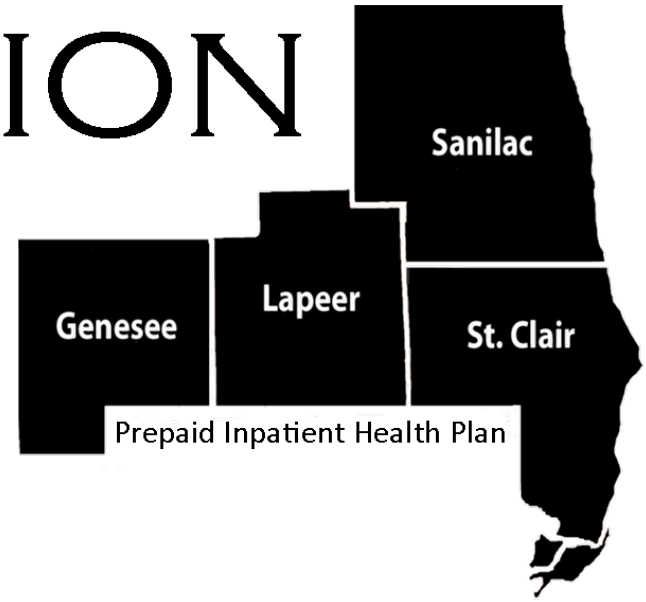
REGION 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2025

Quality Improvement Fiscal Year (FY) 2025 Work Plan (October 1, 2024 – September 30, 2025)

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Annual Evaluation	The goals for FY2025 Reporting Year are as follows: • Submit FY2024 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 10/1/2024. o Present the Annual Evaluation to the Quality Improvement Committee. The Quality Improvement Committee will be responsible for providing feedback on the qualitative analysis, proposed interventions, and implementation plan. o After presentation to the Quality Improvement Committee, the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Divine May Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q1 (Oct-Dec)** **The FY2024 Quality Improvement (QI) Program and Workplan has been presented and approved by the PIHP Board. It is being prepared for submission to MDHHS.** **Q2 (Jan-Mar)** **Region 10's FY2024 QI Program Annual Report, FY2025 Quality Improvement Program & Workplan, MDHHS Governing Body Form, and related Performance Improvement Project (PIP) materials for PIPs #1 and #2 were submitted timely to MDHHS in the 2nd quarter.** **Q3 (April-June)** **This goal is considered met as the FY2024 Quality Improvement (QI) Program and Workplan has been approved by Quality Improvement Committee (QIC) and the Region 10 PIHP Board.** **Q4 (July-Sept)** **No updates. The FY2024 Quality Improvement (QI) Program and Workplan was submitted timely. The FY2025 Program Evaluation will be submitted to the QIC and PIHP Board for approval in September.** **Evaluation: This goal has been met. The October 1, 2024, deadline was met for presentation and approval of the FY2024 Annual Evaluation by both the Quality Improvement Committee (QIC) and the Region 10 PIHP Board.** **Barrier Analysis: No barriers were encountered.** **Next Steps: This goal will carry over into FY2026.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Program Description	The goals for FY2025 Reporting Year are as follows: • Submit FY2025 QI Program Description and QI Workplan to Quality Improvement Committee and the Region 10 PIHP Board by 11/1/2024. o Review the previous year's QI Program and make revisions to meet current standards and requirements. o Include changes approved through committee action and analysis. • Develop the FY2025 QI Program Work Plan standard by 11/1/2024. o Present the work plan to the committee by 11/1/2024. o Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year. o Prepare work plan including measurable goals and objectives.	Divine May Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q1 (Oct-Dec)** **The Quality Improvement Committee (QIC) and the Region 10 PIHP Board approved the QI Program and Workplan at their respective October meetings. The FY2025 QI Program and Workplan are being prepared for submission to MDHHS. Responsible staff designations in the areas of Provider Network, Verification of Services, and Members Experience were updated to reflect organizational structure changes at the PIHP.** **Q2 (Jan-Mar)** **In the 2nd quarter, responsible Staff designations for the areas of Aligned Systems of Care; Event Reporting; Members' Experience; Utilization Management; Credentialing and Privileging; Corporate Compliance; and Substance Use Disorder (SUD) Health Home were changed to reflect current job tasks.** **Q3 (April-June)** **In the 3rd quarter, responsible staff designations in the areas of Certified Community Behavioral Health Clinic (CCBHC) Demonstration; 1915(i)SPA; Michigan Mission Based Performance Indicator System (MMBPIS); and Long-Term Services & Supports were updated to reflect current job tasks.** **Q4 (July-Sept)** **In the 4th quarter, responsible staff designations in the areas of QI Program Structure, Credentialing/Privileging and Verification of Services were updated to reflect changes to job task assignments.** **Evaluation: This goal has been met as the PIHP was able to meet the stated November 1, 2024, submission deadline for Board approval.** **Barrier Analysis: No barriers identified**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps:</u> This goal will carry over into FY2026.
Aligned System of Care	The goals for FY2025 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service. o Monitor utilization of the PIHP Clinical Practice Guidelines. o Complete annual and biennial evaluation reports as per policy. o Review Evidence-Based Practices (EBPs) and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., Integrated Dual Disorders Treatment (IDDT), Level of Care Utilization System (LOCUS), Opioid Health Home (OHH). o Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan. o Support CMHSP implementation of the nine core Certified Community Behavioral Health Clinic (CCBHC) EBPs.	Crystal Eddy Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec)** **This Clinical Practice Guidelines (CPG) Annual Evaluation Report was completed and reviewed for final feedback. Sanilac CMH presented its recent ACT/IDDT MiFAST review report. The End of Fiscal Year (EOFY) Level of Care Utilization System (LOCUS) Implementation Plan Report and the FY2025 LOCUS Implementation Plan were completed and reviewed for final feedback. The Employment Services Committee (ESC) quarterly report was reviewed, and support was noted for GHS' plans to implement Individual Placement and Support (IPS) during FY2025. The Certified Community Behavioral Health Clinic (CCBHC) evidence-based practices (EBP) discussion took place at the December meeting, with follow up monitoring and support activities beginning in January. MichiCANS implementation monitoring and annual training requirements were discussed, along with current issues experienced by the CCBHCs in accessing detailed information on the Screening tool. The updated SAMHSA Opioid Treatment Provider (OTP) best practices document was briefly discussed, and programs were encouraged to access this document as needed.** **Q2 (Jan-Mar)** **IPLT members discussed Clinical Practice Guidelines FY 2025 evaluation activities. IPLT members have been provided with the UM Analysis Report for review and have been asked to provide recommendations for services evaluation prior to the April IPLT meeting.** **Q3 (April-June)** **The Committee continued efforts to identify clinical practices for review and evaluation in the Annual Evaluation Report. During the June meeting the committee narrowed the service typed to Case**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Management, Wraparound, Peer Supports, and Crisis Intervention services. The scope of evaluation will be further discussed in upcoming meetings. Additionally, progress is being made toward the biennial evaluation report. **Q4 (July-Sept)** **In quarter 4, the Improving Practices Leadership Team (IPLT) selected clinical services to be reviewed for the Clinical Practice Guidelines (CPG) Annual Evaluation Report which will include a review of Wraparound, Peer Support, and Crisis Intervention Services. The committee contributed to furthering the work of the Biennial Evaluation by finalizing the PIHP's evidence-based practice (EBP) offerings. Lastly, the LOCUS Annual Plan Mid-Year Report was completed and reviewed by the IPLT.** **<u>Evaluation:</u> This goal has been met** **<u>Barrier Analysis:</u> No barriers identified** **<u>Next Steps:</u> Continue goal to FY 2026**
Employment Services	The goals for FY2025 Reporting Year are as follows: • Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC). Monitor quarterly ESC meetings designed to facilitate share and learn discussions on: o CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) o Standardized employment services data and report formats o In-service / informational materials o Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS])	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q1 (Oct-Dec)** **Individual Placement and Support (IPS) training updates and share and learn discussion took place. The Employment Services Committee (ESC) quarterly report was reviewed at the Improving Practices Leadership Team (IPLT) meeting, and support was noted for GHS' plans to implement IPS during FY2025.** **Q2 (Jan-Mar)** **GHS is continuing its IPS implementation planning and St. Clair CMH has begun its pilot IPS for person with I/DD. Demand for employment services is increased throughout the region and programs and working hard to increase service capacity. Feedback from employment services case holders indicate no**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Discuss/support consideration of Individual Placement and Support (IPS) service model.		**issues with utilizing the service request auto-approval system.** **Q3 (April-June)** **At the May quarterly meeting, the St. Clair IPS 2Q report was reviewed. Discussion covered this EBP report format and findings, noting standards of practice and favorable service outcomes. Group discussion also took place regarding member participation in the April MDHHS Recharging Competitive Employment quarterly meeting, where program successes and celebrations were shared.** **Q4 (July-Sept)** **The Employment Services Committee (ESC) met per its quarterly schedule. Share and learn discussions took place regarding topics presented at the July Individual Placement and Supports (IPS) Summit meeting: Bridges out of Poverty, the Benetif-2-Work model, and IPS/Michigan Rehabilitation Services (MRS) collaboration. GHS continues contract discussions pertaining to IPS implementation.** **<u>Evaluation:</u> This goal has been achieved, but it should be continued to support GHS and Sanilac interests in IPS and to include a new objective to explore the Benefit-2-Work model.** **<u>Barrier Analysis:</u> No barriers.** **<u>Next Steps:</u> Continue per the recommended plan updates.**
Home & Community Based Services	The goals for FY2025 Reporting are as follows: • Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure quality of clinical care and service. o Monitor network completion of the HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process. o Monitor the provisional approval process.	Dena Smiley / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec)** **Individual Placement and Support (IPS) training updates and share and learn discussion took place. The Employment Services Committee (ESC) quarterly report was reviewed at the Improving Practices Leadership Team (IPLT) meeting, and support was**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			noted for GHS' plans to implement IPS during FY2025. **Q2 (Jan-Mar)** **At the close of March, the PIHP received thirteen (13) requests for provisional approvals. Six (6) from Lapeer CMH, four (4) from GHS, and three (3) from St. Clair. They have all been approved and were in compliance with the HCBS Final Rule.** **Region 10 has submitted HCBS draft Policy to MDHHS in Q2 and is awaiting feedback/approval before proceeding with the PIHPs process of presenting draft policy before the PIHP Board. MDHHS deadline for Corrective Action to CMS is April 11th, 2025.** **To fulfill this Corrective Action, CMHSPs are asked to complete a case audit which is underway, and Region 10 has been leading training modules on the HCBS Final rule set. Region 10 has hosted 9 of 12 training modules. The modules were established by MSU and MDHHS and are another fulfillment to the Corrective Action Plan to CMS.** **Q3 (April-June)** **At the close of June, the PIHP received Ten (10) requests for provisional approvals. Two (2) from Lapeer CMH, one (1) from GHS, four (4) from St. Clair CMH and three (3) from Sanilac CMH. They have all been approved and were in compliance with the HCBS Final Rule.** **MDHHS held a meeting with Region 10 this month to discuss their expectations around the HCBS Restriction/Modification CAP. Prior to 12.30.25 the PIHP must conduct reviews of all IPOS and Behavior Treatment Plans for individuals receiving HCBS services and/or living in HCBS settings to ensure full compliance with the HCBS Final Rule.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			All plans will need to be in compliance with the HCBS Final Rule using the tool provided by MDHHS at the end of the 6-month period or no later than July 2026. **Region 10 has completed a series of the Quarterly trainings for the HCBS Final Rule Training that were established by MSU as part of the fulfillment to the Corrective Action plan to CMS. The next series of training courses will take place in September.** **Region 10 held the first Round Table Session with CMH HCBS Leads in June. These sessions are designed to clarify any questions related to an individual's IPOS by bringing redacted examples of any complicated restrictions up for discussion. The next Round Table is scheduled for July 14th.** **Q4 (July-Sept)** **Within this quarter, the PIHP received six (6) provisional approvals. One (1) from Sanilac CMH, one (1) from GHS, two (2) from Lapeer and two (2) from St. Clair CMH. Sanilac and GHS followed process and were approved. One of Lapeer CMH's requests requires more licensing information to be approved, and one is a restrictive setting and is in the process of being reviewed by MDHHS. One of St. Clair CMH's requests were approved, and one request required a consultation with MDHHS. This placement was approved for temporary 30-day approval and required a follow-up consultation in August. Following that meeting, permanent placement was granted.** **The HCBS Provisional Approval Policy was approved by the PIHP Board and distributed to CMH leads.** **Region 10 created a Corrective Action Plan submission for MDHHS around bringing Behavioral Treatment Plans and Individual Plans of Service into compliance with the HCBS final rule. That document was submitted to MDHHS timely by the July 31st due date. Region 10 is now requesting that each CMH Behavioral Treatment Plan (BTP) Committee review**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			BTPs and individual plans of service (IPOS) for HCBS compliance and report to the PIHP on any findings on a quarterly basis. A memo was sent to the CMH HCBS Leads in July outlining this new requirement. **MDHHS announced that, beginning September 2, the state is changing the process of requesting the approval of secured settings. MDHHS is no longer requiring a meeting with MDHHS to take place. It will be the responsibility of the PIHP to make sure that the documentation meets the requirements of the HCBS Final Rule.** **HCBS Round table meetings continue with CMH HCBS leads. Next one is scheduled for September 8th.** **<u>Evaluation:</u> This goal is considered not met as Region 10 will be continuing to monitor process throughout the year. The PIHP received 23 provisional requests throughout FY2025 and had one (1) consultation with MDHHS regarding a secured/Heightened Scrutiny setting. MDHHS announced that beginning September 2, the state is changing the process of requesting the approval of secured settings. They are no longer requiring a meeting with MDHHS to take place. It will be the responsibility of the PIHP to make sure that the documentation meets the requirements of the HCBS Final Rule. Region 10 created a Corrective Action Plan submission for MDHHS around bringing Behavioral Treatment Plans and Individual Plans of Service into compliance with the HCBS final rule All plans will need to be in compliance with the HCBS Final Rule using the tool provided by MDHHS at the end of the 6-month period or no later than July 2026. All corrective action plans were completed and approved by MDHHS. The HCBS Provisional Approval Policy was approved by the PIHP board and distributed to CMH leads.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis:</u> Annual barriers we faced in this program were on CAP work, waiting on documents and directive from the State. **<u>Next Steps:</u> Quarterly HCBS Final Rule Trainings will continue for CMH case holders and staff. In FY2026, we will be removing the provisional process from the IPLT goal and adding a separate goal to monitor network completion of the HCBS assessment process, continue efforts to bring provider settings into compliance, and continue ongoing monitoring of service and settings for HCBS Final Rule compliance. Additionally, we will monitor and update Behavioral Treatment Plan Review Committee progress to ensure that Behavioral Treatment Plans and Individuals Plans of Service are in compliance with the HCBS Final Rule.**
Integrated Health Care	The goals for FY2025 Reporting are as follows: • Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. o Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CareConnect360 (CC360) system. o Participate in PIHP/MHP Workgroup initiatives. o Develop a plan to identify members of the youth population appropriate for care coordination.	Dena Smiley / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec)** **At the end of the first quarter, a total of 95 case discussions were facilitated: Twenty-Two (22) care plans were opened and sixteen (16) were closed. Six members were closed with all goals met, seven (7) members were closed with some goals met and two (2) members lost coverage.** **In late October, MDHHS made changes to the measure specifications within CareConnect360 for the Risk Stratification Job Aid (Easy List). With this change, Region 10 will see a decrease in our individual denominator. Region 10 staff met internally to discuss the joint care measure initiative related to the focus on care coordination goals. Region 10 is following up with MDHHS regarding these initiatives.** **At the close of the first quarter, MDHHS made the announcement that The Risk Stratification page in CC360 now has five tabs: Adult Easy, Child Easy, Adult Filter, Child Filter and History. The Child Easy tab is a work in progress and Optum will be working**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			to adjust the Chronic Conditions selections and count parameters to provide the best predictions it can, with the input of the work group. Additionally, there is some "…minor visual cleanup on the filter tabs…" and they have that slated for early 2025. **Q2 (Jan-Mar)** **At the close of March, a total of ninety-eight (98) case discussions were facilitated: Nineteen (19) care plans were opened and thirteen (13) were closed. Seven (7) members were closed with all goals met, two(2) members closed with no goals met, one (1) member closed with some goals met and two(2) dropped from services. Of the members opened, five (5) were brought to the agenda that were not open to CMH services and were opened as a one-time encounter. They will close after our meetings next month.** **In the PIHP/ MHP Collaboration Workgroup this month, it was shared that during Care Coordination meetings, we should still be pulling children off the children easy tab for our discussion. There is not a denominator for this right now, and they do not expect this to happen this year. It will be announced in FY26. Additionally, Optum and MDHHS would like to incorporate a Foster Care Flag into the child easy tab pull. This will be brought to a future meeting for discussion.** **Q3 (April-June)** **At the close of June, a total of one hundred thirty-three (133) case discussions were facilitated: Thirty-five (35) care plans were opened and thirty (30) were closed. Twenty-two (22) members were closed with all goals met, six (6) members closed with some goals met and six (6) members closed with no goals met.** **In the PIHP/ MHP Collaboration Workgroup this month, it was shared that there has been no significant progress to engage subject matter experts in creating a plan to reduce disparities in Black/African Americans. They plan to discuss this again at the next meeting scheduled for July 24th.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q4 (July-Sept) **At the end of August, a total of eighty-five (85) case discussions were facilitated. Fifty-eight (58) care plans were opened and twenty-one (21) were closed. Sixteen (16) members were closed with all goals met, six (6) members were closed with some goals met and three (3) members closed with no goals met.** **In the MHP/PIHP Collaboration Workgroup meeting in August, it was shared that MDHHS is still actively working on bringing a subject matter expert from a State Level to a future meeting to discuss reducing disparities of the Follow-Up After Hospitalization (FUH) measure and what is occurring throughout the nation. Region 10 is currently working on the Patient Centered Medical Home Narrative. That will be submitted by the November 15th due date.** **<u>Evaluation:</u> At the time of this report, a total of two-hundred eighteen (218) case discussions were facilitated. Fifty-eight (58) care plans were opened and forty-six (46) were closed. Thirty-eight (38) members were closed with all goals met, twelve (12) members were closed with some goals met and three (3) members closed with no goals met. Within this quarter, Region 10 has made a stronger effort to bring more Foster Care individuals to the monthly Care Coordination Meetings. We are doing this by using the Foster Care list in CC360 and stratify individuals based on chronic conditions and high emergency room visits. This has been a topic in our PIHP/MHP Collaboration group. Currently, there is not a goal for how many Foster Care Individuals we must open a care plan for annually, however, there is discussion of this happening in the future.** **<u>Barrier Analysis:</u> It has been identified in the PIHP/MHP Workgroup that FUH disparity continues to be a barrier for many statewide. Region 10 will continue to monitor in FY26.** **<u>Next Steps:</u> This goal will continue in FY2026. Region 10 is currently working on the Patient Centered**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Medical Home Narrative. That will be submitted by the November 15th due date.

