Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

2022–2023 PIP Validation Report

Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial or Ethnic Disparities Between the Black/African American Population and the White Population

for

Region 5—Mid-State Health Network

November 2023

For Validation Year 2

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Copyrights

1. Background

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Michigan, Department of Health and Human Services, (MDHHS)—responsible for the overall administration and monitoring of the Michigan Medicaid managed care program. MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

For this year's PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[1-1] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[1-2] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that **Region 5—Mid-State Health Network** referred to as **Mid-State Health Network** in this report, designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well **Mid-State Health Network** improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 16, 2023.

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Sept 21, 2023.

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and non-clinical areas.

For this year's 2022–2023 validation, **Mid-State Health Network** continued its clinical PIP topic: ***Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial or Ethnic Disparities Between the Black/African American Population and the White Population***. The PIP topic selected by **Mid-State Health Network** addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Summary

Through data analysis, **Mid-State Health Network** identified a disparity between its Black/African American and White populations for the PIP topic. The goals of the PIP are to improve the rate of members new to services, receiving a medically necessary service within 14 days of completing a biopsychosocial assessment for the Black/African American population and eliminate the identified disparity without a decline in performance for the White population. Receiving timely necessary services and addressing biological, psychological, and social influences improves overall mental and physical health and well-being.

Table 1-1 outlines the performance indicators for the PIP.

Table 1-1—Performance Indicators

PIP Topic	Performance Indicators
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial or Ethnic Disparities Between the Black/African American Population and the White Population	1. The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. 2. The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Validation Overview

For State Fiscal Year (SFY) 2022–2023, MDHHS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIHP's compliance with each of the nine steps listed in the CMS Protocol 1. With MDHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

Table 1-2—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the information and data needed to conduct the PIP validation from **Mid-State Health Network**'s PIP Submission Form. This form provides detailed information about **Mid-State Health**

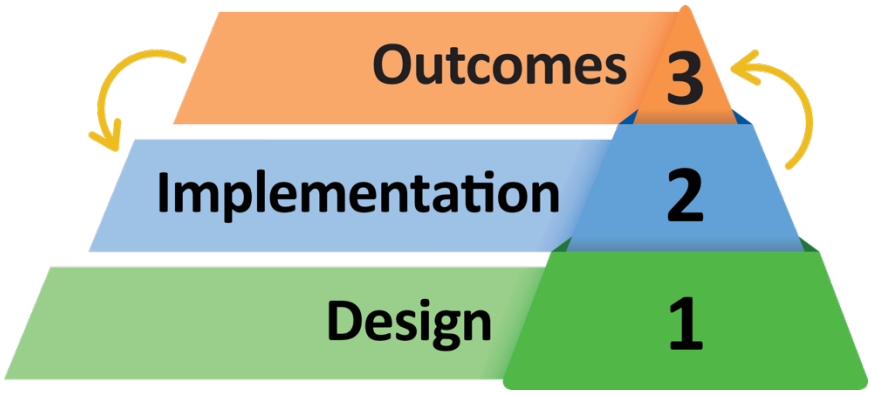
Network's PIP related to the steps completed and evaluated by HSAG for the 2022–2023 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. **Mid-State Health Network** would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides *Validation Feedback* with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure 1-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure 1-1—Stages



Once **Mid-State Health Network** establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7-8). During this stage, **Mid-State Health Network** evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or

programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, **Mid-State Health Network** should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

2. Findings

Validation Findings

HSAG's validation evaluated the technical methods of the PIP (i.e., the PIP design). Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 2-1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status.

Table 2-1 illustrates the validation scores for both the initial submission and resubmission.

Table 2-1—2022–2023 PIP Validation Results for Mid-State Health Network

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial or Ethnic Disparities Between the Black/African American Population and the White Population	Submission	100%	100%	*Met*
	Resubmission	*The PIHP did not resubmit*		

[1] **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the PIHP was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Mid-State Health Network submitted the Design and Implementation stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met*. The following subsections highlight HSAG's findings associated with each validated PIP stage.

Design

Mid-State Health Network designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. **Mid-State Health Network**'s Aim statement set the focus of the PIP, and the eligible population was clearly defined. **Mid-State Health Network** selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the PIP was sufficient to measure and monitor PIP outcomes.

