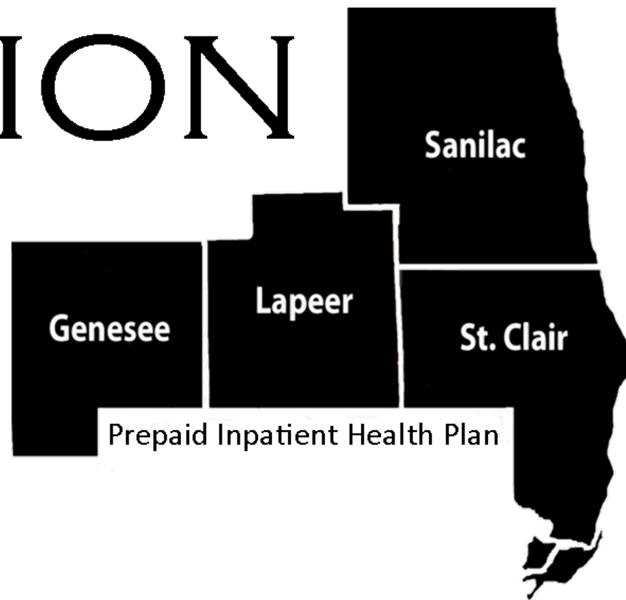

Region 10

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:
			
			Q 1 (Oct-Dec):
			The FY2024 Quality Improvement (QI) Program and Workplan has been presented and approved by the PIHP Board. It is being prepared for submission to MDHHS.
			
			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 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:
			
			Q 1 (Oct-Dec):
			The Quality Improvement Committee (QIC) and the Region 10 PIHP Board approved the QI Program and Workplan at their respective October meetings. The FY2025 QI Program and Workplan are being prepared for submission to MDHHS. Responsible staff designations in the areas of Provider Network, Verification of Services, and Members Experience were updated to reflect organizational structure changes at the PIHP.
			
			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 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.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **This Clinical Practice Guidelines (CPG) Annual Evaluation Report was completed and reviewed for final**

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.		**feedback. Sanilac CMH presented its recent ACT/IDDT MiFAST review report. The End of Fiscal Year (EOFY) Level of Care Utilization System (LOCUS) Implementation Plan Report and the FY2025 LOCUS Implementation Plan were completed and reviewed for final feedback. The Employment Services Committee (ESC) quarterly report was reviewed, and support was noted for GHS' plans to implement Individual Placement and Support (IPS) during FY2025. The Certified Community Behavioral Health Clinic (CCBHC) evidence-based practices (EBP) discussion took place at the December meeting, with follow up monitoring and support activities beginning in January. MichiCANS implementation monitoring and annual training requirements were discussed, along with current issues experienced by the CCBHCs in accessing detailed information on the Screening tool. The updated SAMHSA Opioid Treatment Provider (OTP) best practices document was briefly discussed, and programs were encouraged to access this document as needed.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> Barriers were encountered in accessing the MichiCANS screening tool in CareConnect360 and MDHHS is aware of the issue.** **<u>Next Steps:</u> Continue per annual plan**
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	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Individual Placement and Support (IPS) training updates and share and learn discussion took place. The Employment Services Committee (ESC) quarterly report was reviewed at the Improving Practices Leadership Team (IPLT) meeting, and support was noted for GHS' plans to implement IPS during FY2025.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> No barriers encountered** **<u>Next Steps:</u> Continue per annual plan**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS]) ○ Discuss/support consideration of Individual Placement and Support (IPS) service model.		
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. ○ Monitor network completion of the HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process. ○ Monitor the provisional approval process.	Dena Smiley / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **At the close of first quarter, The PIHP received seven (7) requests for provisional approvals. Three (3) from GHS, one (1) from Lapeer CMH, one (1) from Sanilac CMH, and two (2) from St. Clair CMH. GHS, Sanilac CMH, Lapeer CMH, and St. Clair CMH followed the process and were in compliance with the Final Rule. The latest provisional for St. Clair CMH has not been approved. Region 10 is waiting for guidance from MDHHS regarding what type of documentation is needed to move forward.** **MDHHS is working with Beacon to ensure they are making the required changes to their resident handbook and ensuring all signs at all settings indicating that alcohol is not allowed are removed. Region 10 is still awaiting final guidance from MDHHS regarding the status of their Resident Rights Handbook.** **The PIHP is still awaiting remediation work following the Secured Settings Survey that took place earlier this calendar year.** **Region 10 PIHP will be holding an HCBS Leads meeting in January with CMH leads.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> No barriers** **<u>Next Steps:</u> Continue progress towards goal**
Integrated Health Care	The goals for FY2025 Reporting are as follows:	Dena Smiley / Tom Seilheimer	**Quarterly Update:** **Q 1 (Oct-Dec):**

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

	• 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.
		Improving Practices Leadership Team (IPLT)	**At the end of the first quarter, a total of 95 case discussions were facilitated: Twenty-Two (22) care plans were opened and sixteen (16) were closed. Six members were closed with all goals met, seven (7) members were closed with some goals met and two (2) members lost coverage.**
			
			In late October, MDHHS made changes to the measure specifications within CareConnect360 for the Risk Stratification Job Aid (Easy List). With this change, Region 10 will see a decrease in our individual denominator. Region 10 staff met internally to discuss the joint care measure initiative related to the focus on care coordination goals. Region 10 is following up with MDHHS regarding these initiatives.
			
