned (2022)	Distributed (2020)	Returned (2020)	Distributed (2019)	Returned (2019)
AMHS	2,153	394 (18.3%)	1,998	261 (13.1%)	763	620 (84.2%)
Families Forward	1,180	112 (9.5%)	970	91 (9.4%)	112	109 (97.32%)
CSDD Adults	961	217 (22.6%	--	--	1013	285 (28.13%)
CSDD Youth	454	51 (11.2%)	--	--	--	--

Summary of General Satisfaction 2012-2019 (Including SUD)

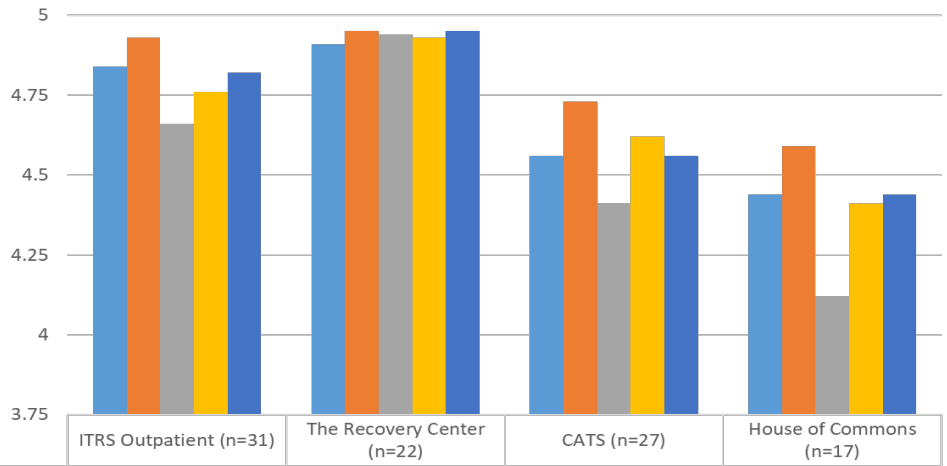
	2012 %	2013 %	2014 %	2015 %	2016 %	2017 %	2018 %	2019 %	2021-2022
1. CMHA-CEI responded promptly to my request for services.	91	91	91	90	91	87	88	91	Survey not completed FY2020 due to COVID-19 Transitioned from internal survey to MHSIP and YSS
2. CMHA-CEI staff are courteous and respectful.	96	94	96	95	95	95	94	96	
3. CMHA-CEI staff helps me to get the right type of services for my problem.	92	91	91	90	91	93	89	91	
4. In general, I am satisfied with the services provided by CMHA-CEI.	94	93	93	93	92	91	91	91	
5. CMHA-CEI staff understand my needs and situation.	92	91	92	90	90	90	90	90	
6. CMHA-CEI staff have the knowledge and skills to serve me well.	93	94	91	92	93	92	92	93	
7. If a friend or family member were in need of similar services, I would recommend my CMHA-CEI program to him or her.	92	90	89	90	90	88	88	89	
8. The services I receive help me to function better in my life.	91	91	91	90	90	89	89	91	
9. If I were to seek help again, I would come back to the same program.	99	89	91	90	89	89	89	91	
10. CMHA-CEI staff follows my person centered plan (PCP) or family centered plan.	91	91	90	89	89	89	88	92	
11. CMHA-CEI helped me identify natural supports.	87	87	85	84	87	83	85	88	

Summary of General Satisfaction (ITRS Programs 2022

ITRS FY2022 SUD Consumer Satisfaction Report (n=97)

Consumers from each ITRS program were surveyed on the quality of ITRS care using a series of 15 questions from 5 subscales.

A score of 5 indicates strongly agreeing with the question and positive outcomes.



More information on performance evaluations can be found in our annual Quality Improvement Plan (QIP) and QIP Evaluations found online here: http://ceicmh.org/about-us/quality-and-compliance

ICDP and CC360 Data

To assist CMHA Departments with Performance Improvement QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. In FY22, QI accessed the Integrated Care Delivery Platform (ICDP) to pull Service Utilization data for consumers enrolled in CCBHC services. QI increased access to monitor CCBHC specific measurements and address Care Alerts noted in the program. The Care Alerts identified as priorities to be addressed in FY22 were Diabetes Monitoring, Cardiovascular Screening, Follow-Up After Hospitalization for Mental Illness - Adults, and Follow-Up After Hospitalization for Mental Illness - Child. In FY23 QI will continue to monitor CCBHC specific measurements and address priority Care Alerts noted in the program.

Annual Submission to MDHHS FY22

Requests for Service and Disposition of Requests

	CMHSP Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	586	3217	1769	1085	6657
2	Is Info on row 1 an unduplicated count? (yes/**no**)	No	No	No	No	No
3	# referred out due to non-MH needs (of row 1)	38	116	43	64	261
4	Total # who requested services the CMHSP provides (of row1)	548	3101	1726	1021	6396
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	9	674	146	21	850
6	Of the # in Row 4 - How many people were scheduled for assessment	539	2427	1580	1000	5546
7	other--referred to SA treatment, referred to Crisis services	0	24	4	2	30
	CMHSP ASSESSMENT	**DD All Ages**	**Adults with MI**	**Children with SED**	**Unknown and All Others**	**Total**
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)	Unknown	Unknown	Unknown	Unknown	
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	Unknown	Unknown	Unknown	Unknown	
10	Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan	unknown	unknown	unknown	unknown	
11	Of the # in Row 6 - how many otherwise did not meet cmhsp non-entitlement eligibility criteria	216	1110	322	842	2490
11 a	Of the # in row 11 - How many were referred out to other mental health providers	unknown	unknown	unknown	unknown	
11 b	Of the # in row 11 - How many were not referred out to other mental health providers	unknown	unknown	unknown	unknown	
12	Of the # in Row 6 - How many people met the cmhsp eligibility criteria	323	1293	1254	156	3026
13	Of the # in Row 12 - How many met emergency/urgent conditions criteria	13	504	410	35	962

