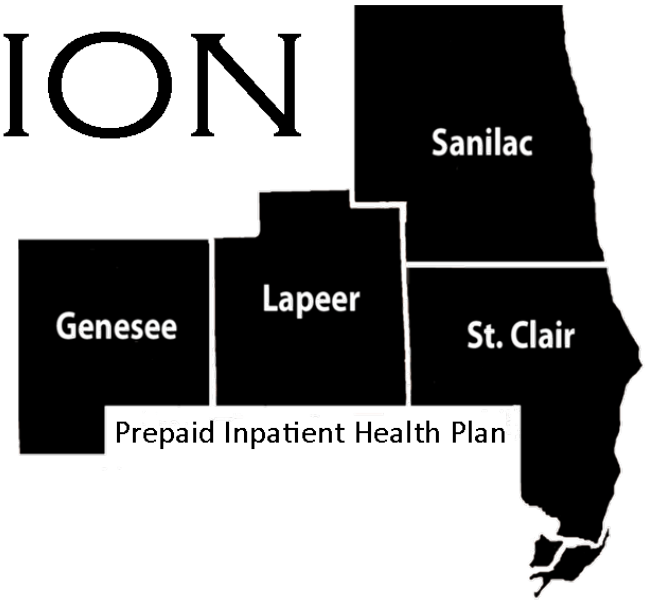
REGION 10



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:** **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.** **Evaluation: This goal has been met.** **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:** **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.** **<u>Evaluation:</u> 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.** **<u>Barrier Analysis</u>: No barriers.** **<u>Next Steps</u>: 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. o Monitor utilization of the PIHP Clinical Practice Guidelines.	Crystal Eddy Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **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 Management, Wraparound, Peer Supports, and Crisis**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.		**Intervention services. The scope of evaluation will be further discussed in upcoming meetings. Additionally, progress is being made toward the biennial evaluation report.** **Evaluation: progressing toward goal** **Barrier Analysis: None** **Next Steps: Continue monitoring and progress**
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:** **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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue annual plan**
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.	Dena Smiley / Tom Seilheimer Improving Practices	**Quarterly Update:** **Q3 (April-June)** **At the close of June, the PIHP received Ten (10) requests for provisional approvals. Two (2) from**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor network completion of the HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process. ○ Monitor the provisional approval process.	Leadership Team (IPLT)	**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.** **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.** **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.	Dena Smiley / Tom Seilheimer	**Quarterly Update:** **Q3 (April-June)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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. ○ Participate in PIHP/MHP Workgroup initiatives. ○ Develop a plan to identify members of the youth population appropriate for care coordination.	Improving Practices Leadership Team (IPLT)	**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.** **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. ○ 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. ○ Monitor CMHSP and SUD sentinel event review processes and ensure follow-up as deemed necessary. ○ Monitor CMHSP and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary. ○ Monitor CMHSP and SUD risk events review processes and ensure follow up as deemed necessary.	Crystal Eddy Sentinel Event Review Committee (SERC)	**Quarterly Update:** **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.** **Evaluation: Progressing toward goal** **Barrier Analysis: No barriers** **Next Steps: Continue routine monitoring and progress toward the development of a Regional Longitudinal Mortality Report.**
Michigan Mission Based Performance	The goals for FY2025 Reporting are as follows:	Lauren Campbell / Brooke Ryan	**Quarterly Update:** **Q3 (April-June)**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Indicator System (MMBPIS)</td>
<td>

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>79.80%*</td></tr>
<tr><td colspan="5">*Region 10 estimate (to be calculated by MDHHS)</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>
</table>
</td>
<td>Quality Management Committee (QMC)</td>
<td>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.