			At the close of the first quarter, MDHHS made the announcement that The Risk Stratification page in CC360 now has five tabs: Adult Easy, Child Easy, Adult Filter, Child Filter and History. The Child Easy tab is a work in progress and Optum will be working to adjust the Chronic Conditions selections and count parameters to provide the best predictions it can, with the input of the work group. Additionally, there is some "…minor visual cleanup on the filter tabs…" and they have that slated for early 2025.
			
			Evaluation: **Progress**
			Barrier Analysis: **No barriers**
			Next Steps: **Awaiting guidance from MDHHS regarding care coordination initiative questions.**

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.
		Tom Seilheimer
		
		Sentinel Event Review Committee (SERC)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			One sentinel event was received from Sanilac CMH and is now in the monthly monitoring process. An update to the Risk Management (RM) third quarter report was reviewed, with follow-up outreach continuing with SUD programs that have not yet matriculated into the quarterly reporting process. Quarterly RM and critical incident (CI) reports along with the End of Year (EOY) Mortality Reports were provisionally reviewed and are

<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>
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.
</td><td></td><td>
scheduled for further review and discussion at the January meeting.

<u>Evaluation:</u> Progress
<u>Barrier Analysis:</u> Challenges remain in the SUD network as efforts continue to align all programs into a quarterly reporting process.
<u>Next Steps:</u> Continue per annual plan
</td></tr>
<tr><td>Michigan Mission Based Performance Indicator System (MMBPIS)</td><td>
The goals for FY2025 Reporting are as follows:
The goal is to attain and maintain performance standards as set by the MDHHS contract.
Report indicator results to MDHHS quarterly per contract.
Review quarterly MMBPIS data.
Achieve and exceed performance indicator standards and benchmarks.
Ensure follow up on recommendations and guidance provided during External Quality Reviews
Provide status updates to relevant committees, such as the PIHP QIC, PIHP CEO, PIHP Board.
Discuss and prepare for the transition from MMBPIS to standardized measures.
<table>
<tr><th></th><th>FY24 Q3</th><th>FY24 Q4</th><th>FY25 Q1</th><th>FY25 Q2</th></tr>
<tr><td colspan="5">Ind. 1 – Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td>98.97%</td><td></td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td>99.90%</td><td></td><td></td><td></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></td><td></td><td></td></tr>
<tr><td>2a.1 MI-Children</td><td>48.60%</td><td></td><td></td><td></td></tr>
<tr><td>2a.2 MI-Adults</td><td>51.30%</td><td></td><td></td><td></td></tr>
<tr><td>2a.3 DD-Children</td><td>54.89%</td><td></td><td></td><td></td></tr>
<tr><td>2a.4 DD-Adults</td><td>45.68%</td><td></td><td></td><td></td></tr>
<tr><td colspan="5">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</td></tr>
</table>
</td><td>Lauren Campbell

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

Q 1 (Oct-Dec):
The FY2024 Q3 Performance Indicator (PI) Report was finished. FY2024 Q4 PIs are due to MDHHS January 2, 2025.