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2025 Reporting are as follows: • To review and monitor the safety of clinical care. o Review CMHSP and SUD critical incidents, to ensure adherence to timeliness of data and reporting standards and to monitor for trends, to improve systems of care. o Monitor CMHSP and SUD sentinel event review processes and ensure follow-up as deemed necessary. o Monitor CMHSP and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary. o Monitor CMHSP and SUD risk events review processes and ensure follow up as deemed necessary.	Crystal Eddy Sentinel Event Review Committee (SERC)	**Quarterly Update:** **Q1 (Oct-Dec)** **One sentinel event was received from Sanilac CMH and is now in the monthly monitoring process. An update to the Risk Management (RM) third quarter report was reviewed, with follow-up outreach continuing with SUD programs that have not yet matriculated into the quarterly reporting process. Quarterly RM and critical incident (CI) reports along with the End of Year (EOY) Mortality Reports were provisionally reviewed and are scheduled for further review and discussion at the January meeting.** **Q2 (Jan-Mar)** **Committee members reviewed monthly tracking and trending of Critical Incident reports submitted by CMHSP and SUD Provider networks during each meeting that occurred this quarter. No significant concerns or outliers noted. Committee reviewed the FY2025 Q1 Critical Incident Report and Risk Event Report. The SUD and CMHSP Provider Networks appear to be tracking and trending required critical incidents and risk events.** **Q3 (April-June)** **The committee continued monthly review of Critical Incidents reported by the CMHSP and SUD treatment providers. The quarterly analysis of Critical Incidents was completed and reviewed at the June 2025 meeting utilizing updated calculations of persons served by each CMHSP. In June, the Q3 Risk Event report was reviewed as well. Continued gradual progress toward development of a regional Longitudinal Mortality Report. Lastly, the committee reviewed 1 Sentinel Event reported by St. Clair and determined this was handled satisfactorily and could be closed out.** **Q4 (July-Sept)** **In quarter 4, the Sentinel Event Review Committee (SERC) continued its monthly review of Critical Incidents reported by the CMHSP and SUD Provider**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Network. Critical Incidents continue to be reported in a timely manner. There were zero Sentinel Events reported and reviewed during this quarter. The committee has made progress toward the development of a Longitudinal Mortality Report that will cover Calendar Years 2023 and 2024. The quarterly Risk Event Report and Critical Incident Report Analysis will be reviewed during the September SERC meeting. **<u>Evaluation:</u> Goal is met** **<u>Barrier Analysis:</u> Receiving Risk Event Reports from all SUD providers has been a barrier to comprehensive risk event analysis across the SUD Provider Network.** **<u>Next Steps:</u> Continue goal in FY2026**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2025 Reporting are as follows:

The goal is to attain and maintain performance standards as set by the MDHHS contract.

Report indicator results to MDHHS quarterly per contract.
Review quarterly MMBPIS data.
Achieve and exceed performance indicator standards and benchmarks.
Ensure follow up on recommendations and guidance provided during External Quality Reviews
Provide status updates to relevant committees, such as the PIHP QIC, PIHP CEO, PIHP Board.
Discuss and prepare for the transition from MMBPIS to standardized measures.

<table>
<tr><th></th><th>FY24 Q3</th><th>FY24 Q4</th><th>FY25 Q1</th><th>FY25 Q2</th></tr>
<tr><td colspan="5">Ind. 1 – Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td>98.97%</td><td>99.59%</td><td>98.26%</td><td>99.16%</td></tr>
<tr><td>1.2 Adults</td><td>99.90%</td><td>99.20%</td><td>97.73%</td><td>96.59%</td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. Standards = 57% and 62%</td></tr>
<tr><td>2a PIHP Total</td><td>50.66%</td><td>54.41%</td><td>52.68%</td><td>55.13%</td></tr>
<tr><td>2a.1 MI-Children</td><td>48.60%</td><td>54.83%</td><td>50.08%</td><td>47.89%</td></tr>
<tr><td>2a.2 MI-Adults</td><td>51.30%</td><td>55.87%</td><td>55.03%</td><td>60.84%</td></tr>
<tr><td>2a.3 DD-Children</td><td>54.89%</td><td>43.26%</td><td>48.56%</td><td>44.05%</td></tr>
<tr><td>2a.4 DD-Adults</td><td>45.68%</td><td>68.42%</td><td>48.21%</td><td>58.57%</td></tr>
<tr><td colspan="5">Ind. 2e – Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. Standards = 68.2% and 75.3%</td></tr>
<tr><td>2e SUD</td><td>77.74%</td><td>79.04%</td><td>79.65%</td><td>80.83%</td></tr>
<tr><td colspan="5">Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. Standards = 72.9% and 83.8%</td></tr>
<tr><td>3 PIHP Total</td><td>75.02%</td><td>78.72%</td><td>78.19%</td><td>78.65%</td></tr>
</table>
</td>
<td>Lauren Campbell / Brooke Ryan

Quality Management Committee (QMC)</td>
<td>Quarterly Update:

Q1 (Oct-Dec)
The FY2024 Q3 Performance Indicator (PI) Report was finished. FY2024 Q4 PIs are due to MDHHS January 2, 2025.

Weaknesses and recommendations from the 2024 Performance Measure Validation (PMV) Review were discussed with the Quality Management Committee (QMC). Processes for review of PIs will change to address feedback from the Health Services Advisory Group (HSAG).

At the Annual Fall Conference, MDHHS Leads presented a session on the Behavioral Health Quality Transformation (the transition to standardized measures). A question-and-answer document is available on MDHHS' website. Information was shared with the QMC, CEO group, and PIHP Board.

Q2 (Jan-Mar)
FY2024 Q4 Performance Indicators (PIs) were submitted to MDHHS on January 2, 2025. The FY2024 Q4 PI Report was prepared, finalized, and approved.

To address feedback and recommendations from the 2024 Performance Measure Validation (PMV) Review, the PIHP and CMHs conducted a review of PI #1 events and pre-admission screenings.

The PIHP PI Team worked to develop a new Continuous Improvement Plan Template for CMHs and SUD Providers to use to report root cause analysis and plan of improvement activities.

FY2025 Q1 PIs were reviewed but were not submitted to MDHHS on March 31, 2025.
No further information was received regarding the Behavioral Health Quality Transformation during January.</td>
</tr>
</table>

Component	Goal/Activity/Timeframe					Responsible Staff/Department	Status Update & Analysis
	3.1 MI-Children	75.16%	80.60%	78.73%	77.57%		**Q3 (April-June)** **FY2025 Q2 performance indicators (PIs) were finalized and submitted timely to MDHHS on June 27, 2025. Region 10 is exploring recommendations to help CMHSPs strengthen their internal review efforts.** **Q4 (July-Sept)** **The FY2025 Q2 Performance Indicator (PI) Report was prepared, finalized, and approved. The PIHP PI Team continued with the process to review CMHSP and SUD Provider Continuous Improvement Plan submissions. During the August Quality Management Committee meeting, the committee discussed how to report PI #2a in FY2026 with the changes expected for Access decentralization and the CCBHC Demonstration.** **<u>Evaluation:</u> During FY2025, the PIHP successfully reported indicator results to MDHHS, reviewed quarterly MMBPIS data, ensured follow-up on recommendations and guidance from External Quality Reviews, and provided status updates to relevant committees. However, the PIHP did not meet and exceed the performance standards each quarter. The PIHP monitored performance against MDHHS' established performance standards for indicators 2, 2b/2e, and 3. CMHs and SUD Providers were asked to provide an initial root cause analysis and plan of correction quarterly updates. For FY2025, the PIHP replaced the Plan of Correction template with Continuous Improvement Plan (CIP) templates to help guide more effective quality analyses and plans of action. Additionally, to address feedback and recommendations from the 2024 Performance Measure Validation (PMV) Review, the PIHP and CMHs conducted a review of PI #1 events and pre-admission screenings.** **<u>Barrier Analysis:</u> Region 10's secondary review of CMHSP-submitted PI data identified technical issues that were not addressed during the CMHSPs' initial review. These issues often required involvement from**
	3.2 MI-Adults	71.38%	75.69%	76.54%	77.47%		
	3.3 DD-Children	90.34%	88.30%	87.50%	86.29%		
	3.4 DD-Adults	78.79%	78.69%	71.79%	82.14%		
	Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%						
	4a.1 Children	100%	97.70%	100%	97.26%		
	4a.2 Adults	97.90%	95.18%	95.91%	98.23%		
	4b SUD	93.90%	91.67%	90.48%	79.63%		
	Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less						
	10.1 Children	12.08%	10.77%	9.72%	4.95%		
	10.2 Adults	13.89%	13.90%	13.32%	15.75%		