Implementation

Mid-State Health Network met 100 percent of the requirements for the data analysis and implementation of improvement strategies. **Mid-State Health Network** used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to their corresponding barriers.

Outcomes

The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in 2024.

Analysis of Results

Table 2-2 displays baseline data for **Mid-State Health Network**'s ***Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial or Ethnic Disparities Between the Black/African American Population and the White Population*** PIP.

Table 2-2—Performance Improvement Project Outcomes for Mid-State Health Network

Performance Indicator Results				
Performance Indicator	**Baseline (1/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2023–12/31/2023)**	**Remeasurement 2 (1/1/2024–12/31/2024)**	**Sustained Improvement**
The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	65.04%			

Performance Indicator Results				
Performance Indicator	**Baseline (1/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2023–12/31/2023)**	**Remeasurement 2 (1/1/2024–12/31/2024)**	**Sustained Improvement**
The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	69.49%			

For the baseline, **Mid-State Health Network** reported that 65.04 percent of new Black/African American persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and that 69.49 percent of new White persons received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. The goals for the PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American population) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White population).

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The PIHP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the PIHP's overall success in achieving the desired outcomes for the PIP.

Mid-State Health Network's causal/barrier analysis process involved a QI team which brainstormed and developed a fishbone diagram to identify barriers to care. The PIHP prioritized the identified barriers based on potential impact to the affected communities, its strategic planning timeline, and available resources.

From these processes, **Mid-State Health Network** determined the following barriers and interventions in order by priority.

Table 2-3 displays the barriers and interventions as documented by the PIHP.

Table 2-3—Interventions Implemented/Planned

Barriers	Interventions
Workforce shortage; lack of qualified, culturally competent clinicians resulting in inadequate, limited available appointments within 14 days.	Recruit student interns and recent graduates from colleges and universities with diverse student populations. Use external contractors to provide services.

Barriers	Interventions
	Conduct a feasibility study to collect information from CMHSPs and substance use disorder (SUD) providers regarding specific cultural competency requests.
Members do not show up for appointments.	Implement an appointment reminder system and modify the process for coordination between providers.
Minority groups are unaware of services offered.	Identify and engage with partner organizations that predominantly serve communities of color. Distribute community mental health services program (CMHSP) informational materials to individuals through identified partner organizations within communities of color.
Lack of insight into what resources and community partners are available to address disparities.	Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community. Conduct an assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity.
Insufficient data to identify social determinants of health (SDOH) such as inadequate housing, food insecurity, transportation needs, and employment/income challenges.	Develop a system to effectively collect SDOH data for individuals served, also to regionally analyze SDOH data and develop action steps.

3. Conclusions and Recommendations

Conclusions

The ***Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population*** PIP received a *Met* validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across all steps validated, and a *Met* validation status. The PIHP developed a methodologically sound improvement project. The causal/barrier analysis process included the use of appropriate QI tools identify and prioritize barriers, and interventions were initiated in a timely manner.

Recommendations

Based on the validation of the PIP, HSAG has the following recommendations:

- **Mid-State Health Network** should ensure that it follows the approved PIP methodology to calculate and report the remeasurement data accurately in next year's submission.
- **Mid-State Health Network** should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions.
- **Mid-State Health Network** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- **Mid-State Health Network** should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

Appendix A. PIP Submission Form

Appendix A contains the final PIP Submission Form from **Mid-State Health Network** submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix A: State of Michigan 2022-23 PIP Submission Form
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Demographic Information			
PIHP Name: Midstate Health Network Region 5			
Project Leader Name:	Sandy Gettel	Title:	Quality Manager
Telephone Number:	517-220-2422	Email Address:	sandy.gettel@midstatehealthnetwork.org
PIP Title: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.			
Submission Date: July 14, 2023			
Resubmission Date (if applicable): Not Applicable			

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population **without a decline in performance for the White population**.

MDHHS has provided a broad focus for the PIP that is aligned with the Michigan Comprehensive Quality Strategy. PIHPs are to identify existing racial or ethnic disparities within the region(s) and populations served and determine its plan-specific topic and performance indicator(s).

Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. The topic was chosen to improve access and engagement with services addressing any racial disparities that exist during the onset of treatment.

The MSHN Quality Improvement Council, through consensus chose the following topic: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.