Evaluation: Progressing toward goal.
Barrier Analysis: Region 10’s secondary review of CMHSP-submitted PI data continues to identify technical issues that were not addressed during the CMHSPs’ initial review. These issues often require involvement from CMHSP IT staff, and the short timeframe between the PIHP’s review and the MDHHS submission deadline limits the ability to complete necessary corrections.
Next Steps: Region 10 is evaluating strategies to help strengthen the CMHSPs’ review process, with a focus on early identification and correction of data issues. Preparation of the PI Report is underway, pending MDHHS’s calculation of Indicator 2e. Region 10 will begin reviewing the Continuous Improvement Plans (CIPs) submitted by CMHSPs, and will develop and distribute CIP templates for SUD providers based on their Q3 compliance results.</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>
<table>
<tr><td>3 PIHP Total</td><td>75.02%</td><td>78.72%</td><td>78.19%</td><td>78.65%</td></tr>
<tr><td>3.1 MI-Children</td><td>75.16%</td><td>80.60%</td><td>78.73%</td><td>77.57%</td></tr>
<tr><td>3.2 MI-Adults</td><td>71.38%</td><td>75.69%</td><td>76.54%</td><td>77.47%</td></tr>
<tr><td>3.3 DD-Children</td><td>90.34%</td><td>88.30%</td><td>87.50%</td><td>86.29%</td></tr>
<tr><td>3.4 DD-Adults</td><td>78.79%</td><td>78.69%</td><td>71.79%</td><td>82.14%</td></tr>
<tr><td colspan="5">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%</td></tr>
<tr><td>4a.1 Children</td><td>100%</td><td>97.70%</td><td>100%</td><td>97.26%</td></tr>
<tr><td>4a.2 Adults</td><td>97.90%</td><td>95.18%</td><td>95.91%</td><td>98.23%</td></tr>
<tr><td>4b SUD</td><td>93.90%</td><td>91.67%</td><td>90.48%</td><td>79.63%</td></tr>
<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>4.95%</td></tr>
<tr><td>10.2 Adults</td><td>13.89%</td><td>13.90%</td><td>13.32%</td><td>15.75%</td></tr>
</table>
</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:

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.

Evaluation: Progress towards goal to conduct annual regional survey.
Barrier Analysis: No barrier noted.</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Next Steps: To send the approved survey memo and guidelines to CMHSPs and SUD Network Providers. To prepare the pre-printed survey materials and mail it to the SUD Network Providers by the second week of July.
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. • 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.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue 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]:	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions. ○ Ensure both Professional and Aide staff meet required qualifications. ○ Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. ○ Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. ○ Discuss and follow up on HSW slot utilization and slot maintenance.		**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.** **Evaluation: Progress** **Barrier Analysis: Slot Utilization for HSW Programs** **Next Steps: Continue to monitor**
Monitoring of Quality Areas	The goals for FY2025 Reporting are as follows: • To explore and promote quality and data practices within the region. ○ Monitor critical incident data and reporting. ○ Monitor risk event data and reporting. ○ Monitor emerging quality and data initiative / issues and requirements. ○ Monitor and address Performance Bonus Incentive Pool activities and indicators. ○ Monitor and address changes to service codes. ○ Review / analysis of various regional data reports. ○ Review / analysis of Behavioral Health Treatment Episode Data Set (BH TEDS) reports.	Lauren Campbell & Laurie Story-Walker Quality Management Committee (QMC)	**Quarterly Update:** **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.** **The Critical Incident numbers were reviewed and acknowledged as accurate.** **Evaluation: Progress** **Barrier Analysis: None Identified** **Next Steps: Continue with Goal**
Financial Management	The goals for FY2025 Reporting are as follows: • Establish consistent Region-wide finance reporting and provide training as needed.	Richard Carpenter	**Quarterly Update:** **Q3 (April-June)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.	Finance Committee	**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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Training 2 of 2 is scheduled in September following the PIHP Board meeting. This session will focus on the data sets, formulas, and mechanics to properly complete the report.**
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:** **Q3 (April-June)** **The committee reviewed monthly crisis services utilization reports. There appears to be little variance in utilization from month to month. CMHSPs continue routine tracking and trending.** **Evaluation: On track** **Barrier Analysis: None** **Next Steps: Continue monthly monitoring**
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. ○ 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:** **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.** **Evaluation: On track** **Barrier Analysis: None** **Next Steps: Continue quarterly monitoring**
Utilization Management	The goals for FY2025 Reporting are as follows: • Ensure regional Utilization Review (UR). ○ PIHP UM Department to conduct UR on:	Crystal Eddy	**Quarterly Update:** **Q3 (April-June)** **Quarter 3 CMHSP Utilization Management case record reviews and reports were completed and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ 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).	Utilization Management (UM) Committee	**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 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.** **Evaluation: On Target to goal** **Barrier Analysis: None** **Next Steps: Continue quarterly evaluation.**
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. o 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.	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q3 (April-June)** **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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue annual plans**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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:** **Q3 (April-June)** **A reconfigured AMS M-Y Report has been completed and is pending UMC review.** **Evaluation: Progress** **Barrier Analysis: No barriers** **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. o Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **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.** **Evaluation: On track** **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. o Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Crystal Eddy Utilization Management (UM) Committee	**Quarterly Update:** **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.** **Evaluation: On track** **Barrier Analysis: None** **Next Steps: Continue quarterly tracking and trending**
Corporate Compliance	The goals for FY2025Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements	Brittany Simpson	**Quarterly Update:** **Q3 (April-June)** **The PIHP revised policies to meet the Office of Inspector General (OIG) 6.9 Compliance Report**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Identify and document responsible entities ○ Identify and document supporting evidence / practice ○ Policy review ○ 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. ○ Review of reporting process. ○ Review of contractual language changes in reporting. ○ Ongoing discussion on OIG feedback (e.g., Program Integrity Report feedback).	Corporate Compliance Committee	**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.** **Evaluation: Progress made** **Barrier Analysis: New reporting requirements identified for FY26.** **Next Steps: Submission of approved policies to the OIG. Introducing the planned FY26 report to Providers.**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Compliance with 45 CFR 164.520 Notice of Privacy Practices ○ Review requirements. ○ Identify and document responsible entities. ○ Identify and document supporting evidence / practice. ○ Policy review.	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **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.** **Evaluation: Progress made** **Barrier Analysis: None identified** **Next Steps: Review and update the Notice of Privacy Practices.**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes. ○ Review regional PIHP contract monitoring results. ○ Review current CMH Subcontractor contract monitoring process / content.	Brittany Simpson Corporate Compliance Committee	**Quarterly Update:** **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.** **Evaluation: Progress made** **Barrier Analysis: None identified** **Next Steps: Coordinate with Provider Network Management and Providers to resolve any outstanding Corrective Action Plans.**