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			CMHSP IT staff, and the short timeframe between the PIHP's review and the MDHHS submission deadline limited the ability to complete necessary corrections. Additionally, related to performance, CMHSPs and SUD Providers reported challenges preparing root cause analyses and plans of correction due to person-driven reasons for noncompliance. Last, further action was needed in some instances related to submission and completion of Continuous Improvement Plans. **<u>Next Steps:</u> Region 10 is continuing to evaluate strategies to help strengthen the CMHSPs' review process, with a focus on early identification and correction of data issues. Region 10 will continue reviewing the Continuous Improvement Plans submitted by CMHSPs and will develop and distribute CIP templates for SUD providers based on their compliance results. The PIHP will also continue participating in the Behavioral Health Quality Transformation Workgroup. The PIHP will modify PI reporting processes as needed to accommodate the changes in the MDHHS PI Reporting Codebook.**
Members' Experience	The goals for FY2025 Reporting are as follows: • Conduct assessments of members' experience with services. o Conduct annual regional customer satisfaction survey. o Conduct qualitative assessments (e.g., focus groups). o Conduct other assessments of members' experience as needed. o Develop action steps to implement interventions to address areas for improvement based on member satisfaction survey. o Facilitate a workgroup consisting of members of the SUD Provider Network to inform future survey planning. o Develop and implement action steps to address response rates / totals.	Divine May Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec)** **The FY2024 Customer Satisfaction Survey Report was completed and presented to the Quality Management Committee (QMC), Quality Improvement Committee (QIC), CEO group, and PIHP Board in December. The report was added to the Region 10 website and notifications were sent to the provider network and PIHP staff.** **Q2 (Jan-Mar)** **The Quality Team started planning for the FY2025 Customer Satisfaction Survey. Timeline, workplan and confirmed Survey Lead list were prepared. Date of survey administration will be scheduled after the contract monitoring review. Administration period to be lengthened to a month long.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			A meeting with the PIHP Survey Leads will be scheduled to inform this year's survey plan, discuss the barriers encountered last year, possible survey administration improvements and to address if there's any timeline issues. The information and feedback we will gather from this meeting will help the PIHP prepare this year's survey methodology to better plan the survey administration and improve this year's survey response rate. **Q3 (April-June)** **The Quality Team met with CMH and SUD Survey Leads to discuss changes to this year's survey administration period, methodology and survey tool revisions. The Survey Leads did not express any concerns about the changes and identified no issues with the timeline. The FY2024 Customer Satisfaction Survey Report and FY2025 Customer Satisfaction process were presented to the SUD Advisory Board meeting in June.** **The survey methodology was finalized in May. Survey memos and guidelines were prepared for final review and approval to be sent to the CMHSPs and SUD Provider Network. The Data Team will be asked to provide the number of open SUD cases to get the estimated number of pre-printed survey materials to be mailed to the SUD Network Providers.** **Q4 (July-Sept)** **The Annual Customer Satisfaction Survey went live on July 28 and ran through August 29. Survey raw data, response rate details and survey report from the providers will be due for submission to the PIHP in mid-September.** **<u>Evaluation:</u> This goal is considered met. The Annual Customer Satisfaction Survey was conducted from July 28, 2025 to August 29, 2025 across the Region 10 Provider Network. To address the goal regarding response rate and total, the Quality Team extended the duration of the survey administration period from 3**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			weeks to 5 weeks and broadened the survey administration method where providers may not only administer the survey in-person but also by phone or mail to reach consumers who are unable to personally present for service during the administration period. The FY2025 survey data aggregation will begin in last week of September. The Quality Management Committee (QMC) will continue to discuss efforts aimed to increasing response rate and interventions to address areas for improvement based on FY2025 survey result findings. **<u>Barrier Analysis:</u> No barriers were encountered.** **<u>Next Steps:</u> This goal is ongoing and will be carried over into FY2026. Survey data will be aggregated, and draft survey report will be prepared in October.**
State Mandated Performance Improvement Projects (PIPs)	The goals for FY2025 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 This PIP topic is on racial/ethnic disparities in access-to-service-engagement with Substance Use Disorder (SUD) services. Improvement activities are aimed at reducing the rate of disrupted access-to-service-engagement for persons (Medicaid members and non-Medicaid persons) served within Region 10. Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec)** **Performance improvement project (PIP) 1 barrier analysis (BA) survey tasks are underway to help inform calendar year (CY) 2024 evaluation and CY2025 improvement planning activities. The Health Services Advisory Group (HSAG) Validation Report was discussed at the Quality Management Committee (QMC) meeting to further inform planning activities mainly to address essential disparity factors.** **PIP 2 preliminary/quarterly findings for Remeasurement 3 are being utilized by the CMHs to inform their CY2024 evaluation and CY2025 improvement planning activities.** **Q2 (Jan-Mar)** **PIP 1 analyses of re-measurement 2 data, EOCY2024 implementation monitoring report data, and EOCY2024 barrier analysis data are in-process and will inform CY2025 improvement action planning. PIP 2 analysis of EOCY2024 implementation monitoring report findings is in-process and draft CY2025 improvement action plans are being received, as**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• Review Health Services Advisory Group (HSAG) report on PIP interventions and baseline. • Provide / review PIP status updates to Quality Management Committee. • QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality.		**informed by preliminary analyses of re-measurement 2 data.** **Q3 (April-June)** **PIP 1 CY2024 evaluation reports and barrier analysis reports have been completed and are being shared with the SUD program providers. Marginal progress is noted. Call for and review of CY2025 improvement action plans are in process.** **PIP 2 CY2024 data are expected to be available by the end of June. Most of the CY2024 implementation monitoring reports and CY2025 improvement plans have been received.** **Q4 (July-Sept)** **PIP 1: The HSAG Validation Report has been received. Although CY 2024 improvement activities reveal significant progress toward increasing show rates for both groups, the findings fell slightly short of resolving the disparity goal. Technical assistance has been requested to address one Partially Met score in Step 7.** **PIP 2: Mixed progress was noted, and a consultative review of CMH improvement action plans has been completed, with follow up discussions scheduled for the next QMC. Also, a recent memo from MDHHS pertaining to the Disparity PIPs and the rebid process did not seem to clearly address whether/how PIHP second PIPs will operate during FY2026. Clarification request has been sent to MDHHS.** **<u>Evaluation:</u> Mixed progress with remediation efforts in process.** **<u>Barrier Analysis:</u> CC360 is configured such that its data are subject to six-month delays.** **<u>Next Steps:</u> Continue the PIP until otherwise advised by MDHHS.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
External Monitoring Reviews	The goals for FY2025 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW]: o Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions. o Ensure both Professional and Aide staff meet required qualifications. o Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. o Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. o Discuss and follow up on HSW slot utilization and slot maintenance.	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec)** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Quarter 1 was 534 of the PIHP's total 627 slots. MDHHS approved ten (10) new enrollees this quarter, and there are four (4) cases pending approval in the State work queue. Slot utilization, however, continues to be a struggle for the Habilitation Supports Waiver.** **Continued conversation is happening during quarterly Leads meetings and with CMH representatives at the Quality Management Committee monthly meetings on program utilization barriers.** **During quarter 1, the MDHHS State Site Review wrapped up with the submission of CMH corrective action plans (CAPs) to MDHHS. The State incentivized the CAPs this year for timeliness and deliverability.** **There were in total 36 citations found by MDHHS, of those 15 CAPs were not accepted in the first round of review. On December 10th, MDHHS accepted all of the amended submissions on the State site Review CAPs and now the CMHs are in the implementation and follow-up phase of their CAPs.** **Q2 (Jan-Mar)** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Q2 was 529 of the PIHP's total 627 slots. Slot Utilization continues to be a barrier for this program. MDHHS approved 3 New enrollees this quarter, it was confirmed in the quarter that the CMHs are working on around 55 additional enrollment packets.** **At the close of the quarter, MDHHS lifted their 5-case limit on new enrollee submission by region. Region 10 is working on submitting all the remaining cases in the work queue for MDHHS approval. Submissions**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			continue to be delayed at all levels, because of the review of compliance with the HCBS final rule. **In Q2, the PIHP lead met with all CMH Site Review leads to discuss progress of the CAPs. These meetings will continue quarterly to monitor ongoing progress and actions toward these systemic issues.** **The submission for the 90-day follow-up items for the State Site Review were due at the beginning of March. Of the CAP work submitted, 8 citations from our region needed additional documentation to prove these CAPs resolved the citations found in the State Site Review. There has been some back and forth since then, follow-up documents were submitted March 24th and March 31st. MDHHS is now requesting documentation from one CMH to close the 90-day review and mark all CAPs as resolved.** **Training also took place this quarter in our region with a MDHHS State Site Reviewer to discuss Person-centered Planning and the requirements within the IPOS. This was set up due to the repeat citations on the State Site Review in this area, the training was well attended and had great discussion.** **Q3 (April-June)** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Q3 was 526, of the PIHP's total 627 slots. Slot Utilization continues to be a barrier for this program, as is initial packet submissions. There were 5 new cases approved by MDHHS this quarter. Continued TA and education is occurring to help the CMH Leads understand the HCBS requirements for case submission.** **The State Site Review FY24 has concluded, final reports have not been provided at this time. MDHHS hosted a meeting in June on the State Site review annual process beginning in FY26.** **Q4 (July-Sept)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The number of Habilitation Supports Waiver (HSW) enrollees near the end of Quarter 4 was 527 of the PIHP's total 627 slots. In Quarter 4, MDHHS approved eight (8) new pending applications. There are currently ten (10) new enrollee applications in varying stages of approval. CMHs continue to work hard to push new enrollees for this program and increase these numbers. In Q4 MDHHS requested information on slot utilization and Region 10 requested that 43 slots be moved to other PIHPs. **In the fourth quarter, the MDHHS Site Review Team confirmed via email that Region 10 submitted evidence at the 90-day follow-up that confirmed actions taken by the PIHP/Region 10 were effective in correcting the findings in the initial review. The PIHP meets quarterly with the CMH Site Review leads to follow-up on CAP progress and provide support.** **<u>Evaluation</u>: During the QMC meetings in FY2025, the PIHP Waiver Coordinator addressed 1915(c) Waiver outstanding items, requested updates on late and or missing case actions and provided discussion on these programs. Slot Utilization continued to be a struggle for the Habilitation Supports Waiver in FY2025. Reviewing Plans of Service for HCBS Final Rule compliance was identified as one of the greatest barriers for new enrollment approvals. Region 10 provided Case Management training on the HCBS Final Rule, Technical Assistance when necessary and established the HCBS RoundTable work group to aid with this barrier. Because of the continued work needed with this goal, it is marked as unmet but progress was made.** **With these additional efforts, enrollment in FY2025 has gone up over the last fiscal year. Region 10 had 26% more new packets submitted over last fiscal year which gave us 31 new enrollees approved and on the HAB Support Waiver. Education has proven to be helpful with understanding the HCBS final rule and the PIHP will continue to support the CMHSPs through this process.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The MDHHS State Site Review took place in FY2024 with the 90-day follow-up and closings occurring in FY2025. The PIHP continues to meet quarterly with the CMH State Site Review Leads to follow-up on ongoing CAP work and progress. State Site Review findings and follow-up have been discussed at the QMC meetings to make progress towards this goal. **In the FY2024 review Region 10's case selection size increased by 66% with the addition of the 1915(i) State Plan Amendment. If we look at our performance from the FY2022 State Site Review with the FY2024 State Site Review, we see an overall improvement. In FY2022, 79% of the cases reviewed received a corrective action plan. In FY24, 55% of the cases reviewed received a corrective action plan. One of the focuses of this goal was to work on repeat citations, our number of repeat citations when comparing FY2022 and FY2024 did not increase but remained the same at 18 repeat citations.** **In FY24 MDHHS added an incentive on the effectiveness of the Corrective Action Plans submitted with the intention of improving the quality of CAP submissions. Looking at the percentage of CAPs approved on the first submission, in FY2022 35.5% were approved on the first submission. In FY2024 58.4% of CAPs were approved with the first submission. Follow-up with the CMHSPs and continued support are happening to ensure improvement continues in the State Site Review set for FY2026.** **<u>Barrier Analysis</u>: Enrollment packet submission has increased this fiscal year; however, slot utilization continues to be a barrier for the Habilitation Supports Waiver Program. There continues to be a review by the MDHHS HCBS Team for HCBS Final Rule compliance with these enrollment packets, so the PIHP will continue to provide support and education in this area.** **<u>Next Steps</u>: This goal will be removed from the Quality Management Committee goals as these actions and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			discussion occur in other meetings and had topic discussion had started to get duplicative. Monitoring of the 1915(c) Waivers, the 1915(i) SPA, and the efforts of the State Site Review will continue into the next fiscal year with goals through the Quality Improvement Committee. Continued meetings with the CMH representatives will occur to provide guidance and program updates. MDHHS is evaluating slot utilization and the potential to move some of Region 10's slots for the HSW Program, which would improve our progress towards this goal as well. Finally, Region 10 will continue to provide support and education on the HCBS Final Rule to our CMHSPs to support all these programs.
Monitoring of Quality Areas	The goals for FY2025 Reporting are as follows: • To explore and promote quality and data practices within the region. o Monitor critical incident data and reporting. o Monitor risk event data and reporting. o Monitor emerging quality and data initiative / issues and requirements. o Monitor and address Performance Bonus Incentive Pool activities and indicators. o Monitor and address changes to service codes. o Review / analysis of various regional data reports. o Review / analysis of Behavioral Health Treatment Episode Data Set (BH TEDS) reports.	Lauren Campbell & Laurie Story-Walker Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec)** **During Quality Management Committee (QMC) monthly meetings the BH TEDS completion rates were shared; Mental Health – 98.18%, Q (Crisis) - 92.31%, SUD – 84.22% through December 5, 2024. Each CMHSP present reported no encounter reporting barriers or challenges to the PIHP. PIHP reminder to continue to report FY2024 encounters after December 31st when there are claims received or data corrections to be reported. MDHHS code changes received December 16, 2024, for the January MDHHS Code Chart update was shared with the workgroup. The PIHP asked when the Waiver Support Application (WSA) integration will occur in CHIP and OASIS. No one was aware of the integration date and GHS followed up with PCE. PCE reported this has been delayed. GHS asked if other CMHSPs were seeing Electronic Visit Verification (EVV) visits from providers that are using another EVV system (not HHaX). No others are seeing this, so GHS will follow-up with MDHHS EVV lead.** **The committee discussed the Patient Centered Medical Home (PCMH) Narrative which was submitted to MDHHS in November. Updates from the Critical**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Incident Reporting (CIR) Workgroup meetings were shared. Additionally, CMHs present during meetings reported the critical incident numbers on the PIHP's report were correct. **Q2 (Jan-Mar)** **During the QMC meetings the BH TEDS completion rates, missing BH TEDS and dangling admissions were reviewed. CMHSPs reported any challenges or barriers to encounter reporting. Review of ongoing Electronic Visit Verifications (EVV) meetings and discovery sessions relating to claims processing. Review of EQI timelines for FY24 period 3 and FY25 Period 1. Review of MDHHS Behavioral Health Code Chart and Provider Qualification updates.** **During Quality Management Committee meetings, committee members reviewed the critical incident summary information to confirm report numbers accurately reflected what has been reported to the PIHP.** **Also, a brief update was provided regarding the efforts of the PIHP and Medicaid Health Plan (MHP) Referral Workgroup.** **Q3 (April-June)** **This quarter the Quality Management Committee reviewed the BH TEDS completion rates, MH 99.30%, Q 98.14 and SUD 99.59% and the BH TEDS dangling admission efforts continued, noting progress. The new BH TEDS error code related to the residential care living arrangements such as a Children's therapeutic group home, was reviewed as well as a new "age" edit was added to prevent selecting (22) when the individual is over 21 years of age. Code updates that went into effect April 1, 2025, were reviewed and the code updates effective July 1, 2025, were sent to the workgroup upon receipt. The FY25 Period 1 EQI timeframe was reviewed with CMHSPs reports due to the PIHP May 15, 2025.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The Critical Incident numbers were reviewed and acknowledged as accurate. **Q4 (July-Sept)** **The Quality Management Committee (QMC) met in August and reviewed the BH TDS completion rates, 99.92% for mental health, 100% for Q and 99.76% for SUD. Review of the FY26 changes as well as the BH TEDS virtual training on Friday, September 12th at 9:30 or 1:30 was reviewed. Encourage staff to attend who work with BH TEDS records. No CMHSP reported any barriers or challenges with encounter reporting. The August Electronic Visit Verification (EVV) meeting was cancelled. The claims demonstration identified potential gaps/ needs and MDHHS is waiting for next steps from HHAeXCHANGE. The CCBHC transition to MDHHS oversite effective10/01/2025 was discussed. Encounters, claims and BH TEDS reporting will go directly to MDHHS. WSA drop access to the CCBHC application will be completed. Discussed the CCBHC SUD services as they are included in the transition. The SUD Case Management service (H0006) is not currently a CCBHC qualifying service. This has been identified to the CCBHC Team. The ASAM Continuum to be added to the CMH/CCBHC EHR is being worked on as reported by a CMH/CCBHC. The FY25 P2 EQI report and upcoming due dates were reviewed.** **The critical incident numbers were reviewed. Follow-up was noted for one CMH.** **<u>Evaluation:</u> The PIHP explored and promoted quality and data practices within the region. Discussion occurred during monthly QMC meetings, with additional information shared via email between meetings. Throughout the fiscal year, the CMHs and PIHP navigated the reporting method for critical incident data and submission of remediation responses. The committee monitored and addressed Performance Bonus Incentive Pool activities and indicators, changes**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			to services codes, various regional data reports, and BH-TEDS. Regarding the planned activity to monitor emerging quality and data initiative / issues and requirements, committee members discussed new initiatives such as the implementation of the electronic visit verification (EVV). **<u>Barrier Analysis:</u> No barriers were identified.** **<u>Next Steps:</u> The committee will continue this goal in FY2026 but with a revision to remove critical incident and risk event reporting. A process outside of QMC meetings will be developed to ensure critical incident numbers are still reviewed and validated.**
Financial Management	The goals for FY2025 Reporting are as follows: • Establish consistent Region-wide finance reporting and provide training as needed. o Region 10 Chief Financial Officer (CFO) will provide quarterly training on finance reporting and finance topics, including the Certified Community Behavioral Health Clinic (CCBHC) Demonstration and Encounter Quality Initiative (EQI) reporting.	Richard Carpenter Finance Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The first Certified Community Behavioral Health Clinic (CCBHC) training was held Monday, December 2nd. The training was focused on the Cost Report.** **Q2 (Jan-Mar)** **The second CCBHC training was held virtually on Monday, February 3rd. This was a follow-up to the first training and focused more on how to generate data that is needed within the report. This completed the CCBHC cost report training sessions. The feedback was that the training was helpful, and all four CCBHC's successfully completed their FY24 CCBHC Cost Reports. At the February Finance Committee meeting, the next two training sessions were scheduled, which will be focused on the EQI reporting process. EQI training session 1 of 2 is scheduled to be in person at GHS on Tuesday, 6/17/25 from 10:00-12:00. The primary focus of this training will be on where the data comes from to complete the EQI report. EQI session 2 of 2 is scheduled to be in person at Region 10 on Friday, 9/19/25.** **Q3 (April-June)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			EQI Training 1 of 2 was completed on Friday, June 20th. Attendees learned about the purpose of the EQI report and how MDHHS uses it. Additionally, there was an overview of the template and instructions. There was discussion about how CMHSPs can use this data in managing operations, especially related to productivity and benchmarking. **Q4 (July-September)** **EQI training 2 of 2 is scheduled for Friday, September 19th at 11:00 am following the Board meeting at Genesee CMH. This will complete the four training sessions related to reporting to meet the FY25 financial management goal.** **<u>Evaluation:</u> This goal is Met** **<u>Barrier Analysis:</u> No barriers** **<u>Next Steps:</u> Continue with EQI training 2 of 2, ending with a Q&A session. Begin to focus on FY26 goals, which will focus more on the monitoring of CCBHC direct pay model, rather than on reporting.**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. ○ Monitor and advise on Peter Chang Enterprises (PCE)-based crisis service utilization reports (monthly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **Monthly crisis services utilization reports were reviewed. No significant issues were identified but trends toward underutilization for youth intensive crisis services are being monitored and local efforts to address were discussed.** **Q2 (Jan-Mar)** **Monthly crisis service utilization reports were reviewed during each month of this reporting period. Overall, changes in utilization were minimal and do not demonstrate a trend toward over/under utilization.** **Q3 (April-June)** **The committee reviewed monthly crisis services utilization reports. There appears to be little variance**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			in utilization from month to month. CMHSPs continue routine tracking and trending. **Q4 (July-September)** **During quarter 4, the Utilization Management Committee (UMC) continued to monitor the CMHSP crisis services utilization reports. Utilization varied only slightly from month to month. Often times utilization was impacted by individuals with needs for higher levels of care, such as hospitalization in one of the State Psychiatric Hospitals. CMHSPs continue with monthly tracking and trending of Crisis Service utilization.** **Evaluation: Goal Met** **Barrier Analysis: No Barriers** **Next Steps: Crisis Services utilization will be monitored quarterly during FY2026**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement. o Monitor and advise on BTPRC data spreadsheet reports: Evaluate reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **Quarterly reports were reviewed, with no concerning events or trends identified. GHS noted its priority on evaluating behavior plans for titration opportunities.** **Q2 (Jan-Mar)** **BTPRC quarterly reports were submitted by the CMHSPs and reviewed by the UMC during the March meeting. Reports reflect appropriate monitoring of required areas and adherence to standards.** **Q3 (April-June)** **Each CMHSP submitted their quarterly BTPRC reports including reports of emergency physical management and contact with law enforcement. Each CMHSP continues monitoring these events appropriately.** **Q4 (July-September)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			BTPRC reports were reviewed and discussed during that August UMC meeting. CMHSPs continue to review the use of restrictive intervention as well as emergency physical intervention and contact with law enforcement. The committee discussed trends in MDHHS guidelines for Behavior Treatment Plans including evaluating the need for a BTP versus including restrictions due to health and safety in a person's IPOS. **<u>Evaluation:</u> Goal met** **<u>Barrier Analysis:</u> No barriers** **<u>Next Steps:</u> Continue goal into FY2026 with tracking and trending related to individuals discharged from BTPRC oversight as well as primary reason for BTPRC involvement.**
Utilization Management	The goals for FY2025 Reporting are as follows: • Ensure regional Utilization Review (UR). o PIHP UM Department to conduct UR on: ▪ UR on SUD network provider programs (annually) ▪ UR on CMHSP Optimal Alliance Software Information System (OASIS)-user affiliates (quarterly) ▪ Monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **SUD FY2024 annual utilization review (UR) has been completed, and a longitudinal report was shared at the SUD network quarterly meeting. Quarterly reporting for CMH UR (OASIS, CHIPS) was completed at the December meeting.** **Q2 (Jan-Mar)** **UMC reviewed 2Q UR Case Record Review Reports and findings. Review findings identify that 86.75% of OASIS records and 84.25% of GHS records reviewed are receiving the medically necessary and appropriate services.** **Q3 (April-June)** **Quarter 3 CMHSP Utilization Management case record reviews and reports were completed and reviewed by the UMC in June. Just over 85% of case records reviewed reflect services are provided at the appropriate level of care, while 11.5% of case records reviewed offered a recommendation to reduce the level**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			of care based on the information reviewed in the clinical record. There were no cases found to require more intensive services than what was being provided. Planning continues for the SUD UR activities to be completed by the end of the fiscal year. Case record selection is presently underway. **Q4 (July-September)** **The Quarter 4 CMHSP Utilization Management Case Record Reviews will be conducted during September with UMC reviewing the report in October. The annual SUD UR activities have been completed. An analysis of the findings is underway. The UMC committee will review the SUD Annual UR Report including findings and recommendations for system improvement during the September UMC meeting.** **<u>Evaluation:</u> Goal is met** **<u>Barrier Analysis:</u> Staffing capacity in UM has been a barrier throughout the year. This will be addressed through the realignment of Access and UM functions with Access Decentralization initiative.** **<u>Next Steps:</u> Continue goal in FY2026**
Utilization Management	The goals for FY2025 Reporting are as follows: • Promote aligned care management activities across key areas of network operations. o Achieve full Implementation of the Centralized Utilization Management (UM) System (UM Redesign Project) ▪ Oversight of the OASIS Users Workgroup and Sub-Workgroup ▪ Complete the development of UM Redesign Project implementation monitoring reports. ▪ Complete the development of scheduled UM monitoring/management reports. ▪ Continue to inform and engage GHS in regional implementation of the Centralized UM System.	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The Utilization Management (UM) Redesign launch completed its seventh month. Utilization and implementation monitoring reports are being developed, and service exception request (SER) implementation monitoring reports are in place, noting monthly findings and receiving feedback on report format improvements. Challenges to launch are noted in terms of Certified Community Behavioral Health Clinic (CCBHC) Demonstration implementation boundaries, and these are being discussed across the OASIS Users Work Group and Region 10 Management. Launch activities remain an ongoing Agenda item at UM Committee meetings and therein**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor and advise on the MDHHS/Region 10 Parity Compliance Plan ▪ Oversight of the Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability System. ▪ Oversight of Region 10 participation on the UM Directors Group.		**GHS remains in the loop regarding eventual launch expansion.** **Indicia Inter-Rater Reliability (IRR) activities are completed, and the formal report is scheduled for UMC review as part of the End of Fiscal Year (EOFY) 2024 UM Program Plan Evaluation Report. The November UM Directors Group focused on completing its Inpatient Tiered Rates recommendation paper was sent to the CEO Group. Initial response to the Health Services Advisory Group (HSAG) Standards Validation Report results is being shared and aggregated to help inform regional responses to the report. This topic will be continued at the January meeting.** **For additional information on aligned care management activities, please refer to the FY2025 UM Program Plan report that was submitted to the November QIC for review/approval.** **Q2 (Jan-Mar)** **The OASIS Users work group met monthly during the quarter to address SER track/trend reporting, Bio-mapping updates, and a variety of other procedural clarifications, are scheduled for April. The quarterly service authorization grid update was completed in March. SER ABD processing scheduled to begin in April has been deferred for the time to allow for more consultative feedback with the expanded SER track/trend reporting and analysis. UM implementation monitoring reports are in development. Discussions the UM Directors Group have addressed coverage clarifications for neuropsychological testing, backdating issues, the final communication from MDHHS dismissing the request to incorporate reasonable range discussions in the person-centered planning process, and monitoring implementation planning for CFAP.** **Q3 (April-June)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The OASIS Users Workgroup has been reconfigured and is now called the MIX Users Group. This name change reflects the progress achieved in deploying the centralized automated authorization/approval system and the SER system, the dismantling of the shared OASIS system into separate EHRs, and the appropriate shift of clinical oversight to IPLT and UMC. The MIX Users Group will continue to meet monthly to ensure optimal systems interoperability, attend to the development of monitoring reports, and to process CCW grid updates. At the IRR quarterly meeting, discussion took place regarding system updates scheduled for later this CY, onboarding new clinical staff into the IRR system, and generally noting that things are running well. At the April UM Directors meeting, share and learn discussion took place regarding COFR issues and agreements, CCBHC EBP implementation, the anticipated PIHP bid process, and managing the current round of defunding Federal Grants. **Q4 (July-September)** **The MIX Users Group continues to monitor and address as-needed systems designs and updates. Service utilization discussions/updates and clinical practice discussions/updates will continue to be addressed by UMC and IPLT respectively. The final area of project implementation, pertaining to the SER ABD process, is scheduled to begin 10/01/2025. The MIX Users Group will continue to meet as needed rather than monthly to ensure optimal systems interoperability, attend to the development of monitoring reports, and to process CCW grid updates. At the August IRR quarterly meeting, discussion took place regarding recent system updates, onboarding new clinical staff into the IRR system, and generally noting that things are running well. Annual IRR evaluations began in September. Planning discussions are in process regarding the onboarding of Lapeer CMH and Sanilac CMH into the Indicia system per their Access Decentralization plans scheduled for 10/01/2025.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			At the April UM Directors meeting, share and learn discussion took place regarding COFR issues, CCBHC EBP implementation, and the rebid process. **<u>Evaluation:</u> Progress toward goals.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Continue plan into FY2026.**
Utilization Management	The goals for FY2025 Reporting are as follows: • Promote centralized care management operations across the regional Access Management System (AMS). o Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The Access Management System (AMS) annual report was completed, and the formal report was reviewed at the November Utilization Management (UM) Committee and Quality Improvement Committee (QIC). It will be included in the UM Program Plan Evaluation Report and will be available for presentation to the Region 10 Board.** **Q2 (Jan-Mar)** **The EOFY2024 Annual Report was included in the FY2024 UM Program Plan Annual Evaluation Report sent to QIC for final review/approval.** **Q3 (April-June)** **A reconfigured AMS M-Y Report has been completed and is pending UMC review.** **Q4 (July-September)** **The AMS M-Y report was reviewed and forwarded to QIC. The EOY AMS report is pending.** **<u>Evaluation:</u> Progress.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Continue per plan.**
Utilization Management	The goals for FY2025 Reporting are as follows:	Crystal Eddy	**Quarterly Update:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• Provide oversight on CMHSP affiliate community access / care management activities. ○ Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Utilization Management (UM) Committee	**Q1 (Oct-Dec)** **The Utilization Management Committee (UMC) review of CMHSP affiliate reports revealed a wide range of community outreach, education, and wellness promotion activities, some traditional and others innovative, to engage community members where they are at.** **Q2 (Jan-Mar)** **CMHSPs submitted Customer Involvement, Wellness and Healthy Communities reports as scheduled. The CMHSPs demonstrate innovative ways of engaging their communities. Of note this quarter is the engagement of activities with corrections and law enforcement.** **Q3 (April-June)** **The quarterly Community Involvement/Wellness Reports provided by each of the CMHSPs were reviewed during the May UMC meeting. Community collaboration, social media efforts, and staff training continue across the region. Seven Adult MHFA training sessions and one Youth MHFA training session were provided by the CMHs. The CMHSP participated in 22 community engagement events.** **Q4 (July-September)** **The Community Involvement/Wellness Reports provided by each CMHSP were reviewed and a summary of activities was presented to UMC during the August meeting.** **Evaluation: Goal is met** **Barrier Analysis: None** **Next Steps: Continue goal in FY2026**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on regional Adverse Benefit Determination (ABD) operations and reporting processes.	Crystal Eddy	**Quarterly Update:** **Q1 (Oct-Dec)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Utilization Management (UM) Committee	**Quarterly reports were reviewed, with no concerning events or trends identified. That said, discussion centered around the introduction of graphics and plans for track/trend analysis. This expanded analysis activity was supported by the committee, given their expressed need for a more detailed understanding of compliance issues and improvement opportunities.** **Q2 (Jan-Mar)** **Fiscal Year 25 Quarter 1 ABD reports were submitted by the Provider Network in January. An analysis of these reports was conducted and presented to the UMC in February. Discussion occurred surrounding the reason for ABDs sent** **Q3 (April-June)** **ABD tracking reports were reviewed and discussed during the May UMC meeting. Across the region during FY2025 Q2 there were 3,425 ABDs completed by CMHPs and the PIHP. The SUD provider network reported 67 ABDs completed.** **Q4 (July-September)** **The ABD Reports provided by each CMHSP were reviewed and an analysis of ABDs issued was presented to UMC during the August meeting.** **<u>Evaluation:</u> Goal met** **<u>Barrier Analysis:</u> No barriers** **<u>Next Steps:</u> Continue goal in FY 2026**
Corporate Compliance	The goals for FY2025Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. ○ Review requirements ○ Identify and document responsible entities ○ Identify and document supporting evidence / practice ○ Policy review ○ Review PIHP Corporate Compliance Plan updates	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The FY2025 Corporate Compliance Plan was posted on the PIHP website and distributed to both PIHP staff and Network Providers. The FY2024 Q4 Office of Inspector General (OIG) Program Integrity submission was due November 15, 2024 and submitted timely. OIG-MDHHS issued a Corrective Action Plan**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis

	• Support reporting requirements as defined by MDHHS, Office of Inspector General (OIG), Medicaid Fraud Control Unit (MFCU), PIHP, etc.
	  o Review of reporting process.
	  o Review of contractual language changes in reporting.
	  o Ongoing discussion on OIG feedback (e.g., Program Integrity Report feedback).
			(CAP) for the FY24 Q4 program integrity submission in December – addressing the CAP is in progress. The FY2025 Annual Contracted Entities Report was submitted in a timely manner in November. The FY2025 Annual OIG Program Integrity Report due January 15, 2025 to the OIG is in development. The FY2024 Corporate Compliance Annual Report is pending final review and revision.
			
			Q2 (Jan-Mar)
			The MDHHS Office of Inspector General (OIG) FY2025 Annual OIG Program Integrity Report was submitted timely to MDHHS in February. No Corrective Action Plan was received; however, resubmission was required to expand on narrative explanations. FY2025 Annual OIG Compliance Plan Report was submitted to MDHHS OIG timely in March. A discussion is scheduled in April with the OIG to review the findings of the report. The FY25Q1 OIG Program Integrity Report required corrective action, which was submitted and pending acceptance from the OIG.
			
			Q3 (April-June)
			The PIHP revised policies to meet the Office of Inspector General (OIG) 6.9 Compliance Report corrective action plan (CAP). These revisions were approved by the Region 10 Board. The FY Q2 Program Integrity report was submitted and accepted by the OIG. A new report was introduced by the OIG in the Biannual OIG / Compliance Officers meeting to begin in FY26.
			
			Q4 (July-September)
			The FY2025 Q3 Program Integrity report was submitted timely to MDHHS OIG. A Corrective Action Plan (CAP) has been issued to remediate deficiencies. Updated FY26 reporting templates and guidance were received from the Office of Inspector General and disseminated across the network. The Corporate Compliance Committee meeting was held