Provide <u>plan-specific</u> data: (Baseline CY21 data)

Baseline data was obtained for CY2021. The data was drawn from Michigan Mission Based Performance Indicator Data, Indicator 3 with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity. The Black/African American and White individuals were chosen for further analysis. A numerator and denominator were obtained for each group (Table 1), and the rate was calculated by dividing the numerator by the denominator.

Fisher's Exact Test was performed to determine if the black/African American minority group had a statistically significantly (p-value < 0.05) lower rate than the white (index) population. A 95% confidence interval and margin of error was also calculated for each group (Table 2). The black group (95% CI: 62.46, 67.62) had a statistically significantly lower rate than the white group (95% CI: 68.48, 70.49) with p-value = 0.0015.

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Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period in CY2023 to determine if the intervention strategies were a success.

Table 1: MSHN CMHSP Rates by Racial/Ethnic Group CY2021

Race/Ethnicity	Numerator	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper	p-value
Black/African American	852	1310	65.04%	2.58%	62.46%	67.62%	0.0015
White	5655	8138	69.49%	1.00%	68.48%	70.49%	Reference

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

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.

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Step 2: Define the PIP Aim Statement(s). Defining the aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s): Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment **without a decline in performance for the White population**?

1.

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition: The population includes all Medicaid individuals, adult and children, who are new to services and have received a Biopsychosocial Assessment by the PIHP.

The biopsychosocial must have been completed within the measurement period. If the completion of the biopsychosocial occurs over more than one visit the date of completion is when the professional has submitted an encounter for the assessment and has determined a qualifying diagnosis.

The African American/ Black and the white race and ethnicity will be obtained through the race/ethnicity field included in the 834 file. The 834 file is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. Information transmitted includes initial enrollment and subsequent maintenance of individuals who are enrolled in CHAMPS.

The PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20 (Attachment 2) is being utilized to identify the eligible population.

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Attachment 1: Appendix B: Crosswalk for Race or Ethnicity Code (page 21)

Enrollment requirements (if applicable):

Count as Medicaid eligible any person who qualified as a Medicaid Beneficiary during at least one month of the MDHHS MMBPIS defined reporting period. MDHHS defined reporting period is quarterly, therefore all individuals must be enrolled in Medicaid for at least one month per quarter to be included in this project.

This includes individuals with traditional Medicaid, Healthy Michigan, and both Medicaid and Medicare.

It should be noted that currently all Medicaid beneficiaries have continuous enrollment. Medical Service Administration as issued a bulletin on April 6, 2020, suspending all Medicaid Closures. Once the public health emergency is terminated the continuous enrollment will also be terminated over a specific period of time as indicated by MDHHS.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

The PHE ended May 11, 2023. Attachment 7a Policy Crosswalk table (Michigan.gov/mdhs/end-phe/Medicaid-benefitchanges/phe-unwind-policy-crosswalk) identifies the Medicaid response Bulletins and L letters issued with crosswalks to the corresponding Medicaid Bulletin or Letter.

The PHE policy action and impacts analysis from such action is included in Section 7.

Attachment 3a MSA 20-36
Attachment 3b MSA 20-19
Attachment 3c MSA 20-13
Attachment 3f MSA 20-28
Attachment 3g MSA 20-12

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

Inclusion, exclusion, and diagnosis criteria:

Inclusions

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Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Individuals who have received a completed Biopsychosocial during the measurement period, have been diagnosed with a mental illness and/or an intellectual developmental disability, and have been determined eligible for mental health or intellectual and developmental disability services.

Exclusions

Individuals covered under **the Omnibus Budget Reconciliation Act** (OBRA).

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):

Allowable assessment codes based on year, as indicated in Attachment 3d and Attachment 3e.

Definitions:

- Intellectual Disability and Developmental Disability as defined in the Mental Health Code 330.1100 (12 & 25)
- Mental Illness /Serious Emotional Disturbance as any MI DSM Diagnosis
- Individuals with both a mental illness and an intellectual or developmental disability should be categorized.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

- New is defined as either never seen by the PIHP for mental health services or for services for intellectual and developmental disability, or it has been 90 days or more since the individual had received any MH or IDD service from the PIHP.
- "Service" means any non-emergent face-to-face CMHSP service that is included in the person's plan of service or moves a person toward development of their plan of service.