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:** **Q3 (April-June)** **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 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:** **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 start of new school year.** **St. Clair:** **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.** **Evaluation: Progress continues on this goal as those identifying gaps are working to address them.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Barrier Analysis: No new barriers. **Next Steps: Discuss progress at the July Provider Network Committee Meeting.**
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:** **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 findings.** **Evaluation: This goal remains partially met. The PIHP continues to review requirements and review policies surrounding Network Adequacy.** **Barrier Analysis: Unclear methodology has made it difficult to validate findings.** **Next Steps: Review summary report with the CMHSPs at the July Provider Network Committee Meeting.**
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:** **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.** **Evaluation: This goal is partially met. Work has taken place toward the drafting of final reports so that the PIHP can assess network performance.** **Barrier Analysis: No noted barriers.**

<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></td><td></td><td>Next Steps: Review new documentation received and score tools.</td></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>Q2</th><th colspan="3">Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th></th><th></th><th></th><th>Apr</th><th>May</th><th>Jun</th><th></th><th></th></tr>
<tr><td>GHS</td><td>15</td><td>10</td><td>3</td><td>2</td><td>4</td><td></td><td>34</td></tr>
<tr><td>Lapeer</td><td>5</td><td>0</td><td>0</td><td>1</td><td>0</td><td></td><td>6</td></tr>
<tr><td>PIHP</td><td>1</td><td>0</td><td>2</td><td>0</td><td>0</td><td></td><td>3</td></tr>
<tr><td>Sanilac</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td>St. Clair</td><td>1</td><td>3</td><td>0</td><td>0</td><td>2</td><td></td><td>6</td></tr>
<tr><td>SUD</td><td>6</td><td>14</td><td>0</td><td>3</td><td>1</td><td></td><td>24</td></tr>
<tr><td>TOTAL</td><td>28</td><td>28</td><td>5</td><td>6</td><td>7</td><td></td><td>74</td></tr>
</table>
<table>
<tr><th>Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td>Appeal</td><td>8</td></tr>
<tr><td>Grievance</td><td>10</td></tr>
<tr><td>Referral to Access</td><td>8</td></tr>
<tr><td>Rights Complaint</td><td>1</td></tr>
<tr><td>Referral to Provider</td><td>28</td></tr>
<tr><td>Other</td><td>6</td></tr>
<tr><td>Pending</td><td>2</td></tr>
<tr><td>Unable to Reach</td><td>11</td></tr>
</table></td><td>Katie Forbes