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			and discussed barriers to new reporting requirements for FY2026. **<u>Evaluation:</u> This goal is considered not met. All required reports have been submitted timely to MDHHS OIG and there is one outstanding CAP pending submission to the OIG. Network providers indicated policies are under review for this goal and training is needed for new reporting requirements. The OIG will be providing guidance or training on the new 6.11 report which will be disseminated to network providers. The Corporate Compliance Committee will continue to discuss efforts aimed to increasing compliance with reporting requirements and address areas for improvement based on corrective action from the OIG.** **<u>Barrier Analysis:</u> Potential administrative burden with new reporting requirements.** **<u>Next Steps:</u> Attend training hosted by the OIG on the new 6.11 Monthly Overpayment Report requirement. This goal will be carried into FY2026.**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Compliance with 45 CFR 164.520 Notice of Privacy Practices o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **Discussion occurred regarding changes to policy 03.03.01 HIPAA Privacy& Security Measures and policy 03.03.02 HIPAA Privacy Measures – Protected Heath Information. These changes were influenced from the findings of the Health Services Advisory Group (HSAG) SFY2022 Compliance Review. The changes to the following policies were outlined in a Privacy Notice Action Plan. In December, policies 03.03.01 and 03.03.02 were reviewed and revised according to the action plan and then submitted for approval.** **Q2 (Jan-Mar)** **HIPAA Privacy and Security Measures Policy (03.03.01) and HIPAA Privacy Measures- Protected**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Health Information Policy (03.03.02) were reviewed, approved, and posted to Region 10's website. PIHP FY2025 Annual Contract Monitoring Tools were reviewed, and updates have been completed. **Q3 (April-June)** **The HIPAA Breach Notification Policy (03.03.04) was reviewed for changes. Health Services Advisory Group (HSAG) FY2025 Compliance Review took place this quarter with a focus on Privacy Rights throughout the Confidentiality Standard.** **Q4 (July-September)** **The Corporate Compliance Committee was held in August which determined two (2) providers were still in the process of reviewing their Privacy Notice and related requirements. Three (3) network providers stated that they have reviewed their Privacy Notice and sent any applicable updates to consumers.** **<u>Evaluation:</u> This goal is considered not met. This goal is ongoing as requirements for Privacy Notices are consistently being updated. Providers indicated that privacy notices were revised for FY2025, and applicable changes were sent to consumers. Policies are still under review for some Network Providers. The Corporate Compliance Committee will continue to discuss efforts aimed to increasing compliance with Privacy requirements.** **<u>Barrier Analysis:</u> No barriers identified.** **<u>Next Steps:</u> This goal will be carried into FY2026. Continue to review Privacy requirements and policies.**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes. o Review regional PIHP contract monitoring results.	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **FY2024 Annual Contract Monitoring Provider Plan of Correction development. Standards identified for plan of correction required provider response which was**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Review current CMH Subcontractor contract monitoring process / content.		**reviewed for acceptance or non-acceptance and potential resolution.** **Q2 (Jan-Mar)** **FY2024 Contract Monitoring has one provider plan of correction pending resolution. FY2025 Annual Contract Monitoring Tools were reviewed, and updates have been completed.** **Q3 (April-June)** **Review of provider documentation for Contract Monitoring took place throughout May. On site visits were held with all Providers throughout the month of June.** **Q4 (July-September)** **Contract Monitoring review scores were compiled for each network provider. Plans of correction were issued to providers for gaps that were identified throughout the monitoring process.** **<u>Evaluation:</u> This goal is considered not met. There are 10 outstanding plans of correction to address the compliance standards for the PIHP contract monitoring process. The Corporate Compliance Committee requested to continue this goal going into FY2026 until all providers receive contract monitoring results and have to opportunity to resolve outstanding plans of correction. The Corporate Compliance Committee will continue to discuss efforts aimed to increasing compliance with standards and address areas for improvement based on FY2025 contract monitoring findings.** **<u>Barrier Analysis:</u> No barriers identified.** **<u>Next Steps:</u> This goal will be carried into FY2026. Gaps in the network were identified through the contract monitoring process and are being addressed with each provider individually.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Provider Network	The goals for FY2025 Reporting are as follows: • Address service capacity concerns and support resolution of identified gaps in the network. o Review and address CMH Network gaps and capacity concerns. o Review and address SUD Network gaps and capacity concerns.	Deidre Slingerland Provider Network Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **During the first quarter, the PIHP continued to note issues with Autism services. GHS reported internal discussions on staffing issues and lack of workers in the community. Additionally, they continue to discuss the need for evening availability for Applied Behavior Analysis (ABA) providers. GHS has an open request for proposal (RFP) for ABA providers.** **In December, the quarterly Provider Network Committee meeting was held. Updates were shared from each of the CMHSPs as follows:** **GHS – service lines are struggling to find staff. GHS is looking at incentives to obtain and retain staff.** **Lapeer CMH – Noting difficulty in finding staff for residential homes. Also, the Children's Department has a delay list due to the fact that they have not found the proper space to expand.** **Sanilac CMH – Current posted RFP for CLS, respite, and supported employment.** **St. Clair CMH – Current RFP for a children's therapeutic group home. Noting that ABA tends to attract most of the staffing leaving other needs with inadequate coverage.** **Q2 (Jan-Mar)** **Discussions continued through the quarter regarding service capacity. At the committee meeting in March, GHS indicated that they are still struggling with finding ABA providers with evening/weekend availability. There is an open RFP for ABA providers. They also shared that staffing issues have been noted across service lines. Lapeer CMH shared that their children's department moved locations last month into a larger space which may decrease delays. In order to address the evening/weekend availability issue, they are discussing holding groups to be able to serve more than one person at a time. They shared that persons in services prefer to come in, but providers tend to more readily offer in-home services. At Sanilac CMH, they**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			are in the process of contracting a new Skill Building and Respite provider. St. Clair shared that they still have an RFI out for an ABA provider but have had limited interest as providers are hesitant due to the travel costs. They also recently obtained property to build a children's therapeutic group home. They have a current RFP for additional outpatient services and noted that a contract for youth peer support services from Touchstone was going to the Board in March. **Q3 (April-June)** **The Provider Network Committee was rescheduled for this quarter due to Contract Monitoring visits and to allow for an in-person meeting in July. However, the PIHP has collected the following updates:** **GHS:** **Internal discussions continue on staffing issues and the lack of workers in the community. Continued discussions with the current ABA provider network regarding the large demand of evening availability as most waiting for services are school aged and in school during the day. GHS reports an open RFP for ABA providers and is in the process of contracting with a new provider with training being scheduled.** **Lapeer:** **The Autism Department is working to open more treatment rooms to have more space to bring more individuals into treatment. At the Contract Monitoring site visit, LCMH indicated that they are purchasing the building next door for its Children's Department which will provide more space for the Autism program. They are very hopeful that this expansion will eliminate their current wait list. Remodeling will begin in September. Staff are reviewing current scheduling patterns to explore areas of improvement. The department has identified 4-5 individuals that will be ending services for various reasons by the start of the new school year.** **St. Clair:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			St. Clair CMH is inquiring into a potential new ABA provider. There is no current update on status of potential new ABA provider except that interview did take place and still gathering additional information from provider. **Q4 (July-September)** **The Committee met on July 10th for an in-person session. During the meeting, follow up was conducted on each of the updates shared during the previous meeting. The PIHP Autism Lead led a discussion regarding the ongoing identified gap in availability of ABA services. GHS noted that they are revamping their RFP but stated they are still struggling with staffing shortages. St. Clair CMH indicated similar barriers. No other network issues were cited.** **Following the meeting, CMH Autism leads followed up in regular monthly reporting with the PIHP lead. The following updates were communicated:** **GHS: Internal discussions on staffing issues and lack of workers in the community continue. Continued discussions are taking place with the current ABA provider network regarding the large demand of evening availability as most waiting for services are school aged and in school during the day. GHS is rewriting RFP seeking afterschool/evening hour providers. They also added contracted provider.** **Lapeer CMH: The Autism Department is working to open more treatment rooms and adjust scheduling to bring more individuals into treatment.** **BCBAs have completed assessments to bring additional individuals to replace those that ended services from May and more treatment rooms with 5 assessments completed with varying start dates in July and August. Three more assessments are scheduled to be completed.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			St. Clair CMH: One ABA provider is working on a potential solution to shortage with BCBAs. St. Clair is looking into the idea. **Sanilac CMH continues to not have an issue with Network capacity.** **<u>Evaluation:</u> This goal is partially met. While discussions internally at the PIHP as well as with the Provider Network Committee (PNC) as a whole continue to center around service capacity, the network identifies the challenges surrounding ABA to be ongoing. The Committee does continue to address service capacity but will not consider the goal met until issues reach resolution.** **<u>Barrier Analysis:</u> No new barriers. The lack of ABA providers aligning with the needs of individuals requesting services has been a longstanding issue.** **<u>Next Steps:</u> Continue to share ideas related to ABA capacity. Additionally, PNC acknowledges the importance of continued monitoring for new gaps; thus, the Committee recommended this goal continuing into FY26.**
Provider Network	The goals for FY2025 Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards. o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Deidre Slingerland Provider Network Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The PIHP staff met internally to discuss findings from the FY2024 Compliance Review from the Health Services Advisory Group (HSAG), Follow up took place with GHS regarding outstanding questions on the Network Adequacy Report.** **The Provider Network Management (PNM) Team met with other PIHP staff to begin preparations for the upcoming report, due to MDHHS April 30th, 2025. Meetings were held with staff who completed the FY2023 report to share best practices.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			MDHHS scheduled a meeting for January 15th, 2025, to outline expectations for the upcoming FY2024 report. A draft template and invitation for questions was received on December 20th. Feedback and questions are due to the Department on January 8th. **Q2 (Jan-Mar)** **The PIHP attended an information session hosted by MDHHS to learn the new requirements for Network Adequacy reporting activities. At the end of January, the State sent out an updated template and instructions, which was forwarded to the CMHSPs. The PIHP determined that it would be more efficient to handle SUD network reporting internally this year. In March, the CMHSPs returned their completed draft reports and the PIHP aggregated the data and worked internally on Narratives.** **Q3 (April-June)** **The PIHP worked to calculate information for the Network Adequacy Reporting Template based on Performance Indicator data. Region 10 submitted the report timely in relation to the April 30 deadline. MDHHS distributed a preliminary summary of results in June and asked for PIHP feedback. Region 10 requested further information about the methodology used by the State as the PIHP was unable to replicate the findings.** **Q4 (July-September)** **The Summary Report provided by MDHHS was shared at the Committee meeting in July. Members continue to stress the need for standardized methodology. The Summary Report noted the Network meeting Standards in the areas of Assertive Community Treatment (ACT), Psychosocial Rehabilitation Programs, Pediatric Crisis Residential Programs, and Pediatric Wraparound. Unmet areas were identified as Adult Crisis Residential Programs, Opioid Treatment Programs, and Pediatric Home-Based Services.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Additionally, the PIHP participated in the Network Adequacy Validation (NAV) review on July 30th. Included in the review was the internal process for completing the Network Adequacy Template. No concerns were noted by HSAG. **<u>Evaluation:</u> This goal is considered partially met. Although the Committee identifies adherence to each objective as requirements were reviewed, responsible entities were identified and documented along with supporting evidence, and policies were reviewed, the Committee cites the need for more guidance in order to fully implement the intent of this goal.** **<u>Barrier Analysis:</u> This year, unclear guidance and standardized methodology was a noted challenge. Additionally, the barrier from FY24 remained in terms of inadequate staffing at the Provider level.** **<u>Next Steps:</u> The Committee will continue this goal in FY26. The PIHP will work to improve the process for reporting and will utilize the resulting information to make decisions about filling any identified deficiencies in the network.**
Provider Network	The goals for FY2025 Reporting are as follows: • Review most recent FY PIHP Contract Monitoring Results. o Review FY Contract Monitoring Aggregate Report. o Discuss trends and improvement opportunities.	Deidre Slingerland Provider Network Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The FY2024 Contract Monitoring Aggregate Report was completed. Overall score averages are as follows: The CMH Network Average came in at 90%, down from 93% in the 2023 monitoring cycle. The SUD Treatment Network Average was 78%, down from 87% in the 2023 monitoring cycle. SUD Prevention Network Average was 89%, down from 95% in the 2023 monitoring cycle. Lastly, the SUD Recovery Housing Network Average was 89% which remains the same as the 2023 monitoring cycle. Areas for improvement exist for the majority of providers in the areas of appeals, performance measurement and staff qualification and training.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Plans of Correction (POCs) as a result of the FY2024 reviews were sent to providers with the majority being accepted. Phone calls took place between the PIHP and Providers with outstanding plans in order to eliminate back-and-forth emails. **Q2 (Jan-Mar)** **All CMHSPs and SUD service providers prepared accepted Plans of Correction (POCs) in response to FY2024 Contract Monitoring activities. The PIHP met with each department internally to plan for FY2025 activities. A new CMHSP tool was drafted and will be used. Additionally, the PIHP decided to use the SUD Statewide Reciprocity Monitoring Tool.** **Q3 (April-June)** **Contract Monitoring Tools went out to Providers in April with early May submission deadlines. Upon receipt of desk audit documentation, Region 10 SMEs reviewed and scored all applicable standards. In June, the Provider Network Management Department along with representatives from the SUD Team and Quality Team conducted site visits of all contract providers. Discussion took place about standards and consultation occurred to assist providers in coming into compliance with any identified gaps.** **Q4 (July-September)** **The PIHP conducted site visits of subcontractors in July. Network Management staff compiled Final Reports for network providers as a result of FY2025 monitoring activities. Plans of Correction (POCs) were sent to Providers, and the PIHP began a new process for ongoing monitoring.** **Contract Monitoring findings have been used by the Network Management Team to determine recommendations for FY26 contracts.** **The PIHP notes stability and improvement across the Provider Network. The CMHSP Network Average**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			score for FY25 was 90%, unchanged from FY24. For SUD Treatment, the Network also averaged 90%, an increase of 12% over FY24. The SUD Prevention score was 94%, up from 89% in FY24. Lastly, Recovery Housing scored 94% in FY25, compared to 89% in FY24. **The FY25 Contract Monitoring Aggregate Report will go to the Region 10 PIHP Board on September 19.** **Subject Matter Experts met to debrief from the contract monitoring process in a set of meetings in order to inform FY26 planning.** **<u>Evaluation:</u> This goal was met for FY25. The Contract Monitoring process took place successfully, and tracking and trending has been completed. Issues have been identified and are currently going through the POC process.** **<u>Barrier Analysis:</u> The use of the Statewide SUD Standardized Tool impacted the PIHP's ability to trend SUD results longitudinally. Additionally, as both the PIHP and Providers were unfamiliar with the tool, there were some adaptations in the timeline that needed to be made.** **<u>Next Steps:</u> The PNC will continue with an amended version of this goal in FY26. The goal will be more action-based and cover more of the Contract Monitoring process with the intent of gathering feedback from identified Provider stakeholders earlier in the process going forward. Plans for FY26 monitoring are already taking place.**
Customer Service Inquiries	The goals for FY2025 Reporting are as follows: • To review and analyze baseline customer service inquiry data for the region for FY2025. ○ To track and trend internally the customer service inquiries on a monthly basis.	Katie Forbes PIHP Customer Service Department	**Quarterly Update:** **Q1 (Oct-Dec)** **There was a total of twenty-eight (28) customer service inquiries in Q1, this is a decrease from FY24 Q1 which had thirty-four (34) inquiries.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Identify consistent patterns related to customer service inquiries. ○ Develop interventions to address critical issues within the Network.		**Q2 (Jan-Mar)** **There was a total of twenty-eight (28) customer service inquiries in Q2, this was a decrease from FY24 Q2, which had twenty-nine (29).** **Q3 (April-June)** **There was a total of eighteen (18) customer service inquiries in Q3, which was a decrease from FY24 Q3, which had twenty-nine (29).** **Top resolution categories:** **6 (33.33%) resulted in a referral to a provider.** **5 (27.77%) resulted in a referral to Access.** **Q4 (July-September)** **Thus far in Q4 there have been nineteen (19) inquiries received. This is the same number of inquiries from July and August of FY24. Which also had nineteen (19) inquiries.** **<u>Evaluation:</u> The goal has been met. The Customer Service Department has tracked and reviewed trends related to customer service inquiries monthly. No critical issues were identified; therefore, no interventions were developed. Referrals to a Network Provider resulted in the highest resolution category at almost 41%.** **<u>Barrier Analysis:</u> None identified.** **<u>Next Steps:</u> FY26 goals will be developed.**

Reporting Period: FY							
	Q1	**Q2**	**Q3**	**Q4**			**Total**
				July	Aug	Sept	
GHS	15	10	9	3	6	n/r	43
Lapeer	5	0	1	3	0	n/r	9
PIHP	1	0	2	0	0	n/r	3
Sanilac	0	1	0	0	1	n/r	2
St. Clair	1	3	2	0	0	n/r	6
SUD	6	14	4	3	3	n/r	30
TOTAL	28	28	18	9	10	n/r	93

Inquiry Resolution Categories:	**Total**
Appeal	11
Grievance	13
Referral to Access	9
Rights Complaint	1
Referral to Provider	38
Other	8
Pending	2
Unable to Reach	11

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Appeals</td>
<td>The goals for FY2025 Reporting are as follows:

To review and analyze baseline appeals data for the region for FY2025.

To track and trend internally the appeals on a monthly basis.
Identify consistent patterns related to appeals.
Develop interventions to address critical issues within the Network.

<table>
<tr><th colspan="8">Reporting Period: FY2025</th></tr>
<tr><th rowspan="2"></th><th rowspan="2">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>July</th><th>Aug</th><th>Sept</th></tr>
<tr><td>GHS</td><td>4</td><td>0</td><td>2</td><td>2</td><td>1</td><td></td><td>9</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>SUD</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td></td><td>2</td></tr>
<tr><td>TOTAL</td><td>4</td><td>1</td><td>3</td><td>2</td><td>1</td><td></td><td>11</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Service Denial</td><td>7</td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td>1</td></tr>
<tr><td colspan="7">Service Reduction</td><td>0</td></tr>
<tr><td colspan="7">Service Suspension</td><td>0</td></tr>
<tr><td colspan="7">Service Termination</td><td>3</td></tr>
</table>
</td>
<td>Katie Forbes

PIHP Customer Service Department</td>
<td>Quarterly Update:

Q1 (Oct-Dec)
There were four (4) appeals in Q1. This is a decrease from FY24 Q1, which had six (6) appeals.

The PIHP Grievance and Appeal System Policy was revised and posted on the PIHP website.

Q2 (Jan-Mar)
The PIHP had one (1) appeal in Q2. This is a decrease from FY 24 Q2, which had four (4) appeals.

Q3 (April-June)
There was a total of five (3) appeals in Q3, which was an increase from FY24 Q3, which had two (2).
Reason for the appeal:
Two (2) appeals were for service denial.
One (1) appeal was for service termination.

Appeal outcomes:
For all three (3) appeals in Q3 the PIHP upheld the ABD notice, meaning the PIHP agreed with the decision to terminate or denial services.

Q4 (July-September)
Thus far in July and August Q4 there have been three (3) appeals. This is an increase from July and August FY 24 Q4 which had two (2).