14	Of the # in Row 12 - How many met immediate admission criteria	unknown	unknown	unknown	unknown	
15	Of the # in Row 12 - How many were put on a waiting list	0	0	0	0	0
15 a	Of the # in row 15 - How many received some cmhsp services, but wait listed for other services	0	0	0	0	0
15 b	Of the # in row 15 - How many were wait listed for all cmhsp services	0	0	0	0	0
16	Other - explain	0	0	0	0	0

Priority Needs and Planned Actions - CMHSP's were asked to identify priority issues.

CMHSP's Planned Action and Response - Brief overview of CMHA-CEI's response and planned action to each priority issue.

Priority Issue	Reasons For Priority	CMHSP Plan	FY22 Update
1. **Access to Care**	Receiving record numbers or request for services.	CMHA-CEI is continuing to increase access to care through our clinics utilizing the CCBHC model. CMHA-CEI will continue to increase CCBHC services by working with the state on being a demonstration site and to continue to apply for CCBHC Expansion Grant funds.	Served an additional 943 individuals this year. (FY21 served 11,812, FY22 served 12,755) Continuing to work on increasing the number of individuals served, especially those in the mild and moderate population.
2. **Training of Direct Care Staff**	The pandemic put a hold on some in-person trainings like Culture of Gentleness Trainings.	Begin in-person Working with People (Culture of Gentleness) training during FY22 for internal and contracted direct care staff.	Began monthly Culture of Gentleness Training again and is open to internal and contracted staff. Looking to start piloting direct care providers to utilize the Improving MI Practice training platform managed by MDHHS to improve training compliance and provider more comprehensive training.
3. **Recruitment and Retention of Staff**	Behavioral health workforce shortage and would like to	Current efforts and plans for recruitment and retention are:	1. Wage increase to staff was completed in April 2022
	make CMHA-CEI the behavioral health employer of choice in our catchment area. Will need additional staff to serve a mild-to- moderate population in anticipation of CCBHC.	1. Wage Increase to all staff 2. Wage Compensation Study on positions a. Phase 1 completed for hardest-to-fill positions – Master's Level Clinical Positions and Nursing. Wage adjustment was done 4/1/22	2. Wage Compensation Study was completed in November 2022 3. An additional retention payment was issued in November 2022. 4. MSU Scholars Cohort launched with 8 staff 5. Media Campaign to recruit additional staff and have been able to fill some open positions. Also expanded recruitment

		b. Phase 2 to study wage and compensation for other positions not recently reviewed. 3. Retention payment implemented in December 2021 4. One-to-One Vacation buyout implemented in December 2021 5. Expanded Student Debt Relief for 2022 6. Planning for a MSU Scholars Cohort to launch in upcoming MSU summer and fall semesters. CEI will sponsor a cohort of nine (9) Bachelor's level clinical staff in obtaining a Master's of Social Work degree. 7. Media Campaign underway that includes commercials, digital ads, and billboards and is titled "Work at CMHA- CEI and make a difference". 8. Resume Manager Adaptive Leadership training and other manager training supports.	efforts to out of state Job Fairs to bring candidates to Michigan. 6. Adaptive Leadership Training resumed for Managers in 2022 and additional training will be offered in 2023. Resumed Quarterly Manager trainings.

4. Strain on Crisis Service Units and Emergency Departments due to lack of local psychiatric beds.	Individuals boarding in crisis services or hospital emergency units while waiting for hospital bed. Need for additional diversion services to prevent boarding.	CMHA-CEI has been informed that we will receive funds to start up a local Crisis Stabilization Unit for the Capital Area. A Crisis Stabilization Unit (CSU) is a structured, secure, and multidisciplinary service, functioning within a coordinated continuum of care, and is crucial in filling the gaps in our community in treating persons experiencing an acute episode of mental illness and/or substance use who are a risk to themselves or others. A CSU is a key element in reducing psychiatric hospitalizations, eliminating psychiatric boarding in emergency departments, and providing a resource for local law enforcement. CMHA-CEI will be working with local entities to plan for a local CSU.	CMHA-CEI has secured several streams of start-up funding for both staffing and renovations for the Crisis Stabilization Unit. Utilized the expertise of consultants, TBD Solutions, to develop internal workgroups. Each workgroup has its own charter with action steps. Have participated in MDHHS CSU Certification workgroup and have applied and been accepted into the MDHHS CSU pilot learning cohort, which will begin in 2023.
5. Lack of Housing options - Improve on access and delivery of housing resources to adults with SPMI.	Housing continues to be a universal need across the population of those persons with mental illness. CMHA CEI has addressed this need by adding staff in our AMHS Housing Unit. The priority exists to deliver this service to consumers in a way that best meets their needs and the needs of the community.	1. Continue to work with community partners for options for housing for adults with SPMI. 2. Add staff to provide community living services, case management, and provider support.	There continues to be a lack of housing options and recent closing of beds at state hospitals has increased the need. Have continued to work with local providers to open more AFC housing. Have grown the AMHS Housing Unit to include additional staff to assist with this need.