Attachment 2: PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20

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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods should be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample: 100% of the Medicaid population is being used for the project.

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment
	The study topic aligns with the Michigan Mission Based Performance Indicator System (MMBPIS) Codebook Indicator 3, initiated in 2020 by MDHHS with the addition of the disparity analysis which supports MSHN's strategic priority to eliminate disparities among persons served offering the same access to all persons served. The African American/black population group is the largest minority group within the MSHN region.
Numerator Description:	Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment.
Denominator Description:	Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid State Health Network region and are determined eligible for

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	ongoing services. The records submitted for the MMBPIS reporting to MDHHS will be used for the denominator.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023
Remeasurement 2 Period	01/01/2024 to 12/31/2024
Mandated Goal/Target, if applicable	Eliminate the disparity without decreasing the performance of the index (white) population group. Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.
Indicator 2	The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	The study topic aligns with the Michigan Mission Based Performance Indicator System (MMBPIS) Indicator 3, initiated in 2020 by MDHHS with the addition of the disparity analysis which supports MSHN's strategic priority to eliminate disparities among persons served offering the same access to all persons served. The white population group is the largest population group within the MSHN region.
Numerator Description:	Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment.
Denominator Description:	Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services. The records submitted for the MMBPIS reporting to MDHHS will be used for the denominator.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023
Remeasurement 2 Period	01/01/2024 to 12/31/2024

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Mandated Goal/Target, if applicable	Eliminate the disparity without decreasing the performance of the index (white) population group. Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

Use this area to provide additional information.

Numerator Exclusion-

Emergent services are excluded from the numerator. The following codes are considered emergent services:

- Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, H2011
- Intensive Crisis Stabilization, S9484
- Screening for Inpatient Program, T1023
- Psychotherapy for Crisis, 90839 & 90840
- Crisis Residential, H0018
- Any service from a psychiatric inpatient stay

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

    - Partial Hospitalization if T1023 reported, 0912, 0913.

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	[x] Administrative Data Data Source [x] Programmed pull from claims/encounters. [ ] Supplemental data [x] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [x] Appointment/access data [ ] Delegated entity/vendor data _____ [x] Other ____834 eligibility files_____ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately.	[ ] Survey Data Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	[ ] Data completeness assessment attached. [ ] Coding verification process attached. Estimated percentage of reported administrative data completeness at the time the data are generated: __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	

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	encounters that have been submitted to MDHHS successfully and matched with monthly reconciliation reports.	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Step 1: MSHN, through REMI (Managed Care Information System) receives an automated downloads of the Medicaid eligibility files (834) from the File Transfer Service (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: MSHN, through REMI (Managed Care Information System) receives an affiliate upload (Affiliate PI Output File) from each CMHSP quarterly. The affiliate upload is administrative data, obtained from their EMR. Step 6: MSHN, combines, and validates the Affiliate PI Output File to create a PIHP PI File. Step 7: MSHN uses the Medicaid ID to match the race/ethnicity data from the 834 files with each member record in the PIHP PI File. Step8: The eligible population (denominator) will be the member records that are included in PIHP PI file with the race/ethnicity data. Step 9: The eligible population (numerator) will be the member records in the PIHP PI file with race/ethnicity data (denominator) that have a "in compliance" in the service column indicating administrative data has been received for a medically necessary ongoing covered service table where the Medicaid ID matches the Medicaid eligible enrollees in the denominator. The data utilized to determine the study indicator rate will be retrieved 60 days after the end of the measurement period. This will take into account the time lag allowed for the submission of claims for the CMHSP consumers and ensure the completeness and accuracy of the data in determining the study indicator rate.

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
01/01/2021–12/31/2021	**Baseline**	852	1310	65.04%	N/A for baseline	Fisher's Exact Test Statistically lower than the index white group p-value = 0.0015
01/01/2023–12/31/2023	**Remeasurement 1**					
01/01/2024–12/31/2024	**Remeasurement 2**					

Indicator 2 Title: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

01/01/2021-12/31/2021	**Baseline**	5655	8138	69.49%	N/A for baseline	Reference
01/01/2023–12/31/2023	**Remeasurement 1**					
01/01/2024–12/31/2024	**Remeasurement 2**					

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Baseline Narrative:

Baseline data was obtained for CY2021. The data was drawn from MMBPIS Indicator 3 data with 834 Race/Ethnicity data included. The individuals were broken down by race/ethnicity, and the Black/African American and White individuals were chosen for further analysis. 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.