<u>Evaluation:</u> This goal has been met. The Customer Service Department has tracked and reviewed trends related to appeals monthly. No critical issues were identified and therefore, no interventions were developed.

<u>Barrier Analysis:</u> No barriers identified.

<u>Next Steps:</u> FY26 goals will be developed.</td>
</tr>
<tr>
<td>Grievances</td>
<td>The goals for FY2025 Reporting are as follows:</td>
<td>Katie Forbes</td>
<td>Quarterly Update:</td>
</tr>
</table>

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td></td>
<td>

To review and analyze baseline grievance data for the region for FY2025.

To track and trend internally the grievances on a monthly basis.
Identify consistent patterns related to grievances.
Develop interventions to address critical issues within the Network.
Meet with CMHSPs quarterly to discuss procedures for the receipt and completion of grievances.
Conduct a first quarter record review to audit grievance records for alignment with federal and contractual requirements. Interventions will be developed based on findings. Additional record reviews may be developed based on findings.

<table>
<tr><th colspan="8">Reporting Period: FY</th></tr>
<tr><th rowspan="2"></th><th rowspan="2">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>July</th><th>Aug</th><th>Sept</th></tr>
<tr><td>GHS</td><td>45</td><td>5</td><td>0</td><td>n/r</td><td>n/r</td><td></td><td>50</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>2</td><td>1</td><td>n/r</td><td>n/r</td><td></td><td>3</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>1</td><td>n/r</td><td>n/r</td><td></td><td>1</td></tr>
<tr><td>SUD</td><td>3</td><td>4</td><td>5</td><td>1</td><td>0</td><td></td><td>13</td></tr>
<tr><td>TOTAL</td><td>48</td><td>11</td><td>7</td><td>1</td><td>0</td><td></td><td>67</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Interaction with Plan or Provider</td><td>4</td></tr>
<tr><td colspan="7">Quality of Care</td><td>33</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>22</td></tr>
<tr><td colspan="7">Member Rights</td><td>2</td></tr>
<tr><td colspan="7">Other</td><td>4</td></tr>
<tr><td colspan="7">Service Environment</td><td>2</td></tr>
</table>
</td>
<td>PIHP Customer Service Department</td>
<td>
Q1 (Oct-Dec)
Thus far in Q1 the PIHP has received two (2) grievances. The PIHP will not receive Q1 grievance data from the CMH Network until January 15th. This data will be provided in the February Quality Improvement Committee (QIC) meeting with all data received.

Additionally, the PIHP met with each CMH to discuss procedures for the receipt and completion of grievances.

The PIHP Grievance and Appeal System Policy was revised and posted on the PIHP website.

Q2 (Jan-Mar)
Thus far in FY25 Q2 the PIHP has closed three (3) grievances.

PIHP will not receive FY25 Q2 grievance data from the CMH Provider Network until April 15th. This quarterly update will be provided in the May Quality Improvement Committee (QIC) meeting.

Q3 (April-June)
The PIHP received FY25 Q3 data from the CMH Provider Network. There was a total of seven (7) grievances. This was a decrease from FY 24 Q3, which had twenty-one (21).

Q4 (July-September)
Thus far in Q4 the PIHP had one (1) grievance. However, the PIHP will not receive CMH Network grievance data until October 2025.

<u>Evaluation:</u> This goal has been met. The Customer Service Department has tracked and reviewed trends related to grievances monthly. No critical issues were identified and therefore, no interventions were developed. Unable to compare grievance volumes due to not having Q4 data from CMH Network at the time of evaluation.
</td>
</tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis:</u> The PIHP is unable to fully analyze grievance data during annual evaluation due to not having grievance data from CMH Network at the time of annual evaluation. **<u>Next Steps:</u> Develop FY2026 goals.**
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Complete Privileging and Credentialing reviews of Organizational Applications for CMH and SUD Providers. o Review and approve or deny all Organizational Applications: ▪ Current Providers ▪ New Providers ▪ Existing Provider Renewals / Updates ▪ Provider Terminations / Suspensions / Probationary Status ▪ Provider Adverse Credentialing Determinations	Divine May Privileging and Credentialing Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **The St. Clair CMH SUD Additional Location Privileging and Credentialing (P&C) Application for the Broadway location was approved with an effective date of October 1, 2024, which coincides with the FY2025 contract start date. An Organization Application for Great Lakes Recovery Center (GLRC), previously approved by the P&C Committee via email vote, was presented and approved.** **Follow up and revisions for the Provider Applications are pending more information about Universal Credentialing.** **There was no further update on GHS SUD services. There was further discussion and sharing of information with Flint Odyssey House (FOH) regarding moves to two new locations. At the close of the first quarter, the PIHP had not yet received complete P&C Applications with the necessary supporting documentation.** **The MDHHS Semi-Annual P&C Report was submitted timely. Potential remediation for CMHs whose providers exceeded the credentialing period of every two years will be discussed.** **Q2 (Jan-Mar)** **In the second quarter, the Privileging & Credentialing (P&C) Committee received and approved two (2) Additional SUD Location Organization Applications.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q3 (April-June) **In the 3rd quarter, the Privileging & Credentialing (P&C) Committee received and approved three (3) Organization Applications for SUD Providers, as well as five (5) Additional SUD Location Organization Applications for one of these Providers.** **Q4 (July-September)** **In the 4th quarter, the Privileging & Credentialing (P&C) Committee received a total of eleven (11) Organization Applications for renewal. Four (4) organizations were reviewed and approved in August, and seven (7) organization applications are for review and approval in September. Following contract termination with an SUD Provider, the Privileging & Credentialing (P&C) Committee voted and approved revocation of privileges to provide services to beneficiaries within the Region 10 network.** **<u>Evaluation:</u> This goal is considered met. All Organizational Applications for credentialing were reviewed timely in FY2025. One SUD provider contract was terminated in June. Organizational providers due for re-credentialing were asked to complete Universal Credentialing application in MDHHS Customer Relationship Management (CRM) System as well as paper application.** **<u>Barrier Analysis:</u> Understanding and navigating CRM Universal Credentialing process and its impact on processing organization applications.** **<u>Next Steps:</u> This goal is ongoing and will be carried over into FY2026.**
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Complete Privileging and Credentialing reviews of all applicable Region 10 staff. o Review and approve or deny all PIHP Individual Practitioner Applications (includes PIHP Medical	Divine May Privileging and Credentialing Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **In the 1st quarter, the Privileging and Credentialing (P&C) Committee approved Practitioner Applications for two Access Center staff previously approved by the P&C Committee via email vote. Three additional**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	Director, Chief Clinical Officer, Clinical Manager, direct hire Access Clinicians: ▪ Current Practitioners ▪ New Practitioners ▪ Existing Practitioner Renewals / Updates ▪ Practitioner Terminations / Suspensions / Probationary Status ▪ Practitioner Adverse Credentialing Determinations		**Access Staff are in process for recredentialing in January. The P&C team is following up with Region 10's Medical Director as it was recently discovered the Medical Director should be credentialed.** **Q2 (Jan-Mar)** **The Privileging & Credentialing (P&C) Committee reviewed and approved P&C Practitioner Applications for the following Region 10 Access Center staff in the second quarter: two (2) new clinicians were credentialed, and two (2) Access clinicians and a Peer Recovery Coach were recredentialed.** **Q3 (April-June)** **The Privileging & Credentialing (P&C) Committee reviewed and approved the P&C Practitioner Application for Region 10's Medical Director. Two (2) Access clinicians have submitted applications in the CRM for Universal Credentialing, as well as the PIHP's online application for comparison as Region 10 begins implementation of this new process. The P&C Team is awaiting requested application revisions from those staff members.** **Q4 (July-September)** **The Privileging and Credentialing (P&C) Committee approved full privileges for two (2) new clinicians and re-credentialed four (4) existing practitioners. The committee also approved finalized FY2026 goals.** **<u>Evaluation:</u> Region 10 approved a total of twelve (12) practitioner applications this fiscal year. All submitted P&C Practitioner Applications have been reviewed and approved timely. This goal is considered to be met for FY2025.** **<u>Barrier Analysis:</u> Understanding and navigating CRM Universal Credentialing process and its impact on processing practitioner applications.** **<u>Next Steps:</u> This goal is ongoing and will be carried over into FY2026.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. o Review and update the current PIHP Privileging and Credentialing policy content. ▪ Review for alignment between policy and applications. ▪ Revise and clarify language where needed.	Divine May Privileging and Credentialing Committee	**Quarterly Update:** **Q1 (Oct-Dec)** **There were no changes to the Privileging and Credentialing (P&C) policy in the first quarter. A memo was sent to Region 10 CMH and SUD Providers on December 10th to clarify the credentialing time frame maximum credentialing term for practitioners and organizations as two years.** **Q2 (Jan-Mar)** **In the second quarter, PIHP Privileging & Credentialing (P&C) policy was initially reviewed in relation to findings from the FY2024 MDHHS Site Review and found to support the Credentialing Standard reviewed. A more comprehensive review began in March to meet the PIHP's annual policy review timeline. Requested documentation and sample case evidence for the PIHP's FY2025 Compliance Review that included Provider Selection/Credentialing was submitted timely to HSAG on March 19th.** **Q3 (April-June)** **Privileging & Credentialing Policy review and revisions are in process. Findings by the Health Services Advisory Group (HSAG) in the area of Provider Selection during the PIHP's June 18th Compliance Review, along with the Code of Federal Regulations (CFR) and MDHHS P&C Policy, will help inform policy revisions. In May, a brief policy update related to Region 10's alignment with CFR and MDHHS P&C Policy on a change in the re-credentialing period from every two years to every three years was approved by the PIHP Board. All CMHSP and SUD providers were notified of the revision/revised policy posted on Region 10's website. Related contract amendments were prepared for CMHSPs only SUD Provider contracts were not impacted by the change. On-site Contract Monitoring for P&C and alignment with Region 10 policy was completed with all CMHSPs and SUD service**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			providers at the end of June. Preliminary findings were documented. **Q4 (July-September)** **The P&C team is continuing to review and prepare recommendations for PIHP P&C policy updates with consideration of current MDHHS and Medicaid standards, as well recommendations and preliminary findings from the Health Services Advisory Group (HSAG) from the June Compliance Review that included Provider Selection.** **<u>Evaluation:</u> Due to staffing changes, policies and processes are all being reviewed to gain more knowledge. The PIHP is working to maintain a current and comprehensive P&C Policy.** **<u>Barrier Analysis:</u> Further information is needed about Universal Credentialing processes and expectations.** **<u>Next Steps:</u> This goal is ongoing and will be carried over into FY2026.**

Credentialing / Privileging	The goals for FY2025 Reporting are as follows:
	• Participate in MDHHS' Universal Credentialing initiative.
	  o Participate in MDHHS-hosted meetings regarding Universal Credentialing.
	  o Develop necessary processes to support Universal Credentialing efforts.
		Divine May
		
		Privileging and Credentialing Committee
			Quarterly Update:
			
			Q1 (Oct-Dec)
			In the first quarter, the PIHP received meeting invitations for training to begin in January 2025. A comparison of PIHP application forms to Universal Credentialing (UC) requirements in the Customer Relationship Management (CRM) system is planned. The PIHP is awaiting training materials and more guidance on MDHHS expectations.
			
			Q2 (Jan-Mar)
			The PIHP and CMH Universal Credentialing Leads met with MDHHS for scheduled Universal Credentialing (UC) training sessions in February after completing required advance training. MDHHS hosted a Question & Answer session in early March as UC rollout continues. UC Lead contact information was sent to MDHHS as requested and a Leads meeting is