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

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

<u>Evaluation:</u> Progress
<u>Barrier Analysis:</u> No barriers
<u>Next Steps:</u> Complete FY2024 Q4 PIs and submit to MDHHS. Participate in any discussions facilitated by MDHHS regarding the Behavioral Health Quality Transformation.
</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	persons with Substance Use Disorders. Standards = 68.2% and 75.3% 2b SUD | 77.74% **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% 3.1 MI-Children | 75.16% 3.2 MI-Adults | 71.38% 3.3 DD-Children | 90.34% 3.4 DD-Adults | 78.79% **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% 4a.2 Adults | 97.90% 4b SUD | 93.90% **Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less** 10.1 Children | 12.08% 10.2 Adults | 13.89%		
Members' Experience	The goals for FY2025 Reporting are as follows: • Conduct assessments of members' experience with services. o Conduct annual regional customer satisfaction survey. o Conduct qualitative assessments (e.g., focus groups). o Conduct other assessments of members' experience as needed. o Develop action steps to implement interventions to address areas for improvement based on member satisfaction survey. o Facilitate a workgroup consisting of members of the SUD Provider Network to inform future survey planning. o Develop and implement action steps to address response rates / totals.	Lauren Campbell Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The FY2024 Customer Satisfaction Survey Report was completed and presented to the Quality Management Committee (QMC), Quality Improvement Committee (QIC), CEO group, and PIHP Board in December. The report was added to the Region 10 website and notifications were sent to the provider network and PIHP staff.** **Evaluation:** **Progress** **Barrier Analysis:** **No barriers** **Next Steps:** **Monitor recommendations from the FY2024 Customer Satisfaction Survey Report and survey process.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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:** **Q 1 (Oct-Dec):** **Performance improvement project (PIP) 1 barrier analysis (BA) survey tasks are underway to help inform calendar year (CY) 2024 evaluation and CY2025 improvement planning activities. The Health Services Advisory Group (HSAG) Validation Report was discussed at the Quality Management Committee (QMC) meeting to further inform planning activities mainly to address essential disparity factors.** **PIP 2 preliminary/quarterly findings for Remeasurement 3 are being utilized by the CMHs to inform their CY2024 evaluation and CY2025 improvement planning activities.** **Evaluation: Progress** **Barrier Analysis: Delays in data availability for PIP 2 remain but are being addressed with quarterly supplemental reports.** **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]: ○ Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions.	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Quarter 1 was 534 of the PIHP's total 627 slots. MDHHS approved ten (10) new enrollees this quarter, and there are four (4) cases pending approval in the State work queue. Slot utilization, however, continues to be a struggle for the Habilitation Supports Waiver.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.		**Continued conversation is happening during quarterly Leads meetings and with CMH representatives at the Quality Management Committee monthly meetings on program utilization barriers.** **During quarter 1, the MDHHS State Site Review wrapped up with the submission of CMH corrective action plans (CAPs) to MDHHS. The State incentivized the CAPs this year for timeliness and deliverability.** **There were in total 36 citations found by MDHHS, of those 15 CAPs were not accepted in the first round of review. On December 10th, MDHHS accepted all of the amended submissions on the State site Review CAPs and now the CMHs are in the implementation and follow-up phase of their CAPs.** **Evaluation: Progress** **Barrier Analysis: Slot Utilization with 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. ○ 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:** **Q 1 (Oct-Dec):** **During Quality Management Committee (QMC) monthly meetings the BH TEDS completion rates were shared; Mental Health – 98.18%, Q (Crisis) - 92.31%, SUD – 84.22% through December 5, 2024. Each CMHSP present reported no encounter reporting barriers or challenges to the PIHP. PIHP reminder to continue to report FY2024 encounters after December 31st when there are claims received or data corrections to be reported. MDHHS code changes received December 16, 2024, for the January MDHHS Code Chart update was shared with the workgroup. The PIHP asked when the Waiver Support Application (WSA) integration will occur in CHIP and OASIS. No one was aware of the integration date and GHS followed up with PCE. PCE reported this has been delayed. GHS asked if other CMHSPs were seeing Electronic Visit Verification (EVV) visits from providers that are using another EVV system**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			(not HHaX). No others are seeing this, so GHS will follow-up with MDHHS EVV lead. **The committee discussed the Patient Centered Medical Home (PCMH) Narrative which was submitted to MDHHS in November. Updates from the Critical Incident Reporting (CIR) Workgroup meetings were shared. Additionally, CMHs present during meetings reported the critical incident numbers on the PIHP's report were correct.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue activities**
Financial Management	The goals for FY2025Reporting 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:** **Q 1 (Oct-Dec):** **The first Certified Community Behavioral Health Clinic (CCBHC) training was held Monday, December 2nd. The training was focused on the Cost Report.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue**
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).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Monthly crisis services utilization reports were reviewed. No significant issues were identified but trends toward underutilization for youth intensive crisis services are being monitored and local efforts to address were discussed.** **Evaluation: Progress** **Barrier Analysis: No barriers encountered** **Next Steps: Continue per annual plan**
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	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Quarterly reports were reviewed, with no concerning events or trends identified. GHS noted its priority on evaluating behavior plans for titration opportunities.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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).		**Evaluation: Progress** **Barrier Analysis: No barriers encountered** **Next Steps: Continue per annual plan**
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).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **SUD FY2024 annual utilization review (UR) has been completed, and a longitudinal report was shared at the SUD network quarterly meeting. Quarterly reporting for CMH UR (OASIS, CHIPS) was completed at the December meeting.** **Evaluation: Progress** **Barrier Analysis: No barriers encountered** **Next Steps: Continue per annual plan**
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	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Utilization Management (UM) Redesign launch completed its seventh month. Utilization and implementation monitoring reports are being developed, and service exception request (SER) implementation monitoring reports are in place, noting monthly findings and receiving feedback on report format improvements. Challenges to launch are noted in terms of Certified Community Behavioral Health Clinic (CCBHC) Demonstration implementation boundaries, and these are being discussed across the OASIS Users Work Group and Region 10 Management. Launch activities remain an ongoing Agenda item at UM Committee meetings and therein GHS remains in the loop regarding eventual launch expansion.** **Indicia Inter-Rater Reliability (IRR) activities are completed, and the formal report is scheduled for UMC review as part of the End of Fiscal Year (EOFY) 2024**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Oversight of the Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability System. ▪ Oversight of Region 10 participation on the UM Directors Group.		**UM Program Plan Evaluation Report. The November UM Directors Group focused on completing its Inpatient Tiered Rates recommendation paper was sent to the CEO Group. Initial response to the Health Services Advisory Group (HSAG) Standards Validation Report results is being shared and aggregated to help inform regional responses to the report. This topic will be continued at the January meeting.** **For additional information on aligned care management activities, please refer to the FY2025 UM Program Plan report that was submitted to the November QIC for review/approval.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> No barriers encountered** **<u>Next Steps:</u> 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). o Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Access Management System (AMS) annual report was completed, and the formal report was reviewed at the November Utilization Management (UM) Committee and Quality Improvement Committee (QIC). It will be included in the UM Program Plan Evaluation Report and will be available for presentation to the Region 10 Board.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> No barriers encountered** **<u>Next Steps:</u> 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)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Utilization Management Committee (UMC) review of CMHSP affiliate reports revealed a wide range of community outreach, education, and wellness promotion activities, some traditional and others innovative, to engage community members where they are at.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> No barriers encountered** **<u>Next Steps:</u> Continue per annual plan**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Quarterly reports were reviewed, with no concerning events or trends identified. That said, discussion centered around the introduction of graphics and plans for track/trend analysis. This expanded analysis activity was supported by the committee, given their expressed need for a more detailed understanding of compliance issues and improvement opportunities.** **Evaluation:** **Progress** **Barrier Analysis:** **No barriers encountered** **Next Steps:** **Continue per annual plan**

