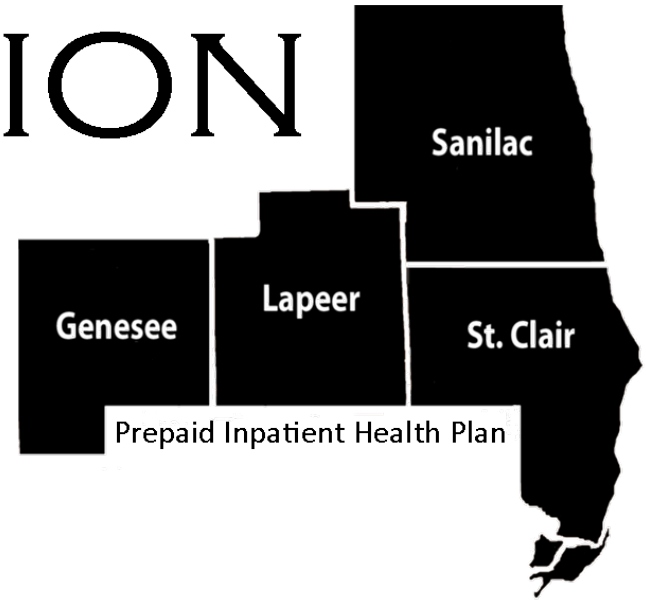
REGION 10



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.	Shelley Wilcoxon Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: This goal has been met as the FY2024 QI Program Evaluation was submitted timely to the Quality Improvement Committee and the PIHP Board.** **Barrier Analysis: No barriers.** **Next Steps: Continue with monthly QI Committee feedback and timeline for FY2025.**
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.	Shelley Wilcoxon Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: This goal is considered met as the FY2025 QI Program Description and Workplan were presented to and approved by the QIC and PIHP Board timely.** **Barrier Analysis: No barriers.** **Next Steps: Continue to monitor the Workplan throughout the year for necessary changes.**
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.	Crystal Eddy	**Quarterly Update:** **Q2 (Jan-March):** **IPLT members discussed Clinical Practice Guidelines FY 2025 evaluation activities. IPLT members have been**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor utilization of the PIHP Clinical Practice Guidelines. ○ Complete annual and biennial evaluation reports as per policy. ○ 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). ○ Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan. ○ Support CMHSP implementation of the nine core Certified Community Behavioral Health Clinic (CCBHC) EBPs.	Improving Practices Leadership Team (IPLT)	**provided with the UM Analysis Report for review and have been asked to provide recommendations for services evaluation prior to the April IPLT meeting.** **Evaluation: Progressing toward target** **Barrier Analysis: None** **Next Steps: Obtain IPLT member recommendations for Clinical Practice Guideline activity and discuss in April IPLT meeting.**
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: ○ CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) ○ Standardized employment services data and report formats ○ In-service / informational materials ○ Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS]) ○ Discuss/support consideration of Individual Placement and Support (IPS) service model.	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q2 (Jan-March):** **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 issues with utilizing the service request auto-approval system.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue per annual plan**
Home & Community Based Services	The goals for FY2025 Reporting are as follows:	Dena Smiley / Tom Seilheimer	**Quarterly Update:** **Q2 (Jan-March):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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.	Improving Practices Leadership Team (IPLT)	**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.** **Evaluation: Progress Noted** **Barrier Analysis: No barriers** **Next Steps: Fulfill MDHHS's requests and meet the Corrective Action plan to CMS**
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:** **Q2 (Jan-March):** **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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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. **Evaluation: Progress Noted** **Barrier Analysis: No barriers** **Next Steps: Continue**
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:** **Q2 (Jan-March):** **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.** **Evaluation: Progressing on target** **Barrier Analysis: 100% compliance with SUD provider Network submitting Risk Event Reports quarterly.** **Next Steps: UM Manager to collaborate with SUD Director and Provider Network Manager about RE/RM quarterly reporting per policy. Continue PIHP quarterly monitoring.**
Michigan Mission Based Performance Indicator System (MMBPIS)	The goals for FY2025 Reporting are as follows: • The goal is to attain and maintain performance standards as set by the MDHHS contract. o Report indicator results to MDHHS quarterly per contract. o Review quarterly MMBPIS data. o Achieve and exceed performance indicator standards and benchmarks. o Ensure follow up on recommendations and guidance provided during External Quality Reviews	Lauren Campbell Quality Management Committee (QMC)	**Quarterly Update:** **Q 2 (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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.		**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.** **Evaluation: Progress** **Barrier Analysis: Follow-up was needed on a few PI events to either change the PI event disposition or for new supporting documentation to be provided.** **Next Steps: Submit FY2025 Q1 PIs to MDHHS. Prepare the FY2025 Q1 PI Report. Participate in the Behavioral Health Quality Transformation Workgroup if/when convened by MDHHS.**