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			being planned. The PIHP is also considering Regional Leads meetings for information sharing and support. **Q3 (April-June)** **The PIHP attended a Universal Credentialing (UC) Leads meeting this quarter. Upon late May PIHP Board approval of a Privileging & Credentialing (P&C) policy change from re-credentialing every two years to every three years. Region 10 began implementation of Universal Credentialing within the MDHHS Customer Relationship Management (CRM) module.** **Q4 (July-September)** **Region 10's practitioners and organizational providers due for re-credentialing were asked to complete Universal Credentialing applications in MDHHS Customer Relationship Management (CRM) System. The practitioner use of CRM System was put on hold as the team is trying to learn more about the system's functionality. For organizational providers, the P&C team requested to complete both CRM Universal Credentialing and paper applications.** **<u>Evaluation:</u> The PIHP continues to participate in the Universal Credentialing (UC) leads meeting. The PIHP has reached out to MDHHS with questions about CRM functionality.** **<u>Barrier Analysis:</u> Learning the Universal Credentialing process / expectations.** **<u>Next Steps:</u> Develop process documents and additional guidance to support this process. Attending PIHP Universal Credentialing Leads meeting hosted by MDHHS.**
Autism Program	The goals for FY2025 Reporting are as follows: • Reduce and monitor the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services. as reported monthly on the Autism Monthly Reporting Form.	Shannon Jackson Monitored by Quality	**Quarterly Update:** **Q1 (Oct-Dec)** **By close of the first quarter, Genesee Health System reported having 251 individuals eligible and not authorized for services. St. Clair CMH reported**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form. ○ Monitor timely submission of the Autism Monthly Reporting Form and timely communication from the CMHSP Autism Leads.	Improvement Committee (QIC)	**having 42 individuals eligible and not authorized for services. Lapeer CMH reported having 30 individuals eligible and not authorized for services and Sanilac CMH reported zero cases of individuals eligible and not authorized for ABA services.** **In the first quarter, MDHHS asked the CMHSPs to submit data on Autism Waitlists and those being served in their CMH. All of those spreadsheets were submitted and MDHHS confirmed receipt.** **There has been a barrier this quarter with the timely submission of the Autism Reporting form, further follow-up and discussion is happening with the Provider Network Management (PNM) Team on how to monitor and follow-up once more with CMH Contract contacts on this matter.** **Q2 (Jan-Mar)** **By the close of Q2, Genesee Health System reported having 230 individuals eligible and not authorized for services. St. Clair CMH reported having 51 individuals eligible and not authorized for services. Lapeer CMH reported having 27 eligible and not authorized for services and Sanilac CMH has zero cases of individuals eligible and not authorized for ABA treatment.** **Genesee reported a drop of 18 individuals in their waitlist this quarter, Genesee reported families have decided to close with the agency or not pursue ABA. Tracking sheet timely submission continues to be a barrier, this monitoring was added to our Contract Monitoring tool for FY2025.** **Q3 (April-June)** **In Q3, three CMH Autism leads reported having individuals eligible and not authorized for services. At the end of the quarter, Genesee reported having 200 individuals eligible and not authorized for services, St. Clair reported having 58 individuals eligible and not authorized for services, and Lapeer reported having 22 individuals eligible and not authorized for services. Sanilac CMH continues to have zero cases of**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			individuals eligible and not authorized for ABA services. **Lapeer and Sanilac did not provide the PIHP with timely reporting forms in Q3. The timely submission of these forms was addressed in Contract Monitoring this year, and Lapeer is addressing this by putting new staff in charge of this data submission. Conversations are happening to assist the CMHs with these barriers and corrective action may be taken.** **Q4 (July-September)** **Near the end of Q4, Genesee Health System, Lapeer CMH, and St. Clair CMH reported having individuals eligible and not authorized for ABA services. GHS reported having 253 individuals eligible and not authorized for service, Lapeer CMH reported 16 individuals eligible and not authorized for services, and St. Clair CMH reported 72 individuals eligible but not authorized for services.** **<u>Evaluation:</u> Throughout FY2025 there was not a consistent improvement in reducing the number of beneficiaries overdue to begin ABA services, so this goal was not met. The PIHP requires that the CMH leads complete a monthly reporting form to provide overdue totals every month, which provided this data. From the beginning of FY2025 to its end, there were fluctuations with these numbers and lots of efforts to improve with additional providers added, this continues to be a follow up item with Corrective Action Plans through the Contract Monitoring process as well, with three of our CMHs. If we compare numbers from FY2024 at end of FY, to FY2025 numbers, Genesee Health System had consistent numbers of individuals waiting for ABA services. Lapeer CMH reduced their number of individuals waiting from last Fiscal year's number considerable, but St. Clair CMH had a significant increase in their number from a year ago of individuals eligible and waiting for ABA services.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis:</u> CMH Leads continue to report challenges with staffing and ABA provider network capacity. **<u>Next Steps:</u> The PIHP will continue to monitor overdue totals through this goal next Fiscal year. The PIHP asks for monthly updates to the ABA Network and the PIHP Autism Lead will continue to collaborate with the PIHP PNM Lead to help improve these efforts. Moving into FY2026, the PIHP will continue to monitor overdue totals with the PNM team providing network updates and this goal addressing data provided monthly on the CMH reporting forms on those not in ABA services.**
Customer Relationship Management (CRM) System	The goals for FY2025 Reporting are as follows: • Monitor the implementation and integration of the Customer Relationship Management (CRM) System and those business processes that are housed within the platform. o Provide technical assistance to users as needed. o Evaluate implementation throughout Region 10. o Maintain oversight of business processes within the CRM, including: ▪ American Society of Addiction Medicine (ASAM) Level of Care ▪ Certified Community Behavioral Health Clinic (CCBHC) Certification ▪ CMHSP Certification ▪ CMHSP Programs & Services Certification ▪ Contract Management ▪ Critical Incident Reporting ▪ Customer Service Inquiry ▪ First Responder Line ▪ Michigan Crisis and Access Line (MiCAL) ▪ Universal Credentialing ▪ Warmline	Laurie Story-Walker Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **Flint Odyssey House (FOH) is working to "transfer" the 529 Martin Luther King and 1108 Lapeer Road Level of Care (LOC) approvals to the two new locations on W. Bristol Road. Awaiting verification from MDHHS the transfers were approved.** **Q2 (Jan-Mar)** **Universal Credentialing application was rolled out in the CRM system. MDHHS provided training sessions to the PIHP and CMHSPs staff in February. PIHP staff from SUD departments were trained in the Level of Care (LOC) application and will be the lead for all future applications and renewals for SUD treatment providers.** **An overview of the CRM system was presented during the March All Staff meeting.** **Q3 (April-June)** **Universal Credentialling progress continues with two PIHP Access staff completing the credentialling process in the system and did not identify any technical issues with the process.** **Q4 (July-September)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP is awaiting training materials on changes to the ASAM Level of Care of the ASAM LOC 4th Edition and supporting the providers with the use of the CRM for Universal Credentialling. **<u>Evaluation:</u> The PIHP is working to obtain information on the upcoming changes to the ASAM LOC and has reached out to MDHHS with questions about CRM functionality for Universal Credentialling.** **<u>Barrier Analysis:</u> Learning the change(s) in the CRM for the ASAM LOC 4th Edition.** **<u>Next Steps:</u> Continue with Goal to FY26 and develop process documents for Universal Credentialling.**
Substance Use Disorder (SUD) Health Home	The goals for FY2025 Reporting are as follows: • Development of the Substance Use Disorder Health Home (SUDHH) model within Region 10. o Identify, enroll, and onboard potential Health Home Partner(s) (HHP). o Increase and manage enrollment of SUDHH beneficiaries. o Development of continuous utilization and quality improvement program.	Stephanie Rebenock Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **During this quarter, the implementation of the SUDHH program has resulted in an increased number of beneficiaries from 527 to 619 enrolled, a 17% increase. Monthly recoupments have dropped from 16% to 8% throughout the quarter as well.** **Health Home Partners (HHPs) attended all monthly meetings held by the PIHP and concerns about the improper discharging process of one HHP was addressed and resolved.** **Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released in CC360 for June 30th, 2024. This most recent data reflected the rate of 71.42 for the program in Region 10 and has exceeded the State's rate of 23.77 and total Region 10's rate of 25.45 for Follow-up within 7 days after discharge (FUA-7). For the metric of Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14), Region 10's SUDHH program did not have any beneficiaries identified, but the Program Total rate throughout the state of 21.43 fell below the States rate of 37.16 and the total of Region**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			10's rate of 36.16. This is a remarked 17% decrease for the Program Total's rate compared to the previous quarter's data in this metric. **Current enrollees for Region 10 are 619 (Arbor Recovery 243, BioMed 96, Flint Odyssey House 57, New Paths 82, SHRC Flint 66, SHRC Port Huron 33, SHRC Richmond 42).** **Q2 (Jan-Mar)** **During Q2, enrollments have decreased from 625 to 588 beneficiaries. This is due to one Provider recommending a large number of beneficiaries for disenrollment. Some of the disenrollments have been accepted while others are being researched.** **Health Home Partners (HHPs) have been attending the monthly meetings held by the PIHP. They have been engaging during the meetings and sharing any questions or concerns that they may have.** **Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released in CC360 for September 30th, 2024. For follow-up within 7 days after discharge (FUA-7), Region 10 exceeded the State's rate of 24.02 - ours being 24.23. This was down slightly from June 30th, 2024 with Region 10 being at 25.45.** **For the metric of Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14), Region 10's SUDHH program did not have any beneficiaries identified, but the SUDHH Program Total rate throughout the state was 35.71, which fell below the States (Medicaid total) rate of 37.04 and the total of Region 10's rate of 35.16.** **Current enrollees for Region 10 are 588 (Arbor Recovery 204, BioMed 100, Flint Odyssey House 68, New Paths 100, SHRC Flint 65, SHRC Port Huron 32, SHRC Richmond 42).** **Q3 (April-June)** **During Q3, enrollments have decreased from 588 to 538 beneficiaries. This is due to one provider**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			recommending a large number of beneficiaries for disenrollment and Region 10 no longer approving enrollments for this same provider due to non-compliance. **Health Home Partners (HHPs) have been attending monthly meetings being held by the PIHP. They have been engaging during the meetings and sharing questions or concerns that they may have. They have been communicative since the SUDHH coordinator has been out on leave and the prevention coordinator has been filling in.** **Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released and Region 10 exceeded the State's rate. Region 10 was notified that we will be receiving the Pay 4 Performance funds. Current enrollees for Region 10 are 538 (Arbor Recover 143, BioMed 78, Flint Odyssey House 66, New Paths 96, SHRC Flint 67, SHRC Port Huron 41, SHRC Richmond 47).** **Q4 (July-September)** **During Q4, enrollments increased from 419 beneficiaries to 435 beneficiaries. Current enrollees for Region 10 are 435 (BioMed 78, Flint Odyssey House 72, New Paths 119, Sacred Heart Flint 84, Sacred Heart Port Huron 35 & Sacred Heart Richmond 47).** **In July, FY2024 Q4 and FY2025 Q1 claims verifications were completed by the SUD team and Quality team. In total, we reviewed 25 claims. We are also preparing for the FY2025 SUDHH desk audit that will take place in late September with MDHHS.** **In August, the Region 10 OHH Benefit policy was updated and approved. The revised policy is now called the Substance Use Disorder Health Home benefit. The updated policy was sent to our Providers for awareness.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> This goal is considered partially met. The total SUDHH enrollees for Region 10 at the end of FY2025 stands at 435 beneficiaries, which is a decrease of about 18% from end of FY2024 at 527 beneficiaries enrolled. This was partly caused by our contract ending with one Provider in July 2025. The three (3) quality metrics tracked by MDHHS were met during FY2024 and paid out in August 2025. The metrics that were tracked are: Follow-up within 7 days after discharge (FUA-7), Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14) and Substance Use Disorder Emergency Department Year Review (SUD-EDYR). Each Provider was awarded and received P4P monies with Sacred Heart receiving the most, based on a logic model, approved by MDHHS. **<u>Barrier Analysis:</u> None identified.** **<u>Next Steps:</u> This goal will be continued in FY2026.**
State Opioid Response (SOR) Grant	The goals for FY2025 Reporting are as follows: • Ensure the Government Performance and Results Act (GPRA) survey is completed for all applicable SOR-funded treatment services. o Define specific criteria for GPRA survey requirements based on factors such as the demographics of populations served (including diagnosis and funding source eligibility), types of services delivered, and involvement of providers. o Provide comprehensive training for relevant providers to proficiently administer and report GPRA surveys at the necessary intervals for relevant cases. o Establish a streamlined process to communicate the mandatory completion of GPRA surveys for relevant intake referrals.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **During the first quarter Government Performance and Results Act (GPRA) compliance concerns were addressed throughout the treatment network. A State Opioid Response (SOR) Insurance Policy Funding Source was added in MIX to ensure accurate PIHP GPRA data. Providers were required to have staff attend Wayne State University's GPRA training. The PIHP discussed a SOR claims audit to further ensure SOR compliance. Discussions continue finalizing the SOR claims audit.** **Q2 (Jan-Mar)** **During the 2nd quarter the PIHP addressed GPRA survey compliance concerns with the Jail Based MAT program at the St. Clair County Jail. The PIHP continued monitoring GPRA data to ensure compliance with the SOR grant.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Develop a protocol to guarantee ongoing communication of the necessity for GPRA survey as individuals served transition to alternate providers.		**Q3 (April-June)** **During Q3 the PIHP continued monitoring GPRA compliance across the network ensuring GPRAs were uploaded into MIX. The PIHP submitted the final SOR amendment to MDHHS. Preparations for the FY25 SOR audit began.** **Q4 (July-September)** **During Q4 the PIHP participated in the FY2025 SOR audit. The PIHP received substantial compliance with no areas of concern identified. Throughout the fiscal year the PIHP worked diligently to ensure GPRA compliance and instituted new processes including the introduction of the MIX GPRA functionality for the provider network. This allowed the PIHP to track and monitor GPRA compliance in a streamlined fashion.** **<u>Evaluation:</u> Goal has been met.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Discontinue goal.**
State Opioid Response (SOR) Grant	The goals for FY2025 Reporting are as follows: • Ensure that Government Performance and Results Act (GPRA) completion is tracked and matched to PIHP ID numbers. ○ Establish a streamlined procedure to align GPRA surveys reported to Wayne State University with individual cases served by Region 10. ○ Monitor and analyze GPRA completion data from Qualtrics (Wayne State University) in conjunction with referrals initiated by Region 10 Access, ensuring alignment where GPRA surveys are necessary. ○ Institute clear benchmarks for evaluating provider performance and adherence to Region 10's SOR/GPRA criteria. ○ Implement a structured approach for identifying and addressing data disparities, particularly focusing on	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **During the first quarter, the PIHP worked on aligning Wayne State University's Qualtrics data with individual cases served by the PIHP. The State Opioid Response (SOR) Insurance Policy Funding Source in MIX allowed the PIHP to track Government Performance and Results Act (GPRA) surveys and compare Qualtrics data and MIX data to find inaccuracies in Wayne State University's GPRA Monthly Summary. In the month of October, the PIHP had completed more GPRAs than the Wayne State University report had documented.** **Q2 (Jan-Mar)** **During the 2nd quarter SOR GPRA data was matched with Qualtrics data provided by Wayne State**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	referrals necessitating GPRA surveys with no corresponding data in Qualtrics.		**University. The provider network completed roughly 300 GPRAs.** **Q3 (April-June)** **During Q3 the PIHP continued to monitor GPRA submissions ensuring they were uploaded into MIX. WSU data shows the provider network completed roughly 520 GPRAs. The PIHP is vigilantly monitoring the SOR treatment and recovery housing budgets as the allocated budget is approached.** **Q4 (July-September)** **During Q4 the PIHP participated in the FY2025 SOR audit. The PIHP received substantial compliance with no areas of concern identified. In FY2025 the PIHP's provider network completed over 520 GPRAs. Many processes were put in place to ensure GPRA compliance and the PIHP instituted clear benchmarks for evaluating provider performance and adherence to Region 10's SOR/GPRA criteria.** **<u>Evaluation:</u> Goal has been met.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Discontinue Goal.**
Certified Community Behavioral Health Clinic (CCBHC) Demonstration	The goals for FY2025 Reporting are as follows: • Continue development of the Certified Community Behavioral Health Clinic (CCBHC) demonstration within Region 10. o Follow up on and monitor MDHHS Site Visit deficiencies. o Review CCBHC Reported Measures and State Reported Measures to maintain oversight of CCBHC Demonstration performance measures and to ensure Quality Bonus Payment benchmarks are met. o Oversee enrollment of CCBHC Beneficiaries in the WSA and maintaining accurate enrollee reporting:	Dena Smiley / Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **At the end of the first quarter, there were approximately 1090 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 79 cases in our queue to process. MDHHS announced that they are working with Optum to develop a CCBHC clinic view of the state reported** **measures. There will be a MichiCANS training for all CMHs and PIHPs once this rolls out.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Continue updating WSA processes per the most current version of the Demonstration Handbook changes or implementations. ▪ Complete assignment into the program, transfer cases, and disenroll consumers, as needed. ▪ Continuing WSA Subcommittee meetings with CCBHC staff. o Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. o Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.		**MDHHS has published Version 2.0 of the CCBHC Handbook. That handbook is available on the MDHHS website for review.** **Region 10 held a WSA Quarterly meeting with CMH Leads in December. The PIHP will be following up on questions asked during the meeting.** **There is a CCBHC Cost Report Meeting with MDHHS on January 10th and a CCBHC Lunch & Learn will be held on February 6th.** **Q2 (Jan-Mar)** **At the close of March, there were approximately 696 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 1000 cases in our queue to process.** **MDHHS has distributed the CCBHC Demonstration Handbook, V2.1, for feedback and recommended changes. Region 10 will submit proposed changes and feedback by April 4th due date.** **Work is being done internally on the FY24 CCBHC annual metrics and will be submitted to MDHHS.** **The next CCBHC Lunch and Learn Collaborative with MDHHS will be held on May 1st.** **Q3 (April-June)** **At the close of June, there were approximately 2,636 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 95 cases in our queue to process.** **In the PIHP-CCBHC Payment Transition Meeting last month MDHHS announced there will not be an expansion of CCBHC sites in FY26 since the funds are not available.** **Additionally, they shared that there will be a transitioning period for CCBHC services with the PIHP and changes within the WSA and Reporting Requirements. MDHHS is working on a handbook and expect to have that out by the end of July.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The next CCBHC Bimonthly Meeting with MDHHS will take place on July 17th. **Q4 (July-September)** **During Q4 approximately 535 cases were assigned in the Waiver Support Application. Region 10 has approximately 136 cases in our queue to process. MDHHS distributed the draft CCBHC Handbook and asked for feedback. Starting Oct 1, 2025 Region 10 will no longer have any direct oversight over any CCBHC activities.** **<u>Evaluation:</u> At the time of this report, Region 10 assigned a total of 4,957 cases in the Waiver Support Application. Region 10 has noticed a decrease in compliance issues with cases that are being submitted. This fiscal year MDHHS completed CCBHC site visits to three CMHSPs.** **<u>Barrier Analysis:</u> No barriers noted** **<u>Next Steps:</u> Region 10 will assign outstanding cases in Waiver Support Application and follow-up with CMH on any outstanding questions regarding transfers in WSA before Oct 1. This goal will not continue in FY2026.**