Fisher's Exact Test was performed to determine if the black/African American minority group had a statistically significantly (p-value < 0.05) lower rate than the white (index) population. A 95% confidence interval and margin of error was also calculated for each group (Table 2). The black group (95% CI: 62.46, 67.62) had a statistically significantly lower rate than the white group (95% CI: 68.48, 70.49) with p-value = 0.0015.

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- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Race/Ethnicity	Numerator	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper	p-value
Black/African American	852	1310	65.04%	2.58%	62.46%	67.62%	0.0015
White	5655	8138	69.49%	1.00%	68.48%	70.49%	Reference

The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period in CY2023 to determine if the intervention strategies were a success.

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

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- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

The following factors may affect the validity of the baseline and future remeasurement findings:

- Individuals who were unsure about their race/ethnicity or did not understand the question, and as a result, marked the incorrect category. It is likely, however, that these were not factors for most individuals and will not greatly impact the results.
- The termination of the public health emergency (PHE). Currently under the public health emergency (PHE) MDHHS has issued MSA Bulletins that suspend Medicaid disenrollment and incorporate telehealth services into the service array available. Once the PHE ends, a specific period of time is allotted to account for any changes to state policy. It is unknown at this time when the PHE will end. After such time, Michigan must initiate Medicaid renewals over a period of a 12-month unwinding period. The impact is unknown at this time and will be assessed once the PHE has ended. **The PHE expired at the end of the day May 11, 2023. Michigan has begun the unwinding phase. Medicaid policies have been**

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

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- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

developed to "unwind" policies that were implemented during the pandemic. Table 1 identifies specific action and policies that are impacted.

- **Potential changes in utilization of telehealth services from CY2021 to CY2023**
- Modifications by MDHHS to the specification documents currently used to support the project may affect the data.
  MDHHS combined the race and ethnicity fields within the 834, therefore a manual process was used to accurately obtain the race and ethnicity information.

The factors identified will be assessed. Processes will be put in place to ensure minimal, if any, impact on the data used for the project. **Table 1 provides an outline of the potential impact from policy changes.**

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

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- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Table 1: MDHHS Policy Impact Analysis Grid

PHE Temporary Bulletin	PHE Unwind Policy Action	Impact on Project
MSA 20-36	Bulletin to clarify temporary policies/procedures. MSA 20-36 includes bulletins listed below.	See below
MSA 20-12	MMP 23-17	No direct impact on this project
MSA 20-13	MMP 23-10 (Attachment 3h)	Telemedicine utilization (include summary of trends)

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

MSA20-14	MMP 22-40	No direct impact on this project
MSA 20-16	MMP 23-34	No direct impact on this project
MSA 20-17	MMP 20-41	No direct impact on this project
MSA 20-18	MMP 23-27	No direct impact on this project
MSA 20-19	MMP 23-30	Direct impact on number of enrollees whose data has been included within the baseline data.
L 20-20	L 23-31	No direct impact on this project
MSA 20-28	MMP 22-38	Direct impact on number of enrolled providers and individuals qualified who are available to provide services.

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

MSA 20-12	MMP 23-20 (Attachment 3j)	Direct impact on the number of those who have completed an assessment and consented to additional treatment through verbal communication.

Attachment 3a MSA 20-36
Attachment 3b MSA 20-19
Attachment 3c MSA 20-13
Attachment 3f MSA 20-28 (new)
Attachment 3g MSA 20-12 (new)

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Attachment 7a MDHHS PHE Unwind Policy Crosswalk (new)
Attachment 7b Final Bulletin MMP 22-38 (new)
Attachment 7c Final Bulletin MMP 23-10 (new)
Attachment 7d Final Bulletin MMP 23-20 (new)
Attachment 7e Final Bulletin MMP 23-30 (new)
No other factors that might threaten the comparability of the measurement periods were identified.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Quality Improvement Team and Activities Narrative Description: Under the measurement period placeholder below corresponding to the most recent completed measurement period, add a description of the quality improvement team members, the causal/barrier analysis process, and quality improvement tools used to identify and prioritize barriers for each measurement period below.