	FY24 Q3	FY24 Q4	FY25 Q1	FY25 Q2
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%				
1.1 Children	98.97%	99.59%	98.26%	
1.2 Adults	99.90%	99.20%	97.73%	
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%				
2a PIHP Total	50.66%	54.41%	52.68%	
2a.1 MI-Children	48.60%	54.83%	50.08%	
2a.2 MI-Adults	51.30%	55.87%	55.03%	
2a.3 DD-Children	54.89%	43.26%	48.56%	
2a.4 DD-Adults	45.68%	68.42%	48.21%	
Ind. 2b – 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%				
2b SUD	77.74%	79.04%	78.20%	
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%				
3 PIHP Total	75.02%	78.72%	78.19%	
3.1 MI-Children	75.16%	80.60%	78.73%	
3.2 MI-Adults	71.38%	75.69%	76.54%	
3.3 DD-Children	90.34%	88.30%	87.50%	
3.4 DD-Adults	78.79%	78.69%	71.79%	
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%	
4a.2 Adults	97.90%	95.18%	95.91%	
4b SUD	93.90%	91.67%	90.48%	

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<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td colspan="5">Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td></tr>
<tr><td>10.1 Children</td><td>12.08%</td><td>10.77%</td><td>9.72%</td><td></td></tr>
<tr><td>10.2 Adults</td><td>13.89%</td><td>13.90%</td><td>13.32%</td><td></td></tr>
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</td><td></td><td></td></tr>
<tr><td>Members' Experience</td><td>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.</td><td>Divine May

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

Q 2 (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.

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.

Evaluation: Progress
Barrier Analysis: None
Next Steps: Continue planning for FY2025 Customer Satisfaction Survey</td></tr>
<tr><td>State Mandated Performance Improvement Projects (PIPs)</td><td>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.</td><td>Tom Seilheimer

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

Q2 (Jan-March):
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 informed by preliminary analyses of re-measurement 2 data.

Evaluation: Progress</td></tr>
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Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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. • 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.		**Barrier Analysis: PIP 2 lag in data posting per data based on claims processing** **Next Steps: Continue per annual plan**
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:** **Q2 (Jan-March):** **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 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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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.** **Evaluation: Progress** **Barrier Analysis: Slot Utilization for the HSW Program** **Next Steps: Continue**
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:** **Q2 (Jan-March):** **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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Evaluation: Progress **Barrier Analysis: No barriers** **Next Steps:**
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:** **Q2 (Jan-March):** **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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: The next training session focused on the EQI reporting process to be held at GHS in June.**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. o Monitor and advise on Peter Chang Enterprises (PCE)-based crisis service utilization reports (monthly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: Progressing to target** **Barrier Analysis: None** **Next Steps: Continue monitoring.**
Utilization Management	The goals for FY2025 Reporting are as follows:	Crystal Eddy	**Quarterly Update:** **Q2 (Jan-March):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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).	Utilization Management (UM) Committee	**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.** **Evaluation: Progressing to target** **Barrier Analysis: None** **Next Steps: Continue monitoring quarterly**
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:** **Q2 (Jan-March):** **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.** **Evaluation: Progressing to target** **Barrier Analysis: None** **Next Steps: Continue monitoring.**
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:** **Q2 (Jan-March):** **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**