1915(i) State Plan Amendment (SPA)	The goals for FY2025 Reporting are as follows: • Continue development of the 1915(i)SPA model within Region 10. o Enroll and manage eligible 1915(i) Home and Community-Based Services State Plan Amendment Benefit beneficiaries in the Waiver Support Application (WSA) and maintain accurate enrollee reporting. o Monitor beneficiary enrollment to meet MDHHS guidelines regarding assessments, evaluator credentials, and overlap with other programs. o Monitor the number of beneficiaries with untimely re-evaluations and document efforts to reduce untimeliness.	Laurie Karig Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **Region 10 closed out the first quarter with 2,759 open cases, down 36 cases from October. The number of past due re-evaluation or disenrollment cases for the CMHs to process trended up over the quarter and is currently at 635 cases: GHS-97 cases; Lapeer CMH-53 cases; Sanilac CMH-28 cases; St. Clair CMH-457 cases. The PIHP will meet individually with the CMHs in January to discuss barriers and find resolutions. The December WSA release to correct Medicaid eligibility technical issues was not as effective as hoped as the mismatch between eligibility in MIX and in the WSA continues. The PIHP has sent sample cases at**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Review and share reports and barriers to maintain timely submission and processing of Re-evaluations and disenrollments. o Educate PIHP and CMHSP staff on 1915(i) requirements as changes are made.		**MDHHS' request so they may review the issues. The Waiver Renewal is still pending after the October extension. There was no MDHHS or PIHP iSPA Leads meeting in December. MDHHS updates on bi-directional work are anticipated at January's meeting. Quarterly meetings are being planned with the CMHs to follow up on the CAPs submitted in October after MDHHS shared Site Review findings.** **Q2 (Jan-Mar)** **The PIHP closed out the 2nd quarter with 2,546 open iSPA cases and the following past due evaluation/ disenrollment case counts: GHS - 91; Lapeer CMH - 53; Sanilac CMH – 19; and St. Clair CMH – 278. Toward the goal of reducing the number of past due re-evaluation and disenrollment cases, the overall count was down 32 percent compared to the end of the 1st quarter. Monthly meetings with St. Clair CMH began in January to focus on discussing barriers and finding resolution resulted in a 39 percent reduction in past due cases by the end of the quarter. CMHSPs noted continuing barriers to case processing included Medicaid eligibility issues, as well as new WSA business rules regarding use of the MichiCANs assessment. At the March PIHP-CMH Leads meeting, GHS shared they are unable to process nearly 50 past due cases related to these issues which MDHHS is working on with OPTUM.** **The iSPA Amendment was approved with an effective date of January 16th. MDHHS reviewed the changes during their monthly Leads meetings. Bulletins and Medicaid Provider Manual updates related to those changes are expected soon. Progress on bi-directional work toward Electronic Medical Record (EMR) Integration work has slowed. It is anticipated that this project will be piloted at a PIHP that serves both CCHBC and iSPA beneficiaries. Follow up and meetings with the CMHSPs continued related to MDHHS Site Review Corrective Action Plans (CAPs) issued. Findings had included several iSPA cases.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			CMHSP final responses and documentation were submitted to MDHHS on March 31st **Q3 (April-June)** **Region 10 closed out the second quarter with 2,577 open cases, down 182 cases from the end of the first quarter. The number of past due re-evaluation or disenrollment cases for the CMH's has trended downward significantly. Currently there are 137 cases: GHH 21; Lapeer CMH-27; Sanilac CMH-8; St. Clair CMH-81.** **The 1915(i)SPA Amendment was renewed with an effective date of 1/16/25. Work continues with the WHODAS 2.0 assessment, with information disseminated in May for a steering committee. The training for WHODAS 2.0 is tentatively scheduled to occur in the fall of 2025. WSA update was completed in May, this included updated business rules for disenrollments as well as allowing PIHP's to re-open cases that were once closed. The Bi-directional work with WSA and PCE is continuing. The pilot application for CCBHC was started, however the pilot application for 1915(i)SPA was postponed due to coding issues. The June MDHHS-PIHP iSPA leads meeting was cancelled for June. Quarterly meetings with CMH's are continuing to follow up on the State Site review and the findings.** **Q4 (July-September)** **Medicaid Proposed Policy 2507-BH-P was issued with a proposed start date of September 1, 2025. The proposed policy contained an update in the Assessment tool to be used with individuals with intellectual and developmental disabilities. The bulletin also contains language changes to 1915(i)SPA services. Fiscal Intermediary will be Financial Management Services and Supported Employment services will be two distinct services; Individual Supported Employment and Small Group Employment.** **An Adaptive Equipment flyer was developed in collaboration with the CSHCS and was included in our July meeting information.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			At the end of August, the total enrollment was 2,498. This is a 9.4% decrease over the course of the fiscal year. The number of potential enrollees identified at the end of August is 5,945. The number of past due re-certifications continued to trend downward through August. The total number of past due evaluations was 37, GHS with 31, Lapeer CMH and Sanilac CMH with 1 case each and St. Clair with 4. This was a 94.2% decrease in the number of past due evaluations. **<u>Evaluation:</u> Goals have been met.** **<u>Barrier Analysis:</u> Identification of Medicaid eligibility continues to be a barrier for this program within the WSA, the disenrollment process continues to be cumbersome. Decreasing enrollment is a concern, especially when there is a high number of potential enrollees.** **<u>Next Steps:</u> Monitoring of this program will continue in the next fiscal year, however the iSPA will be combined with the 1915(c) Waiver Goals for external monitoring.**
Verification of Services	The goals for FY2025 Reporting are as follows: • The PIHP will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors. o Conduct quarterly claims verification reviews for each provider contracted during the quarter being reviewed. o Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. o Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. o Send Explanation of Benefits (EOB) letters biannually during the fiscal year.	Divine May Quality Management & Data Management Departments	**Quarterly Update:** **Q1 (Oct-Dec)** **The Claims Verification Team completed an audit of claims from FY2023 and FY2024. The team worked on preparing final letters with findings and next steps in response to findings.** **The PIHP's claims verification processes will be revisited and updated.** **The annual report with claims verification methodology, findings, and actions taken in response to findings was prepared and submitted to MDHHS.** **Explanation of Benefits (EOB) letters were sent out.** **Q2 (Jan-Mar)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Send EOB letters to more than 5% of consumers receiving services.		**In the 2nd quarter, the Claims Verification Team continued the follow up process related to findings from the FY2023 and FY2024 claims review. Final letters regarding PIHP findings were emailed to Providers in early January. A meeting was held with Region 10's CEO to discuss recommendations and obtain clarification following the receipt of Appeal letters from seven (7) Providers. A review of findings related to bed checks, claims submitted by an SUD Treatment Provider, and other items was in process. At the end of March, a final response to Appeal was sent to one Provider and others are being drafted. The FY2025 Q1 Program Integrity Report with activity updates related to Medicaid claims verification reviews was submitted to Region 10's Corporate Compliance Dept. With assistance from the PIHP Finance Department, methodology was discussed and a case sample was selected for the next quarterly claims review, tentatively beginning in April.** **Q3 (April-June)** **In the 3rd quarter, the Claims Verification Team attended internal meetings related to items requiring follow up from the FY2023 Q4 through FY2024 Q3 review. A 2025 schedule for claims reviews was implemented. Methodology for the sample selection for the Claims Verification cycle including FY2024 Q4 and FY2025 Q1 claims was confirmed and the random sample selection was completed. Case samples were sent to all CMH and SUD service providers, and most supporting documentation was received in late May. At the close of June, all CMHSP documentation had been reviewed for the current cycle, and SUD Provider documentation review was in process. Claims Verification policy is also under review. Additionally, Explanation of Benefits (EOB) letters were mailed to the required percentage of consumers receiving services in June.** **Q4 (July-September)** **The Claims Verification Team continues to review FY2024 Q4 and FY2025 Q1 claims documentation**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			submitted by Region 10 service providers. Internal PIHP meetings were held toward wrapping up any outstanding items from the FY2023 Q4 through FY2024 Q3 claims review. FY2026 Quality Assessment Performance and Improvement Program (QAPIP) goal recommendations have been prepared for review. PIHP Claims Verification Policy recommendations revisions are currently in progress. **<u>Evaluation:</u> The Claims Verification team continues to complete verification reviews for all Region 10 Contracted service providers. The annual Claims Verification Report was submitted to MDHHS timely, and the Explanation of Benefits letters were mailed out to the required percentage of consumers receiving services. The Claims Verification team continues to work on recommendations for policy revisions and the implementation of guidance about documentation expectations for service providers.** **<u>Barrier Analysis:</u> For the review of FY2023 Q4 through FY 2024 Q3, documentation issues slowed down the verification process. The new documentation guidance sent to the providers for the FY2024 Q4 and FY2025 Q1 claims documentation has seemingly removed this barrier going forward.** **<u>Next Steps:</u> This goal is ongoing and will be carried over into FY2026.**
Long-Term Services and Supports	The goals for FY2025 reporting are as follows: • The PIHP will assess the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS), including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. Mechanisms to assess include: o Periodic reviews of plans of service o Utilization reviews o Claims verification reviews	Tom Seilheimer / Lauren Campbell / Crystal Eddy Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec)** **SUD FY2024 annual utilization review (UR) has been completed, and a longitudinal report was shared at the SUD network quarterly meeting. Quarterly reporting for CMH UR (OASIS, CHIPS) was completed at the December meeting.** **Periodic reviews of plans of service continue per person-centered planning principles, but the reviews of**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Clinical case record reviews ○ Customer satisfaction surveys • The PIHP will assess each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. Mechanisms to assess include: ○ Biopsychosocial assessments ○ Ancillary assessments • At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.		**these plans are pended to the utilization review case record review process.** **1915(c) Waiver and 1915(i)SPA enrollee cases were reviewed during the 2024 MDHHS Site Review.** **Claims verification reviews were wrapped up for the random sample of claims from FY2023 and FY2024.** **Following the administration of the FY2024 Customer Satisfaction Survey, the PIHP aggregated responses and prepared a final report with findings.** **Through the person-centered planning process, the PIHP ensures the CMHs conduct initial and annual biopsychosocial assessments, and other assessments as needed.** **Q2 (Jan-Mar)** **The Utilization Management Committee reviewed the second quarter utilization review case record review reports and findings.** **Periodic reviews of plans of service continue per person-centered planning principles, but the reviews of these plans are pended to the utilization review case record review process.** **1915(c) Waiver and 1915(i)SPA enrollee cases were reviewed during the 2024 MDHHS Site Review. Follow-up on corrective action plans continued during the second quarter.** **Claims verification reviews were wrapped up for the random sample of claims from FY2023 and FY2024.** **The PIHP continued planning for the FY2025 Customer Satisfaction Survey.** **Through the person-centered planning process, the PIHP ensures the CMHs conduct initial and annual biopsychosocial assessments, and other assessments as**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			needed. In March, a regional training on person-centered planning was facilitated by the MDHHS Lead in this area. **Q3 (April-June)** **Case Record selection is underway for the SUD Network Utilization Review (UR) activities. The Q3 CMHSP utilization case record review was completed, and reports were reviewed by UMC during the June meeting.** **1915(c) Waiver and 1915(i)SPA enrollee cases were reviewed during the 2024 MDHHS Site Review. Through the 2025 Contract Monitoring cycle, the PIHP reviewed a random selection of 1915(c) and 1915(i)SPA enrollee cases for compliance with MDHHS standards and policies.** **The PIHP review of FY2024 Q4 and FY2025 Q1 claims began in late May. Items outstanding from the previous review of FY2023 Q4 through FY2024 Q3 are being wrapped up.** **The FY2025 Customer Satisfaction Survey is progressing as per plan and will commence the last week of July.** **Q4 (July-September)** **Annual SUD Network utilization review (UR) activities have been completed. The Q4 CMHSP UR case record reviews will be conducted during September.** **1915(c) Waiver and 1915(i)SPA enrollee cases were reviewed during the 2024 MDHHS Site Review. Through the 2025 Contract Monitoring cycle, the PIHP reviewed a random selection of 1915(c) and 1915(i)SPA enrollee cases for compliance with MDHHS standards and policies.** **The PIHP review of FY2024 Q4 and FY2025 Q1 claims began in late May. Items outstanding from the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			previous review of FY2023 Q4 through FY2024 Q3 are being wrapped up. **The FY2025 Customer Satisfaction Survey is progressing as per plan.** **<u>Evaluation:</u> The PIHP and the provider network assessed the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS) using periodic reviews of plans of service, utilization reviews, claims verification reviews, clinical case record reviews, and customer satisfaction surveys. The PIHP and provider network also assessed each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring using biopsychosocial assessments and ancillary assessments. The PIHP conducted quarterly utilization reviews.** **<u>Barrier Analysis:</u> Progress** **<u>Next Steps:</u> Continue these activities. Further define the LTSS population per a recommendation from HSAG.**
External Quality Review Corrective Actions	The goals for FY2025 Reporting are as follows: • Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. o Standard Leads will report Compliance Review CAP updates monthly to the External Quality Review Team. o Recommendations resulting from the Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review will be addressed by the Provider Network Management Department, Quality Management Department, and Data Management Department. o Any recommendations resulting from the Encounter Data Validation (EDV) activity will be addressed by the	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation and Network Adequacy**	**Quarterly Update:** **Q1 (Oct-Dec)** **The 2024 Performance Measure Validation (PMV) report was received from the health Services Advisory Group (HSAG). The PIHP PMV Team reviewed and scheduled a meeting to discuss the recommendations in November. An internal Recommendation Tracking Template will be used to track the recommendations and PIHP Team's action steps. The 2024 PMV Review Report was presented to the Quality Management Committee (QMC). The QMC discussed the weaknesses and recommendations provided by HSAG.** **HSAG provided materials for the 2024 Network Adequacy Validation (NAV) Review. All follow-up**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	Quality Management Department and Data Management Department. Following the SFY2024 Compliance Review of Region 10 PIHP, designated Standard Leads will address any recommendations and deficiencies for the following areas: • Standard I. Member Rights and Member Information • Standard III. Availability of Services • Standard IV. Assurances of Adequate Capacity of Services • Standard V. Coordination and Continuity of Care • Standard VI. Coverage and Authorization of Services	**Validation Review:** Lauren Campbell **Encounter Data Validation Activity:** Lauren Campbell and Laurie Story-Walker	**items were addressed and HSAG approved the PIHP's logic for reporting time and distance standards. A draft or final report was not received.** **No further information was received for the Encounter Data Validation (EDV) activity.** **The SFY2024 Compliance Review Report and Corrective Action Plan (CAP) Template documents were received from HSAG.** **The External Quality Review (EQR) Team facilitated a SFY2025 Compliance Review Kick-Off meeting with Standard Leads. HSAG provided a timeline for the Compliance Review activities. The SFY2025 Compliance Review is scheduled for June 18, 2025.** **Q2 (Jan-Mar)** **Materials for the SFY2025 Compliance Review were received from the Health Services Advisory Group (HSAG). The External Quality Review (EQR) Team attended a technical assistance webinar hosted by HSAG. The materials and instructions were distributed to Standard Leads. Standard Leads worked on Compliance Review Tools and collection of evidence documents for the SFY2025 Compliance Review. Compliance Review Tools and evidence documents were submitted to HSAG in March.** **Instructions were received from HSAG for the 2025 Encounter Data Validation (EDV) activity. HSAG hosted a kick-off meeting with PIHPs. PIHPs were asked to submit encounter data to HSAG using a set of specific instructions. PIHPs have discussed how to prepare the requested information. The 2025 Encounter Data Validation (EDV) activity data was submitted to HSAG in February. Region 10 has not received any feedback from HSAG at the conclusion of the second quarter.** **HSAG approved Region 10's SFY2024 Compliance Review Corrective Action Plan (CAP). Additionally,**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Standard Leads from the SFY2024 Compliance Review were asked to provide updates on the CAPs and recommendations. **PIHPs received an invitation for the 2025 Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Technical Assistance Webinar. Reviews will be conducted between July 1, 2025 – August 1, 2025.** **Q3 (April-June)** **During the 3rd quarter, planning and mock review took place in preparation for the interview with the Health Service Advisory Group (HSAG) on June 18th. Following the review, additional documentation was submitted timely.** **Region 10 prepared for the 2025 HSAG Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review, scheduled for July 30, 2025. A technical assistance webinar was attended May 7, 2025, by the PMV/NAV team. The PIHP EDV Leads worked on written responses and updated data extracts to address HSAG's preliminary findings and comments.** **Q4 (July-September)** **The PIHP participated in the 2025 performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review. The PIHP addressed follow-up items from the review immediately following the review and as follow-up items were received from the Health Services Advisory Group (HSAG) into August and September.** **Additionally, the PIHPs learned there will not be a FY2026 Compliance Corrective Action Plan (CAP) Review.** **<u>Evaluation:</u> Standard Leads continue to provide updates on Corrective Action Plans and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Recommendations using the internal tracking templates. **<u>Barrier Analysis:</u> No barriers were identified.** **<u>Next Steps:</u> Continue implementing CAPs and addressing recommendations from External Quality Reviews and await September draft report of SFY2025 Compliance Review findings and recommendations. Continue a similar goal to this in FY2026 to address findings from the SFY2025 Compliance Review and any other EQR activity findings.**

Region 10 PIHP Board Officers

CHAIRPERSON
Lori Curtiss

VICE CHAIRPERSON
Robert Kozfkay

SECRETARY
Ted Hammon

TREASURER
Edwin Priemer

Region 10 PIHP Board General Membership

Bobbie Cutcher

Dr. Niketa Dani

Ellen Ellenburg

John Groustra

Joyce Johnson

Chad Polmanteer

Nancy Thomson

Rev. Dr. Rabon Turner

Jerry Webb

As of 09.04.2025