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

Evaluation: Progress towards goal.
Barrier Analysis: None identified.
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></td><td></td><td></td><td></td></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.
o To track and trend internally the appeals on a monthly basis.
o Identify consistent patterns related to appeals.
o Develop interventions to address critical issues within the Network.

<table><tr><th colspan="8">Reporting Period: FY</th></tr><tr><th rowspan="2"></th><th>Q1</th><th>Q2</th><th colspan="3">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr><tr><th></th><th></th><th>Apr</th><th>May</th><th>Jun</th></tr><tr><td>GHS</td><td>4</td><td>0</td><td>1</td><td>1</td><td>0</td><td></td><td>6</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>2</td><td>1</td><td>0</td><td></td><td>8</td></tr></table><table><tr><th>Reason for Appeal:</th><th>Total</th></tr><tr><td>Service Denial</td><td>4</td></tr><tr><td>Service not started within 14 days</td><td>1</td></tr><tr><td>Service Reduction</td><td>0</td></tr><tr><td>Service Suspension</td><td>0</td></tr><tr><td>Service Termination</td><td>3</td></tr></table></td><td>Katie Forbes

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

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.

Evaluation: Progress towards goal.
Barrier Analysis: None identified.
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:

Q3 (April-June)</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 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>Q1</th><th>Q2</th><th colspan="3">Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th colspan="2"></th><th>Apr</th><th>May</th><th>Jun</th><th></th><th></th></tr>
<tr><td>GHS</td><td>45</td><td>5</td><td>n/r</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>n/r</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>n/r</td><td>n/r</td><td>n/r</td><td></td><td>2</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td>0</td></tr>
<tr><td>SUD</td><td>3</td><td>4</td><td>4</td><td>0</td><td>0</td><td></td><td>7</td></tr>
<tr><td>TOTAL</td><td>48</td><td>11</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td>59</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>2</td></tr>
<tr><td colspan="7">Quality of Care</td><td>31</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>19</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>1</td></tr>
</table>
</td>
<td>PIHP Customer Service Department</td>
<td>Thus far in Q3 the PIHP has received four (4) grievances for the PIHP SUD Network. The PIHP will receive Q3 grievance data from the CMH Network in July.

Evaluation: Progress made towards goal.
Barrier Analysis: No barriers identified.
Next Steps: Receive CMH grievance data. Track and analyze grievance trends.</td>
</tr>
</table>

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:
			
			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.
			
			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: Reach out to additional CMHSPs and SUD Providers following the committee-approved timeline. Complete timely (re)credentialing through Universal Credentialing, ensuring all necessary documentation is received per PIHP requirements.

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:
			
			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.
			
			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.
			Next Steps: Reach out to additional PIHP practitioners following the committee-approved timeline. Complete timely (re)credentialing through Universal