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.		**in the person-centered planning process, and monitoring implementation planning for CFAP.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue per annual plan**
Utilization Management	The goals for FY2025 Reporting are as follows: • Promote centralized care management operations across the regional Access Management System (AMS). ○ Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q2 (Jan-March):** **The EOFY2024 Annual Report was included in the FY2024 UM Program Plan Annual Evaluation Report sent to QIC for final review/approval.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue per annual plan**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate community access / care management activities. ○ Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: On Target** **Barrier Analysis: None** **Next Steps: Continue quarterly monitoring**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on regional Adverse Benefit Determination (ABD) operations and reporting processes. ○ Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: On target**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Barrier Analysis: None **Next Steps: Continue quarterly monitoring**
Corporate Compliance	The goals for FY2025Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements o Identify and document responsible entities o Identify and document supporting evidence / practice o Policy review o Review PIHP Corporate Compliance Plan updates • 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).	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: Progress.** **Barrier Analysis: No new barriers.** **Next Steps: Review findings with MDHHS OIG.**
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:** **Q2 (Jan-March):** **HIPAA Privacy and Security Measures Policy (03.03.01) and HIPAA Privacy Measures- Protected 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.** **Evaluation: Progress.** **Barrier Analysis: No new barriers.** **Next Steps: Monitoring of Network Providers.**
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:** **Q2 (Jan-March):** **FY2024 Contract Monitoring has one provider plan of correction pending resolution. FY2025 Annual Contract**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Review current CMH Subcontractor contract monitoring process / content.		**Monitoring Tools were reviewed, and updates have been completed.** **Evaluation: Progress.** **Barrier Analysis: No new barriers.** **Next Steps: Monitoring of Provider Networks**
Provider Network	The goals for FY2025 Reporting are as follows: • Address service capacity concerns and support resolution of identified gaps in the network. ○ Review and address CMH Network gaps and capacity concerns. ○ Review and address SUD Network gaps and capacity concerns.	Deidre Slingerland Provider Network Committee	**Quarterly Update:** **Q2 (Jan-March):** **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 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.** **Evaluation: Progress continues. Each CMHSP continues to work internally on addressing gaps and shares updates with the PIHP for discussion.** **Barrier Analysis: No new barriers.** **Next Steps: Continue discussions and explore partnering with Head Start or other agencies following upcoming State ABA guidance.**
Provider Network	The goals for FY2025 Reporting are as follows:	Deidre Slingerland	**Quarterly Update:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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.	Provider Network Committee	**Q2 (Jan-March):** **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.** **Evaluation: Progress has been made. Requirements were reviewed this quarter and subsequently distributed.** **Barrier Analysis: No new barriers.** **Next Steps: Complete Network Adequacy reporting activities related to FY2024 and submit to MDHHS. Review policy as a result of findings.**
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:** **Q2 (Jan-March):** **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.** **Evaluation: Progress has been made. The review of FY2024's contract monitoring process led to many improvements in FY2025.** **Barrier Analysis: The SUD Statewide Reciprocity Monitoring Tool does not easily align with current monitoring practices at the PIHP. As it was developed without input of Region 10 staff, its implementation has been challenging.** **Next Steps: Distribute FY2025 Contract Monitoring tools to Providers**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Customer Service Inquiries</td>
<td>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.
Identify consistent patterns related to customer service inquiries.
Develop interventions to address critical issues within the Network.

<table>
<tr><th colspan="8">Reporting Period: FY</th></tr>
<tr><th></th><th>Q1</th><th colspan="3">Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th></th><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th></th><th></th><th></th></tr>
<tr><td>GHS</td><td>15</td><td>2</td><td>0</td><td>8</td><td></td><td></td><td>25</td></tr>
<tr><td>Lapeer</td><td>5</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>5</td></tr>
<tr><td>PIHP</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>1</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>1</td><td>0</td><td></td><td></td><td>1</td></tr>
<tr><td>St. Clair</td><td>1</td><td>0</td><td>1</td><td>2</td><td></td><td></td><td>4</td></tr>
<tr><td>SUD</td><td>6</td><td>8</td><td>4</td><td>2</td><td></td><td></td><td>20</td></tr>
<tr><td>TOTAL</td><td>28</td><td>10</td><td>6</td><td>12</td><td></td><td></td><td>56</td></tr>
<tr><th colspan="7">Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>6</td></tr>
<tr><td colspan="7">Grievance</td><td>9</td></tr>
<tr><td colspan="7">Referral to Access</td><td>3</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>21</td></tr>
<tr><td colspan="7">Other</td><td>6</td></tr>
<tr><td colspan="7">Pending</td><td>2</td></tr>
<tr><td colspan="7">Unable to Reach</td><td>9</td></tr>
</table>
</td>
<td>Katie Forbes

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

Q2 (Jan-March):
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).