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).
		Jim Johnson
		
		Corporate Compliance Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			The FY2025 Corporate Compliance Plan was posted on the PIHP website and distributed to both PIHP staff and Network Providers. The FY2024 Q4 Office of Inspector General (OIG) Program Integrity submission was due November 15, 2024 and submitted timely. OIG-MDHHS issued a Corrective Action Plan (CAP) for the FY24 Q4 program integrity submission in December – addressing the CAP is in progress. The FY2025 Annual Contracted Entities Report was submitted in a timely manner in November. The FY2025 Annual OIG Program Integrity Report due January 15, 2025 to the OIG is in development. The FY2024 Corporate Compliance Annual Report is pending final review and revision.
			
			Evaluation: **Progress on goal.**
			Barrier Analysis: **No barriers identified.**
			Next Steps: **Continue progressing towards goal.**

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.
		Jim Johnson
		
		Corporate Compliance Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Discussion occurred regarding changes to policy 03.03.01 HIPAA Privacy& Security Measures and policy 03.03.02 HIPAA Privacy Measures – Protected Heath Information. These changes were influenced from the

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Identify and document supporting evidence / practice. o Policy review.		**findings of the Health Services Advisory Group (HSAG) SFY2022 Compliance Review. The changes to the following policies were outlined in a Privacy Notice Action Plan. In December, policies 03.03.01 and 03.03.02 were reviewed and revised according to the action plan and then submitted for approval.** **Evaluation: Progress on goal.** **Barrier Analysis: No barriers identified.** **Next Steps: Continue progressing towards goal.**
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. o Review current CMH Subcontractor contract monitoring process / content.	Jim Johnson Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **FY2024 Annual Contract Monitoring Provider Plan of Correction development. Standards identified for plan of correction required provider response which was reviewed for acceptance or non-acceptance and potential resolution.** **Evaluation: Progress on goal.** **Barrier Analysis: No barriers identified.** **Next Steps: Continue progressing towards goal.**
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:** **Q 1 (Oct-Dec):** **During the first quarter, the PIHP continued to note issues with Autism services. GHS reported internal discussions on staffing issues and lack of workers in the community. Additionally, they continue to discuss the need for evening availability for Applied Behavior Analysis (ABA) providers. GHS has an open request for proposal (RFP) for ABA providers.** **In December, the quarterly Provider Network Committee meeting was held. Updates were shared from each of the CMHSPs as follows:** **GHS – service lines are struggling to find staff. GHS is looking at incentives to obtain and retain staff.** **Lapeer CMH – Noting difficulty in finding staff for residential homes. Also, the Children's Department has a delay list due to the fact that they have not found the proper space to expand.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Sanilac CMH – Current posted RFP for CLS, respite, and supported employment. **St. Clair CMH – Current RFP for a children's therapeutic group home. Noting that ABA tends to attract most of the staffing leaving other needs with inadequate coverage.** **Evaluation: Continued evaluation of the network is progress toward the goal. Gaps are being addressed through discussions on incentives.** **Barrier Analysis: No new barriers to network monitoring. Ongoing barrier of sufficient ABA service providers.** **Next Steps: Continue to monitor and facilitate discussion among PIHP and CMHSPs.**
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:** **Q 1 (Oct-Dec):** **The PIHP staff met internally to discuss findings from the FY2024 Compliance Review from the Health Services Advisory Group (HSAG), Follow up took place with GHS regarding outstanding questions on the Network Adequacy Report.** **The Provider Network Management (PNM) Team met with other PIHP staff to begin preparations for the upcoming report, due to MDHHS April 30th, 2025. Meetings were held with staff who completed the FY2023 report to share best practices.** **MDHHS scheduled a meeting for January 15th, 2025 to outline expectations for the upcoming FY2024 report. A draft template and invitation for questions was received on December 20th. Feedback and questions are due to the Department on January 8th.** **Evaluation: Progress has been made toward this goal as requirements have been reviewed and discussions held with staff taking lead on Network Adequacy reporting.** **Barrier Analysis: The PIHP notes some items in the Network Adequacy template don't make sense in terms of the 14 day timeframe outlines for specific services.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps:</u> A meeting will be held on Thursday, January 2nd for PIHP staff to compile questions to send to MDHHS ahead of the January 8th deadline.