Baseline Narrative: The QI Team consists of the MSHN regional Quality Improvement Council, representatives from the Regional Equity Advisory Committee for Health (REACH), representatives from the MSHN regional Clinical Leadership Committee, the MSHN Integrated Healthcare Coordinator, the Technology Project Manager, and the Reports/ Data Coordinator. The fishbone diagram was used to identify barriers. Brainstorming was used to identify potential interventions. The interventions were prioritized based on the potential impact to the affected communities, strategic planning timeline, and available resources. MSHN has 21 counties within the region. Due to the variability of the communities and populations within the 21-county catchment area, interventions are identified, implemented, and evaluated to ensure the barrier has been effectively addressed and the expected outcome has been achieved within the corresponding community.

Attachment 8 Fishbone Diagram PIP 1 Access-Reduction/Elimination of Racial Disparities

Remeasurement 1 Narrative:

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Remeasurement 2 Narrative:

Barriers/Interventions Table: In the table below, report prioritized barriers, corresponding interventions, and intervention details (initiation date, current status, and type.

Barrier Priority Ranking	Barrier Description	Intervention Initiation Date (MM/YY)	Intervention Description	Select Current Intervention Status	Select if Member, Provider, or System Intervention
4	Lack of insight into what resources and community partners are available to address disparities.	10/1/2023	• Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community.	New	Provider Intervention

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

			• Conduct assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity.		
2	No shows-lack of appointment follow up	10/1/2022	• Implement appointment reminder system. • Implement/modify process for coordination between providers (warm hand off)	New	Provider Intervention
1	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in inadequate limited available appointments within 14 days.	10/1/2022	• Recruit student interns and recent graduates from colleges and universities with diverse student populations. • Utilize external contractors to provide services.	New	Provider Intervention

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

5	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in limited available appointments within 14 days.	12/31/2022	• Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.	New	System
3	Minority Groups are not aware of services offered	10/1/2023	• Identify and engage with partner organizations that predominantly serve communities of color. (Examples: faith- based/religious groups, community recreation centers, tribal organizations, etc.) • Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	New	Provider

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

6	Insufficient data to identify Social Determinants of Health (SDOH) such as inadequate Housing, food insecurity, transportation needs, employment/income challenges	6/1/2024 11/1/2024	• Develop system to effectively collect SDOH for individuals served. • Develop system to regionally analyze SDOH and develop action steps.	New New	Provider System

Intervention Evaluation Table: In the table below, list each intervention that was included in the Barriers/Interventions Table, above. For each intervention, document the processes and measures used to evaluate effectiveness, the evaluation results, and next steps taken in response to the evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.

Appendix A: State of Michigan 2022-23 PIP Submission Form Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population for Region 5 – Mid-State Health Network

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps
CY23	Increase the workforce through recruitment of student interns and recent graduates from colleges and universities with diverse student populations, and external contractors to provide services. .	Identify CMHSPs who have utilized interns, and external contractors to determine if the number of appointments scheduled outside of 14 days due to no available appointments has decreased.		
CY23	Implement appointment reminder system.	Identify CMHSPs who have implemented an appointment reminder system and assess if the number of no shows has decreased.		

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

CY23	Implement/modify process for coordination between providers (warm hand off)	Identify those CMHSPs who have implemented or modified a coordination process between providers who complete the assessment and those who provide treatment and assess if the attendance for 1st service appointments has increased.		
CY24	Identify and engage with partner organizations that predominantly serve communities of color. (Examples: faith-based/religious groups, community recreation centers, tribal organizations, etc.)	Identify those CMHSPs that have engaged with partner organization have demonstrated a decrease in the disparity.		

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

CY24	Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	Identify those CMHSPs that have distributed materials through partner organizations within communities of color have had an increase in the number of Black/African American that have completed an assessment		
CY24	Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community. Conduct assessment/survey to clearly identify community partners and resources	CMHSPs that have communities of color will have developed a collaborative group to address disparities		

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

	available to address disparities within those communities that demonstrate a significant disparity.			
CY24	Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.	Cultural competency requests will be defined, with a process to collect the requests, and types of requests will be identified.		