Evaluation: Progress towards goal.
Barrier Analysis: None
Next Steps: Continued efforts towards goal.</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>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: FY</th></tr>
<tr><th></th><th>Q1</th><th colspan="3">Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th></th><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th></th><th></th><th></th></tr>
<tr><td>GHS</td><td>4</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>4</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td></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></td><td></td><td>0</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>1</td><td>0</td><td></td><td></td><td>1</td></tr>
<tr><td>TOTAL</td><td>4</td><td>0</td><td>1</td><td>0</td><td></td><td></td><td>5</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Grievance not resolved within 90 days</td><td>0</td></tr>
<tr><td colspan="7">Grievance not resolved within allowed days</td><td>0</td></tr>
<tr><td colspan="7">Request not acted on within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Denial</td><td>3</td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td>0</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>2</td></tr>
</table>
</td>
<td>Katie Forbes

PIHP Customer Service Department</td>
<td>Quarterly Update:
Q2 (Jan-March):
The PIHP had one (1) appeal in Q2. This is a decrease from FY 24 Q2, which had four (4) appeals.

Evaluation: Progress towards goal.
Barrier Analysis: None
Next Steps: Continued efforts towards goal.</td>
</tr>
<tr>
<td>Grievances</td>
<td>The goals for FY2025 Reporting are as follows:

To review and analyze baseline grievance data for the region for FY2025.
</td>
<td>Katie Forbes</td>
<td>Quarterly Update:

Q2 (Jan-March):</td>
</tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.	PIHP Customer Service Department	**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.** **Evaluation: Progress towards goal.** **Barrier Analysis: None** **Next Steps: Continued efforts towards goal.**

Reporting Period: FY							
	Q1	**Q2**			**Q3**	**Q4**	**Total**
		Jan	**Feb**	**Mar**			
GHS	**45**	n/r	n/r	n/r			45
Lapeer	**0**	n/r	n/r	n/r			0
PIHP	**0**	n/r	n/r	n/r			0
Sanilac	**0**	n/r	n/r	n/r			0
St. Clair	**0**	n/r	n/r	n/r			0
SUD	**3**	0	1	2			6
TOTAL	**48**	n/r	n/r	n/r			51

Reason for Grievance:	**Total**
Financial Matters	0
Interaction with Plan or Provider	2
Quality of Care	26
Service Concerns / Availability	18
Service Environment	1
Suggestions / Recommendations	0
Other	4