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:
			
			Q 1 (Oct-Dec):
			The FY2024 Contract Monitoring Aggregate Report was completed. Overall score averages are as follows: The CMH Network Average came in at 90%, down from 93% in the 2023 monitoring cycle. The SUD Treatment Network Average was 78%, down from 87% in the 2023 monitoring cycle. SUD Prevention Network Average was 89%, down from 95% in the 2023 monitoring cycle. Lastly, the SUD Recovery Housing Network Average was 89% which remains the same as the 2023 monitoring cycle. Areas for improvement exist for the majority of providers in the areas of appeals, performance measurement and staff qualification and training.
			
			Plans of Correction (POCs) as a result of the FY2024 reviews were sent to providers with the majority being accepted. Phone calls took place between the PIHP and Providers with outstanding plans in order to eliminate back-and-forth emails.
			
			<u>Evaluation:</u> Progress has been made as the Aggregate Report was finished and reviewed.
			<u>Barrier Analysis:</u> No new barriers identified.
			<u>Next Steps:</u> Discuss any outstanding unaccepted POCs with Providers to move toward resolution.

<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.
o To track and trend internally the customer service inquiries on a monthly basis.
o Identify consistent patterns related to customer service inquiries.
o Develop interventions to address critical issues within the Network.

<table>
<tr><th colspan="8">Reporting Period: FY2025</th></tr>
<tr><th></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>7</td><td>4</td><td>4</td><td></td><td></td><td></td><td>15</td></tr>
<tr><td>Lapeer</td><td>1</td><td>1</td><td>3</td><td></td><td></td><td></td><td>5</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>1</td><td></td><td></td><td></td><td>1</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>St. Clair</td><td>1</td><td>0</td><td>0</td><td></td><td></td><td></td><td>1</td></tr>
<tr><td>SUD</td><td>5</td><td>0</td><td>1</td><td></td><td></td><td></td><td>6</td></tr>
<tr><td>TOTAL</td><td>14</td><td>5</td><td>9</td><td></td><td></td><td></td><td>28</td></tr>
<tr><th colspan="7">Inquiry Dispositions:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>3</td></tr>
<tr><td colspan="7">Grievance</td><td>2</td></tr>
<tr><td colspan="7">Referral to Access</td><td>1</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>12</td></tr>
<tr><td colspan="7">Other</td><td>4</td></tr>
<tr><td colspan="7">Pending</td><td>2</td></tr>
<tr><td colspan="7">Unable to Reach</td><td>4</td></tr>
</table>
</td><td>Katie Forbes

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

Q 1 (Oct-Dec):
There was a total of twenty-eight (28) customer service inquiries in Q1, this is a decrease from FY24 Q1 which had thirty-four (34) inquiries.

<u>Evaluation:</u> Progress towards goal.
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> Continued effort towards goal.</td></tr>
<tr><td>Appeals</td><td>The goals for FY2025 Reporting are as follows:</td><td>Katie Forbes</td><td>Quarterly Update:

Q 1 (Oct-Dec):</td></tr>
</table>

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

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

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

<table>
<tr><th colspan="8">Reporting Period: FY2025</th></tr>
<tr><th rowspan="2"></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>2</td><td>0</td><td>2</td><td></td><td></td><td></td><td>4</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>TOTAL</td><td>2</td><td>0</td><td>2</td><td></td><td></td><td></td><td>4</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>1</td></tr>
</table>
</td><td>PIHP Customer Service Department</td><td>There were four (4) appeals in Q1. This is a decrease from FY24 Q1, which had six (6) appeals.

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

<u>Evaluation:</u> Progress towards goal.
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> 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

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

Q 1 (Oct-Dec):
Thus far in Q1 the PIHP has received two (2) grievances. The PIHP will not receive Q1 grievance data from the</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="9">Reporting Period: FY2025</th></tr>
<tr><th rowspan="2"></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>Lapeer</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>PIHP</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>Sanilac</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>St. Clair</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>SUD</td><td>2</td><td>0</td><td>0</td><td></td><td></td><td></td><td>2</td></tr>
<tr><td>TOTAL</td><td>2</td><td>0</td><td>0</td><td></td><td></td><td></td><td>2</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Financial Matters</td><td>0</td></tr>
<tr><td colspan="7">Quality of Care</td><td>2</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>0</td></tr>
<tr><td colspan="7">Service Environment</td><td>0</td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td>0</td></tr>
<tr><td colspan="7">Other</td><td>0</td></tr>
</table>
</td><td></td><td>CMH Network until January 15th. This data will be provided in the February Quality Improvement Committee (QIC) meeting with all data received.