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Credentialing, ensuring all necessary documentation is received per PIHP requirements.
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.	Shelley Wilcoxon Privileging and Credentialing Committee	**Quarterly Update:** **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 providers at the end of June. Preliminary findings were documented.** **Evaluation: The PIHP maintains a current and comprehensive P&C policy in alignment with MDHHS and Medicaid standards.** **Barrier Analysis: Clarifying changes needed for this lengthy policy based on research and findings from multiple sources and findings during Contract Monitoring.** **Next Steps: Complete draft recommendations for policy changes. Finalize contract monitoring findings.**
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.	Shelley Wilcoxon	**Quarterly Update:** **Q3 (April-June)** **The PIHP attended a Universal Credentialing (UC) Leads meeting this quarter. Upon late May PIHP**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Develop necessary processes to support Universal Credentialing efforts.	Privileging and Credentialing Committee	**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.** **Evaluation: The PIHP has implemented Universal Credentialing. Related information is being shared and compared with the CMHSPs.** **Barrier Analysis: Navigating this new process and ensuring all documentation is submitted to meet specific Region 10 requirements.** **Next Steps: Develop policy and process changes needed in relation to UC. Continue with 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. ○ 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.	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **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 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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Evaluation: Communication on submission barriers occurred this quarter through Contract Monitoring **Barrier Analysis: Continued provider adequacy struggles and communication barriers** **Next Steps: Continue**
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:** **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.** **Evaluation: Progress Noted** **Barrier Analysis: Not all PIHP required documentation for credentialling is included in the CRM.** **Next Steps: Continue with 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:** **Q3 (April-June)** **During Q3, enrollments have decreased from 588 to 538 beneficiaries. This is due to one provider 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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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).** **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:** **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.** **Evaluation: This goal has been met as the PIHP's provider network continues conducting GPRAs on appropriate SOR grant activities.** **Barrier Analysis: None currently.** **Next Steps: Complete prep work for the SOR 4 Audit which takes place on July 21st.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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. o 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. o Institute clear benchmarks for evaluating provider performance and adherence to Region 10's SOR/GPRA criteria. o Implement a structured approach for identifying and addressing data disparities, particularly focusing on referrals necessitating GPRA surveys with no corresponding data in Qualtrics.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **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.** **Evaluation: The goal has been met and the PIHP will continue to monitor SOR allocations as the budget is approached.** **Barrier Analysis: None.** **Next Steps: Continue to monitor per plan and maintain communication with provider network as necessary.**
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: ▪ 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.	Dena Smiley / Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **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
	○ Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. ○ Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.		**The next CCBHC Bimonthly Meeting with MDHHS will take place on July 17th.** **Evaluation: Progress Notes** **Barrier Analysis: No barriers** **Next Steps: Continue**
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.	Laurie Karig Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **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.** **Evaluation: Continue to monitor re-evaluation timeliness and provide guidance to CMHs on an ongoing basis.** **Barrier Analysis: Medicaid Spenddown issues continue as well as TANF Medicaid issues.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Next Steps: Continue to process enrollments and monitor for untimely re-evaluations and WSA issues and concerns.
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:** **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.** **Evaluation: Claims Verification reviews are being completed for all Region 10 contracted service providers. The PIHP Claims Verification Policy is under review. EOB letters are being sent to consumers biannually, as required.** **Barrier Analysis: Documentation received from providers is sometimes incomplete or incorrect for use in verifying claims.** **Next Steps: Wrap up any outstanding items from the FY2023 Q4 through FY2024 Q3 claims review. Complete the current Claims Verification cycle review and prepare final letters with findings for providers. Complete recommendations for policy revision. Consider developing training for providers on PIPH expectations for documentation.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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 / Crystal Eddy Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **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.** **Evaluation: Region 10 is on target to achieve completion of SUD Network SUD activities by the end of the fiscal year. Review of the person-centered planning process was conducted and verification that services are being provided according to assessed needs was evaluated.** **Barrier Analysis: Region 10 is still waiting on a final report for the 2024 Site Review from MDHHS. Claims verification guidance policy and procedures are being revised.** **Next Steps: Periodic reviews of plans of service continue per person-centered planning principles, but the reviews of these plans are pended to the UR case record review process. Follow-up on corrective action plans related to the State Site Reviews continues with CMHSP leads quarterly. Continue revision of Claims**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			verification policy and procedures. The FY2025 Customer Satisfaction Survey memo and guidelines will be sent to the providers once finalized.

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 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
		Compliance Monitoring: Standard Leads & External Quality Review Team / Lauren Campbell
		
		Performance Measure Validation and Network Adequacy Validation Review: Lauren Campbell
		
		Encounter Data Validation Activity: Lauren Campbell and Laurie Story-Walker
			Quarterly Update:
			
			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.
			
			Evaluation: Standard Leads continue to report Compliance Review SFY2024 Corrective Action Plan (CAP) updates monthly to the External Quality Review Team. PMV and NAV review preparations continue, and the PIHP has responded to preliminary EDV findings.
			Barrier Analysis: No barriers.
			Next Steps: Continue implementing CAPs and addressing recommendations from the SFY2024 Compliance Review and await September draft report of SFY2025 findings and recommendations.

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

Rex Ziebarth

As of 04.30.2025