Delegated Managed Care Quality Assurance Review Summary Report Fiscal Year 2022

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CMHSP Delegated Managed Care Review (DMC)

MSHN conducted full Delegated Managed Care (DMC) reviews for three of the twelve (3/12) Community Mental Health (CMH) agencies within the region in FY22 Q1. Full reviews include a full programmatic review of policies, procedures, and sample files and charts.

MSHN conducted nine of twelve (9/12) interim Delegated Managed Care reviews for CMH's within the region during FY22 Q2-Q4. Interim reviews ensure that all approved corrective action from the previous review has been implemented. In addition, the interim reviews include a review of any new standards identified from contractual or regulatory changes and additional review of charts and files (as applicable) to ensure compliance.

Scoring below represents the three (3) full reviews completed by MSHN during FY22Q1.

Delegated Managed Care Review Tool

Includes review of 192 standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95.47%.

Table 1: Delegated Managed Care Tool

Sections	# Of Standards	FY22 Q1 Results
Information Customer Service	13	100%
Enrollee Rights and Protections	9	100%
24/7/365 Access	17	94.12%
Provider Network Sub-Contract Providers	14	100%
Service Authorization and UM	7	100%
Grievance and Appeals	20	98.75%
Person Centered Planning	30	99.44%
Coordination of Care/Integration	6	100%
Behavior Treatment Plan Review Committee	21	72.22%
Consumer Involvement	3	100%
Provider Staff Credentialing	22	96.83%
Quality and Compliance	7	100%
Ensuring Health and Welfare	8	92.86%
Information Technology	9	100%
Trauma Informed Care	6	100%

Scores represent Oct1- Dec 31, 2021.

Program Specific (PS) Non-Waiver Review Tool

Includes review of fifty-eight (58) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 98.29%.

Table 2: Program Specific Non-Waiver Tool

Sections	# Of Standards	FY22 Q1 Results
ACT	5	100%
Self-Direction/Self-Determination	8	100%

Sections	# Of Standards	FY22 Q1 Results
Peer Delivered and Operated (Drop In)	2	100%
Home-Based Services	6	97.06%
Clubhouse	7	100%
Crisis Residential	10	100%
Targeted Case Management	4	100%
Autism/ABA	9	92.59%
Children's Intensive Stabilization Services	7	100%

Scores represent Oct 1- Dec 31, 2021.

Program Specific (PS) Waiver Review Tool

Includes review of forty-five (45) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 94.31%.

Table 3: Program Specific Waivers Tool

Sections	# Of Standards	FY22 Q1 Results
Habilitation Supports Waiver	7	91.67%
Home and Community Based Services	14	91.67%
Children's Waiver Program	12	93.55%
Severe Emotional Disturbances Waiver	12	100%

Scores represent Oct 1- Dec 31, 2021

Clinical Chart Review Tool

Includes review of eighty-five (85) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 93.98%.

Table 4: Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	FY22 Q1 Results
Intake/Assessment	13	96.74%
Pre-Planning	10	85.12%
PCP/IPOS	21	95.56%
Documentation	3	100%
Customer Service	5	99.09%
Delivery and Evaluation	3	91.82%
Service Delivery	23	92.81%
Discharge/Transfers	4	100%
Integrated Physical/Mental Health Care	3	95.10%

Scores represent Oct 1- Dec 30, 2021

Encounters and BHTEDs Review

Includes a sample review of professional encounters and institutional encounters to ensure compliance in addition to a review of CMHSP business processes related to FY21 CLS changes and LOCUS scores.

Table 5: Encounters and BHTEDs Business Process Review Tools

Encounters and Business Processes	FY22 Q1 Results
Professional Encounters Review	100%
Institutional Encounters Review	100%
BHTEDS/Encounters Business Processes- CLS Changes	100%

Scores represent Oct 1- Dec 31, 2021

Strengths

- In most cases, the HCBS charts the individuals hopes and dreams, wants and needs were addressed and emphasized in the charts reviewed.
- CMHSPs were 100% compliant with FY21 CLS change implementation regarding encounters and business practices.
- CMHSPs have strong consumer involvement in many aspects of day-to-day activities and decisions.

Areas for Improvement

All review findings require corrective action. QAPI shares all review scores and review information within the department quarterly report. The reports are shared with all departments and those departments determine if further action, beyond corrective action, and address as necessary.

- Behavior Treatment continues to be an area that the region struggles with, primarily, meeting all of the required standards as outlined in the MDHHS Technical Requirements. MSHN conducted additional reviews for providers that did not reach 90% (based on evaluation of cumulative scores) compliance during the 2022 calendar year.
- Credentialing files are often missing the NPDB inquiry or allowable alternative documentation. Additionally, some files were not approved by a credentialing committee or a designated credentialed staff. Credentialing primary source verification is not always completed timely.
- Amount, scope, and duration was not met in several charts reviewed.

SUDSP Treatment Provider Delegated Function Reviews

QAPI completed both full and interim reviews during the FY2022 timeframe. The QAPI team conducted twelve (12) full reviews and sixteen (16) interim reviews throughout October 1, 2021 – September 2022.