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

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

<u>Evaluation:</u> Progress towards goal.
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> Continued efforts towards goal.</td></tr>
<tr><td>Credentialing / Privileging</td><td>The goals for FY2025 Reporting are as follows:</td><td>Lauren Campbell</td><td>Quarterly Update:</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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	Privileging and Credentialing Committee	**Q 1 (Oct-Dec):** **The St. Clair CMH SUD Additional Location Privileging and Credentialing (P&C) Application for the Broadway location was approved with an effective date of October 1, 2024, which coincides with the FY2025 contract start date. An Organization Application for Great Lakes Recovery Center (GLRC), previously approved by the P&C Committee via email vote, was presented and approved.** **Follow up and revisions for the Provider Applications are pending more information about Universal Credentialing.** **There was no further update on GHS SUD services. There was further discussion and sharing of information with Flint Odyssey House (FOH) regarding moves to two new locations. At the close of first quarter, the PIHP had not yet received complete P&C Applications with the necessary supporting documentation.** **The MDHHS Semi-Annual P&C Report was submitted timely. Potential remediation for CMHs whose providers exceeded the credentialing period of every two years will be discussed.** Evaluation: **The PIHP continues to monitor timelines and reviews all P&C Organizational applications submitted for approval.** Barrier Analysis: **Awaiting accurately completed applications with all supporting documentation from FOH. The anticipated timeline for GHS to submit application to begin providing SUD service is unclear.** Next Steps: **Provide guidance and review P&C Applications and supporting documentation from FOH and GHS once received.**
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	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **In the 1st quarter, the Privileging and Credentialing (P&C) Committee approved Practitioner Applications for two Access Center staff previously approved by the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	Director, Chief Clinical Officer, Clinical Manager, direct hire Access Clinicians: ▪ Current Practitioners ▪ New Practitioners ▪ Existing Practitioner Renewals / Updates ▪ Practitioner Terminations / Suspensions / Probationary Status ▪ Practitioner Adverse Credentialing Determinations		**P&C Committee via email vote. Three additional Access Staff are in process for recredentialing in January. The P&C team is following up with Region 10's Medical Director as it was recently discovered the Medical Director should be credentialed.** **<u>Evaluation:</u> The P&C Committee continues to complete reviews of all applicable Region 10 staff to allow for timely credentialing and re-credentialing.** **<u>Barrier Analysis:</u> Gaining understanding of the re/credentialing timeframe as it relates to PIHP/MDHHS contract approval.** **<u>Next Steps:</u> Continue per plan.**
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.	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **There were no changes to the Privileging and Credentialing (P&C) policy in the first quarter. A memo was sent to Region 10 CMH and SUD Providers on December 10th to clarify the credentialing time frame maximum credentialing term for practitioners and organizations as two years.** **<u>Evaluation:</u> The PIHP continues to maintain a current and comprehensive policy for Privileging and Credentialing, inclusive of MDHHS and Medicaid standards.** **<u>Barrier Analysis:</u> Understanding of Recredentialing timeline based on MDHHS guidance.** **<u>Next Steps:</u> Review/revise P&C policy as more guidance is available from MDHHS and expectations are clear regarding Universal Credentialing, timelines, and other changes that impact P&C.**
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.	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **In the first quarter, the PIHP received meeting invitations for training to begin in January 2025. A comparison of PIHP application forms to Universal Credentialing (UC) requirements in the Customer Relationship Management (CRM) system is planned. The**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			PIHP is awaiting training materials and more guidance on MDHHS expectations. **Evaluation: The PIHP is continuing to prepare for the Universal Credentialing process, and to share MDHHS guidance and information with Providers.** **Barrier Analysis: The PIHP is awaiting training materials and more guidance on MDHHS expectations.** **Next Steps: Ensure CRM/UC users will have the appropriate access to enable schedule training on Universal Credentialing.**

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:
			
			Q 1 (Oct-Dec):
			By close of the first quarter, Genesee Health System reported having 251 individuals eligible and not authorized for services. St. Clair CMH reported having 42 individuals eligible and not authorized for services. Lapeer CMH reported having 30 individuals eligible and not authorized for services and Sanilac CMH reported zero cases of individuals eligible and not authorized for ABA services.
			
			In the first quarter, MDHHS asked the CMHSPs to submit data on Autism Waitlists and those being served in their CMH. All of those spreadsheets were submitted and MDHHS confirmed receipt.
			
			There has been a barrier this quarter with the timely submission of the Autism Reporting form, further follow-up and discussion is happening with the Provider Network Management (PNM) Team on how to monitor and follow-up once more with CMH Contract contacts on this matter.
			
			Evaluation: Progress
			Barrier Analysis: Timely documentation submission from CMH Autism Leads.
			Next Steps: Meet with the PNM Team to discuss follow-up.