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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	Shelley Wilcoxon Privileging and Credentialing Committee	**Quarterly Update:** **Q2 (Jan-March):** **In the second quarter, the Privileging & Credentialing (P&C) Committee received and approved two (2) Additional SUD Location Organization Applications.** **Evaluation: All submitted P&C Organizational Applications have been reviewed and approved timely.** **Barrier Analysis: Understanding and navigating the impacts of Universal Credentialing (UC) on processing Organizational Applications.** **Next Steps: Continue per plan. Review documentation from The Salvation Army Harbor Light due for Organizational recredentialing in April.**
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 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	Shelley Wilcoxon Privileging and Credentialing Committee	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: All submitted P&C Practitioner Applications have been reviewed and approved timely.** **Barrier Analysis: Understanding and navigating the impacts of Universal Credentialing (UC) on processing Practitioner applications. Coordinating completion of the P&C Practitioner Application and related documentation for credentialing the PIHP's contracted Medical Director.** **Next Steps: Continue per plan. Review the Region 10 Medical Director's application for approval at the April committee meeting. Monitor the P&C Tracking grid for staff due for recredentialing.**
Credentialing / Privileging	The goals for FY2025 Reporting are as follows:	Shelley Wilcoxon	**Quarterly Update:** **Q2 (Jan-March):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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.	Privileging and Credentialing Committee	**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.** **Evaluation: The PIHP maintains a current and comprehensive P&C policy in alignment with MDHHS and Medicaid standards.** **Barrier Analysis: Further knowledge and experience with UC is needed to determine necessary policy changes.** **Next Steps: Present P&C Team draft recommendations for policy changes for review during the April P&C Committee meeting, if complete. Provide approved policy to the PIHP Compliance Manager/Compliance Officer accordingly.**
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.	Shelley Wilcoxon Privileging and Credentialing Committee	**Quarterly Update:** **Q2 (Jan-March):** **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 being planned. The PIHP is also considering Regional Leads meetings for information sharing and support.** **Evaluation: The PIHP continues to participate in the UC rollout process, gathering information and MDHHS guidance to help support the CMHs and prepare for process implementation at Region 10.** **Barrier Analysis: Further guidance is needed from MDHHS. Find resolution for the conflict related to the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			recredentialing timeline change from two (2) to three (3) years. **Next Steps: Develop policy and process changes needed in relation to UC. Begin PIHP implementation and support the CMHs in this process.**
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. o Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form. o Monitor timely submission of the Autism Monthly Reporting Form and timely communication from the CMHSP Autism Leads.	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: Progress** **Barrier Analysis: Timely documentation submission from CMH Autism Leads** **Next Steps: Continue with the addition of this monitoring in the Contract Monitoring tool**
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	Laurie Story-Walker Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: Progress Continues**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ 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		**Barrier Analysis: Ttime and experience is needed in adding credentialed staff into the system for universal credentialling.** **Next Steps: Continue Goal**
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:** **Q2 (Jan-March):** **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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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). **Evaluation: Progress continues.** **Barrier Analysis: No new barriers identified.** **Next Steps: Continue to monitor compliance and identify areas for continued quality improvement**
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. o Develop a protocol to guarantee ongoing communication of the necessity for GPRA survey as individuals served transition to alternate providers.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: GPRA concerns were addressed in a timely manner.** **Barrier Analysis: None.** **Next Steps: Continue per plan.**
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. o Establish a streamlined procedure to align GPRA surveys reported to Wayne State University with individual cases served by Region 10.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **During the 2nd quarter SOR GPRA data was matched with Qualtrics data provided by Wayne State University. The provider network completed roughly 300 GPRAs.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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 referrals necessitating GPRA surveys with no corresponding data in Qualtrics.		**Evaluation: During the 2nd quarter SOR GPRA data was matched with Qualtrics data provided by Wayne State University.** **Barrier Analysis: None.** **Next Steps: Continue per plan.**
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. ○ Follow up on and monitor MDHHS Site Visit deficiencies. ○ 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. ○ Oversee enrollment of CCBHC Beneficiaries in the WSA and maintaining accurate enrollee reporting: ▪ 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. ○ Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made.	Dena Smiley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.		
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. ○ 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. ○ Monitor beneficiary enrollment to meet MDHHS guidelines regarding assessments, evaluator credentials, and overlap with other programs. ○ Monitor the number of beneficiaries with untimely re-evaluations and document efforts to reduce untimeliness. ○ Review and share reports and barriers to maintain timely submission and processing of Re-evaluations and disenrollments. ○ Educate PIHP and CMHSP staff on 1915(i) requirements as changes are made.	Shelley Wilcoxon Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q2 (Jan-March):** **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. CMHSP final responses and documentation were submitted to MDHHS on March 31st** **Evaluation: The PIHP continues to monitor and process iSPA cases with a focus on reducing untimely re-**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			evaluations. MDHHS updates and information are shared at monthly PIHP-CMH Leads meetings. **Barrier Analysis: Barriers include Medicaid eligibility issues and WSA updates and business rule changes.** **Next Steps: Continue processing iSPA enrollments, disenrollments, and case status changes. Monitor for untimely re-evaluation case processing and progress. Continue related monthly CMHSP meetings as needed.**
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. o Send EOB letters to more than 5% of consumers receiving services.	Shelley Wilcoxon Quality Management & Data Management Departments	**Quarterly Update:** **Q2 (Jan-March):** **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.** **Evaluation: The PIHP is working toward a quarterly review of Provider claims.** **Barrier Analysis: Barriers included a high volume of claims over the period reviewed and the need for clarification about bed checks and other concerns.** **Next Steps: Review all findings related to bed checks to ensure continuity in expectations and send revised findings letters accordingly. Send responses to all Provider Appeal letters. Begin the next quarterly review to include FY 2024 Q4 claims. Review and/or update**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Process Documents related to Claims Verification and sampling methodology.
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 o Clinical case record reviews o 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: o Biopsychosocial assessments o Ancillary assessments • At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.	Tom Seilheimer / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 2 (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 needed. In March, a regional training on person-centered planning was facilitated by the MDHHS Lead in this area.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue activities**
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.	**Compliance Monitoring:** Standard Leads & External Quality	**Quarterly Update:** **Q 2 (Jan-Mar):** **Materials for the SFY2025 Compliance Review were received from the Health Services Advisory Group (HSAG). The External Quality Review (EQR) Team**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Standard Leads will report Compliance Review CAP updates monthly to the External Quality Review Team. ○ 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. ○ Any recommendations resulting from the Encounter Data Validation (EDV) activity will be addressed by the 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	Review Team / Lauren Campbell **Performance Measure Validation and Network Adequacy Validation Review:** Lauren Campbell **Encounter Data Validation Activity:** Lauren Campbell and Laurie Story-Walker	**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, 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.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue preparing for the SFY2025 Compliance Review. Continue implementing CAPs and addressing recommendations from the SFY2024 Compliance Review. Attend the PMV and NAV Technical Assistance Webinar and begin planning for the review activities.**

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As of 04.03.2025