Clinical and Programmatic Improvement Table: In the table below, describe any clinical and/or programmatic improvement that was achieved at any remeasurement period during the PIP. Specify each remeasurement period when improvement was obtained and the intervention(s) that led to the improvement. Provide intervention evaluation results in the *Supporting Quantitative or Qualitative Data* column.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Clinical Improvement		
Remeasurement Period	**Narrative Summary of Clinical Improvement**	**Supporting Quantitative or Qualitative Data**
Programmatic Improvement		
Remeasurement Period	**Narrative Summary of Programmatic Improvement**	**Supporting Quantitative or Qualitative Data**

Appendix B. PIP Validation Tool

The following contains the final PIP Validation Tool for **Mid-State Health Network**.

Demographic Information			
PIHP Name:	Region 5 - Mid-State Health Network		
Project Leader Name:	Sandy Gettel	**Title:**	Quality Manager
Telephone Number:	517.220.2422	**Email Address:**	sandy.gettel@mmidstatehealthnetwork.org
PIP Title:	Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service		
Submission Date:	July 13, 2023		
Resubmission Date:	Not Applicable		

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. N/A is not applicable to this element for scoring.	C*	*Met*	
2. Has the potential to affect member health, functional status, and/or satisfaction. The scoring for this element will be ***Met*** or ***Not Met***.		*Met*	
Results for Step 1			
Total Evaluation Elements**	**2**	**1**	**Critical Elements*****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	

Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored Not Applicable [N/A]). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).		*N/A*	
2. Included the title of each indicator.		*N/A*	
3. Included the sampling frame size for each indicator.		*N/A*	
4. Included the sample size for each indicator.	C*	*N/A*	
5. Included the margin of error and confidence level for each indicator.		*N/A*	
6. Described the method used to select the sample.		*N/A*	
7. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**7**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	7	2	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	1	1	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Results for Step 1 - 6			
Total Evaluation Elements	**17**	**8**	**Critical Elements**
Met	9	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	8	3	*N/A*

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Not Assessed*	
2. Included a narrative interpretation of results that addressed all requirements.		*Not Assessed*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Not Assessed*	
Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.		*Met*	
3. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
4. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
5. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	The PIHP should have evaluation processes in place for each intervention initiated and report that process within the Intervention Evaluation Table.
6. Interventions that were continued, revised, or discontinued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Evaluation Elements**	**6**	**3**	**Critical Elements*****
Met	4	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Results for Step 7 - 8			
Total Evaluation Elements	**9**	**4**	**Critical Elements**
Met	4	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

Evaluation Elements	Critical	Scoring	Comments
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Significant improvement in performance is evaluated based on evidence that there was statistically significant improvement over baseline indicator performance OR significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes. Sustained improvement is only assessed after statistically significant improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate statistically significant improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.		*Not Assessed*	
2. The Performance Indicator(s) met the State-specific goal of eliminating the existing disparity.		*Not Assessed*	
3. At least one of the following was demonstrated: ☐ *Statistically significant* improvement over baseline indicator performance (95 percent confidence level, $p < 0.05$). ☐ Significant *clinical* improvement in processes and outcomes. ☐ Significant *programmatic* improvement in processes and outcomes.		*Not Assessed*	
4. Sustained statistically significant improvement over baseline indicator performance was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	

Results for Step 9			
Total Evaluation Elements**	**4**	**0**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A	0	0	*N/A*

** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Table B–1—2022—23 PIP Validation Tool Scores for *Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Services* for Region 5 - Mid-State Health Network										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total Partially *Met***	**Total *Not Met***	**Total *N/A***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *N/A***
1. Review the PIP Topic	2	2	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	7	0	0	0	7	2	0	0	0	2
5. Review the PIP Indicator(s) of Performance	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	*Not Assessed*				1	*Not Assessed*			
8. Assess the Improvement Strategies	6	4	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				0	*Not Assessed*			
Totals for All Steps	**30**	**13**	**0**	**0**	**8**	**12**	**7**	**0**	**0**	**3**

Table B–2—2022—23 PIP Validation Overall Score for *Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Services* for Region 5 - Mid-State Health Network	
Percentage Score of Evaluation Elements *Met* *	**100%**
Percentage Score of Critical Elements *Met* **	**100%**
Validation Status***	***Met***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.* The Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Validation Status: See confidence level definitions on next page.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:	
Met:	High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.
Partially Met:	Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met*.
Not Met:	No confidence in reported PIP results. All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met*.
Validation Status:	***Met***