Customer Relationship	The goals for FY2025 Reporting are as follows:	Laurie Story-Walker	**Quarterly Update:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Management (CRM) System	• 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	Monitored by Quality Improvement Committee (QIC)	**Q 1 (Oct-Dec):** **Flint Odyssey House (FOH) is working to "transfer" the 529 Martin Luther King and 1108 Lapeer Road Level of Care (LOC) approvals to the two new locations on W. Bristol Road. Awaiting verification from MDHHS the transfers were approved.** **Evaluation: Continue with Goal** **Barrier Analysis: Delayed Reponses.** **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.	Jacqueline Gallant Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **During this quarter, the implementation of the SUDHH program has resulted in an increased number of beneficiaries from 527 to 619 enrolled, a 17% increase. Monthly recoupments have dropped from 16% to 8% throughout the quarter as well.** **Health Home Partners (HHPs) attended all monthly meetings held by the PIHP and concerns about the improper discharging process of one HHP was addressed and resolved.** **Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released in CC360 for June**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			30th, 2024. This most recent data reflected the rate of 71.42 for the program in Region 10 and has exceeded the State's rate of 23.77 and total Region 10's rate of 25.45 for Follow-up within 7 days after discharge (FUA-7). For the metric of Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14), Region 10's SUDHH program did not have any beneficiaries identified, but the Program Total rate throughout the state of 21.43 fell below the States rate of 37.16 and the total of Region 10's rate of 36.16. This is a remarked 17% decrease for the Program Total's rate compared to the previous quarter's data in this metric. **Current enrollees for Region 10 are 619 (Arbor Recovery 243, BioMed 96, Flint Odyssey House 57, New Paths 82, SHRC Flint 66, SHRC Port Huron 33, SHRC Richmond 42).** **Evaluation: Progress continues for goals** **Barrier Analysis: MDHHS communications on SUDHH transition has slowed implementation** **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.
		Heather Haley/SOR Coordinator
		
		Monitored by Quality Improvement Committee (QIC)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			During the first quarter Government Performance and Results Act (GPRA) compliance concerns were addressed throughout the treatment network. A State Opioid Response (SOR) Insurance Policy Funding Source was added in MIX to ensure accurate PIHP GPRA data. Providers were required to have staff attend Wayne State University's GPRA training. The PIHP discussed a SOR claims audit to further ensure SOR compliance. Discussions continue finalizing the SOR claims audit.
			
			Evaluation: Progress made.
			Barrier Analysis: PIHP has encountered providers not conducting GPRAs in the required timeframe for SOR grant funds to be utilized.
			Next Steps: Continue per plan.