Interim reviews include a review of any new standards identified for the year and review to ensure implementation of approved corrective action from the previous review. Interim reviews are not scored.

Full reviews include consumer chart reviews, sample files to verify processes, policies, and procedures. Each provider review is inclusive of all provider sites within the MSHN Region. For providers that are located outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region the providers are located.

It should be noted that review tools are updated annually and implemented by calendar year. Each review tool below will have a table to reflect FY22Q1 outcomes and a table to reflect FY22Q2-Q4 outcomes.

Delegated Functions Tool Results

Table 8.1: FY22Q1 SUD Delegated Functions Scores

Sections	# Of Standards	Results
Access and Eligibility	4	100%
Information and Customer Service	17	100%
Enrollee Rights and Protections	14	100%
Grievance and Appeals	17	98.04%
Quality and Compliance	15	100%
Individualized Treatment & Recovery Planning & Documentation	17	98.98%
Coordination of Care	4	100%
Provider Staff Credentialing	22	84.75%
IT Compliance/IT Management	1	100%
Total Overall	**111**	**97.34%**

Scores represent Oct 1- Dec 31, 2021

Table 8.2: FY22Q2-Q4 SUD Delegated Functions Scores

Sections	# Of Standards	Results
Access and Eligibility	4	85.42%
Information and Customer Service	17	99.02%
Enrollee Rights and Protections	14	96.20%
Grievance and Appeals	17	92.16%
Compliance	11	100%
Quality	4	88.24%
Individualized Treatment & Recovery Planning & Documentation	14	78.05%
Coordination of Care	8	76.04%
Provider Staff Credentialing	22	79.10%
IT Compliance/IT Management	1	100%
Trauma Informed Care	6	74.29%
Total Overall	**118**	**88.07%**

Scores represent Jan 1- Sept 30, 2022

Program Specific Results

The Program Specific tool includes a review of specific treatment programs that are not applicable to all providers.

Table 9.1: FY22Q1 SUD Program Specific Scores

Sections	# Of Standards	Results
ASAM	1	100%
Residential	2	NA
Peer Recovery Support Services	1	100%
Women's Specialty Services	3	83.33%
Medication Assisted Programs	10	NA
Recovery Residences	10	100%
Total Overall	**27**	**98.68%**

Scores represent Oct 1- Dec 31

Table 9.2: FY22Q2 – Q4 SUD Program Specific Scores

Sections	# Of Standards	Results
Residential	2	83.33%
Peer Recovery Support Services	1	50%
Women's Specialty Services	3	83.33%
Medication Assisted Programs	10	81.25%
Recovery Residences	9	83.33%
Total Overall	**25**	**79.17%**

Scores represent Jan 1- Sept 30, 2022

Consumer Chart Review Results

Table 10.1: FY22Q1 SUD Chart Review Scores

Sections	# Of Standards	Results
Screening, Admission, Assessment	8	91.07%
Treatment/Recovery Planning	10	83.67%
Progress Notes	2	90.63%
Coordination of Care	4	80%
Discharge/Continuity of Care	3	100%
Residential	5	NA
Medication Assisted Treatment	16	70%
Women's Designated/Women's Enhanced	2	100%

Sections	# Of Standards	Results
Recovery Housing	6	80%
Total Overall	**56**	**85.27%**

Scores represent Oct 1- Dec 31

Table 10.2: FY22Q2-Q4 SUD Chart Review Scores

Sections	# Of Standards	Results
Screening, Admission, Assessment	7	73.20%
Treatment/Recovery Planning	10	73.57%
Progress Notes	3	75.93%
Coordination of Care	4	55.84%
Discharge/Continuity of Care	3	74.07%
Residential	4	85.71%
Medication Assisted Treatment	15	60%
Women's Designated/Women's Enhanced	2	77.27%
Recovery Housing	6	45%
Total Overall	**54**	**71.16%**

Scores represent Jan 1- Sept 30, 2022.

Strengths

- Since the implementation of Adverse Benefit Determination letters in REMI there has been improvement with compliance.
- SUD providers have compliance plans, policies, procedures that meet all requirements.
- The SUD network continues to show resiliency while enduring staffing issues.

Areas for Improvement

All review findings require corrective action. QAPI shares all review scores and review information within the department quarterly report. The reports are shared with all departments and those departments determine if further action, beyond corrective action, and address as necessary.

- Pre-screen in REMI are not always in policies and procedures or fully completed in REMI.
- Clinical charts indicate low compliance when reviewing for effective coordination of care for any consumer currently or previously enrolled with external SUD provider and coordinating care efforts align with best practice guidelines.
- Coordination with MDOC supervising agents is not always outlined in policies and procedures.
- FASD policies and procedures do not include all elements/requirements.
- Credentialing files do not always include all elements. The most common findings include Credentialing was not approved by a credentialing committee or designated credentialed alternative, NPDB reports were not always present or the allowable three alternative documentation requirements.