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Develop a protocol to guarantee ongoing communication of the necessity for GPRA survey as individuals served transition to alternate providers.		
State Opioid Response (SOR) Grant	The goals for FY2025 Reporting are as follows: • Ensure that Government Performance and Results Act (GPRA) completion is tracked and matched to PIHP ID numbers. ○ Establish a streamlined procedure to align GPRA surveys reported to Wayne State University with individual cases served by Region 10. ○ Monitor and analyze GPRA completion data from Qualtrics (Wayne State University) in conjunction with referrals initiated by Region 10 Access, ensuring alignment where GPRA surveys are necessary. ○ Institute clear benchmarks for evaluating provider performance and adherence to Region 10's SOR/GPRA criteria. ○ Implement a structured approach for identifying and addressing data disparities, particularly focusing on referrals necessitating GPRA surveys with no corresponding data in Qualtrics.	Heather Haley/SOR Coordinator Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **During the first quarter, the PIHP worked on aligning Wayne State University's Qualtrics data with individual cases served by the PIHP. The State Opioid Response (SOR) Insurance Policy Funding Source in MIX allowed the PIHP to track Government Performance and Results Act (GPRA) surveys and compare Qualtrics data and MIX data to find inaccuracies in Wayne State University's GPRA Monthly Summary. In the month of October, the PIHP had completed more GPRAs than the Wayne State University report had documented.** **<u>Evaluation:</u> Progress towards goal** **<u>Barrier Analysis:</u> Working with Wayne State University to resolve the data disparities with the GPRA surveys.** **<u>Next Steps:</u> 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.	Dena Smiley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **At the end of the first quarter, there were approximately 1090 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 79 cases in our queue to process.** **MDHHS announced that they are working with Optum to develop a CCBHC clinic view of the state reported measures. There will be a MichiCANS training for all CMHs and PIHPs once this rolls out.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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. o Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. o Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.		**MDHHS has published Version 2.0 of the CCBHC Handbook. That handbook is available on the MDHHS website for review.** **Region 10 held a WSA Quarterly meeting with CMH Leads in December. The PIHP will be following up on questions asked during the meeting.** **There is a CCBHC Cost Report Meeting with MDHHS on January 10th and a CCBHC Lunch & Learn will be held on February 6th.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue Progress towards goal**
1915(i) State Plan Amendment (SPA)	The goals for FY2025 Reporting are as follows: • Continue development of the 1915(i)SPA model within Region 10. o Enroll and manage eligible 1915(i) Home and Community-Based Services State Plan Amendment Benefit beneficiaries in the Waiver Support Application (WSA) and maintain accurate enrollee reporting. o Monitor beneficiary enrollment to meet MDHHS guidelines regarding assessments, evaluator credentials, and overlap with other programs. o Monitor the number of beneficiaries with untimely re-evaluations and document efforts to reduce untimeliness. o Review and share reports and barriers to maintain timely submission and processing of Re-evaluations and disenrollments. o Educate PIHP and CMHSP staff on 1915(i) requirements as changes are made.	Shelley Wilcoxon Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Region 10 closed out the first quarter with 2,759 open cases, down 36 cases from October. The number of past due re-evaluation or disenrollment cases for the CMHs to process trended up over the quarter and is currently at 635 cases: GHS-97 cases; Lapeer CMH-53 cases; Sanilac CMH-28 cases; St. Clair CMH-457 cases. The PIHP will meet individually with the CMHs in January to discuss barriers and find resolutions. The December WSA release to correct Medicaid eligibility technical issues was not as effective as hoped as the mismatch between eligibility in MIX and in the WSA continues. The PIHP has sent sample cases at MDHHS' request so they may review the issues. The Waiver Renewal is still pending after the October extension. There was no MDHHS or PIHP iSPA Leads meeting in December. MDHHS updates on bi-directional work are anticipated at January's meeting. Quarterly meetings are being planned with the CMHs to follow up on the CAPs submitted in October after MDHHS shared Site Review findings.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> The PIHP continues to monitor case enrollments and disenrollments; shares MDHHS guidance with the CMHs; and provides support to resolve barriers to case processing. **<u>Barrier Analysis:</u> Barriers include Medicaid eligibility issues and processing of outstanding re-evaluation cases.** **<u>Next Steps:</u> Coordinate follow-up meetings on outstanding re-evaluations for resolution/reduction in case numbers. Monitor CMH case processing. Meet with CMHs on CAP progress and discuss findings/status on Site Review CAPs quarterly at Leads meetings.**
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.	Lauren Campbell Quality Management & Data Management Departments	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Claims Verification Team completed an audit of claims from FY2023 and FY2024. The team worked on preparing final letters with findings and next steps in response to findings.** **The PIHP's claims verification processes will be revisited and updated.** **The annual report with claims verification methodology, findings, and actions taken in response to findings was prepared and submitted to MDHHS.** **Explanation of Benefits (EOB) letters were sent out.** **<u>Evaluation:</u> Progress** **<u>Barrier Analysis:</u> Challenges noted when compiling findings from claims verification review for final letters and completion of the annual report.** **<u>Next Steps:</u> Send claims verification audit final letters to providers. Revisit and revise claims verification processes.**
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	Tom Seilheimer / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **SUD FY2024 annual utilization review (UR) has been completed, and a longitudinal report was shared at the SUD network quarterly meeting. Quarterly reporting for**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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.		**CMH UR (OASIS, CHIPS) was completed at the December meeting.** **Periodic reviews of plans of service continue per person-centered planning principles, but the reviews of these plans are pended to the utilization review case record review process.** **1915(c) Waiver and 1915(i)SPA enrollee cases were reviewed during the 2024 MDHHS Site Review.** **Claims verification reviews were wrapped up for the random sample of claims from FY2023 and FY2024.** **Following the administration of the FY2024 Customer Satisfaction Survey, the PIHP aggregated responses and prepared a final report with findings.** **Through the person-centered planning process, the PIHP ensures the CMHs conduct initial and annual biopsychosocial assessments, and other assessments as needed.** **Evaluation: Progress** **Barrier Analysis: No barriers noted** **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. 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	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation and Network Adequacy Validation Review:** Lauren Campbell	**Quarterly Update:** **Q 1 (Oct-Dec):** **The 2024 Performance Measure Validation (PMV) report was received from the health Services Advisory Group (HSAG). The PIHP PMV Team reviewed and scheduled a meeting to discuss the recommendations in November. An internal Recommendation Tracking Template will be used to track the recommendations and PIHP Team's action steps. The 2024 PMV Review Report was presented to the Quality Management Committee (QMC). The QMC discussed the weaknesses and recommendations provided by HSAG.** **HSAG provided materials for the 2024 Network Adequacy Validation (NAV) Review. All follow-up items**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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	**Encounter Data Validation Activity:** Lauren Campbell and Laurie Story-Walker	**were addressed and HSAG approved the PIHP's logic for reporting time and distance standards. A draft or final report was not received.** **No further information was received for the Encounter Data Validation (EDV) activity.** **The SFY2024 Compliance Review Report and Corrective Action Plan (CAP) Template documents were received from HSAG.** **The External Quality Review (EQR) Team facilitated a SFY2025 Compliance Review Kick-Off meeting with Standard Leads. HSAG provided a timeline for the Compliance Review activities. The SFY2025 Compliance Review is scheduled for June 18, 2025.** **Evaluation:** **Progress** **Barrier Analysis:** **No barriers** **Next Steps:** **Prepare CAPs and responses to recommendations from the SFY2024 Compliance Review. Submit CAPs to HSAG. Continue planning for the SFY2025 Compliance Review.**

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As of 01.02.2025