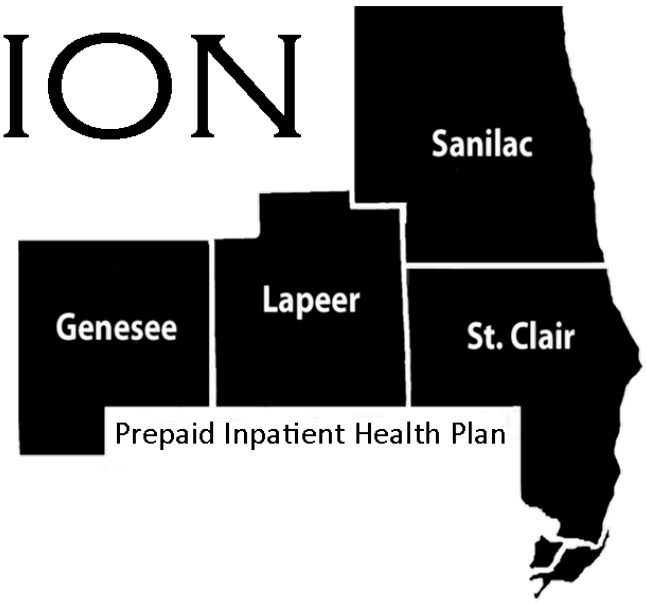
REGION 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2024 – ANNUAL REPORT

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Annual Evaluation	The goals for FY2024 Reporting Year are as follows: • Submit FY2023 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 10/1/2023. 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 / Deidre Slingerland Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q 1 (Oct-Dec):** **The FY2023 Quality Improvement (QI) Program and Workplan Annual Report was submitted to MDHHS on October 24, 2023.** **Q 2 (Jan-Mar):** **No updates. The FY2023 Quality Improvement (QI) Program and Workplan Annual Report was submitted to MDHHS on October 24, 2023.** **Q 3 (Apr-June):** **No updates. The FY2023 Quality Improvement (QI) Program and Workplan was submitted timely MDHHS on October 24, 2023. The QI Committee provides monthly feedback on the plan.** **Q 4 (July-Sept.):** **No updates. The FY2023 Quality Improvement (QI) Program and Workplan was submitted timely MDHHS on October 24, 2023. The FY2024 Program Evaluation will be submitted to the QIC and PIHP Board for approval in September.** **<u>Evaluation</u>: This goal has been met. The October 1, 2023, deadline was met for presentation and approval of the FY2023 Annual Evaluation by both the Quality Improvement Committee (QIC) and the Region 10 PIHP Board.** **<u>Barrier Analysis</u>: No barriers were encountered.** **<u>Next Steps</u>: This goal will carry over into FY2025.**
QI Program Structure - Program Description	The goals for FY2024 Reporting Year are as follows: • Submit FY2024 QI Program Description and QI Workplan to Quality Improvement Committee and the Region 10 PIHP Board by 11/1/2023. o Review the previous year's QI Program and make revisions to meet current standards and requirements.	Shelley Wilcoxon / Deidre Slingerland	**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 FY2024 QI Program and Workplan was then submitted to**

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	○ Include changes approved through committee action and analysis. ○ Include signature pages, Work Plan, Evaluation, Policies and Procedures, and attachments. • Develop the FY2024 QI Program Work Plan standard by 11/1/2023. ○ Present the work plan to committee by 11/1/2023. ○ Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year. ○ Prepare work plan including measurable goals and objectives. ○ Include a calendar of main project goal and due dates.	Quality Management Department QI Program Standing Committees	**MDHHS on October 24, 2023. Responsible staff designations in the area of Corporate Compliance were updated to reflect organizational structure changes at the PIHP.** **Q 2 (Jan-Mar):** **The responsible staff designation for the area of the Michigan Mission Based Performance Indicator System (MMBPIS) was changed to reflect current job tasks.** **The FY2024 Quality Improvement (QI) Program and Workplan was revised to remove references to the Recovery Self-Assessment (RSA) Survey. This change was recommended to the Quality Management Committee (QMC) on February 26th and approved by the Quality Improvement Committee (QIC) on March 7th and the Region 10 PIHP Board on March 15th.** **Q 3 (Apr-June):** **In May, the Region 10 Board approved the addition of Substance Use Disorder (SUD) Health Home goals, as well as two State Opioid Response (SOR) Grant goals. Responsible staff was designated for the SOR Grant goals and changes were made in the areas of QI Program Structure-Annual Evaluation and Program Description; Michigan Mission Based Performance Indicator System (MMBPIS); and Customer Relationship Management (CRM) System to reflect current job tasks.** **Q 4 (July-Sept.):** **Updates were made to the Responsible Staff Designations for Corporate Compliance and Provider Network Management to reflect current job tasks. The FY2025 QI Program Description Workplan will be presented to the committee in October 2024.** **Evaluation: This goal has been met as the PIHP was able to meet the stated November 1, 2023, submission deadline for Board approval.** **Barrier Analysis: No barriers identified** **Next Steps: This goal will carry over into FY2025.**

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Aligned System of Care	The goals for FY2024 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service. o Monitor utilization of the PIHP Clinical Practice Guidelines. o Complete annual and biennial evaluation reports as per policy. o Review Evidence-Based Practices and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., Integrated Dual Disorders Treatment (IDDT), Level of Care Utilization System (LOCUS), Opioid Health Home (OHH). o Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Annual and Biennial Clinical Practice Guidelines (CPG) Evaluation Reports are completed. The reports' findings and recommendations will be integrated into the Utilization Management (UM) Program Plan Annual Evaluation Report, which will be sent to QIC for review/approval. The FY2023 LOCUS Implementation Plan report is completed per goals attained. The FY2024 LOCUS Implementation Plan report is completed, with special attention to CMHSPs minimizing over-ride rates, ensuring timely completion, and encouraging CMHSPs to have updated MIFAST fidelity reviews.** **Q 2 (Jan-Mar):** **The Clinical Practice Guidelines (CPG) Annual and Biennial Evaluation Reports were submitted to the Quality Improvement Committee (QIC) at the March meeting as attachment documents to the FY2023 Utilization Management (UM) Program Plan Evaluation Report. Discussion was initiated with committee members regarding the FY2024 CPG Annual Evaluation Report process. Follow up discussion on the St. Clair CMH LOCUS MiFAST Fidelity Report was completed, and Sanilac CMH and GHS were again encouraged to consider scheduling a follow up LOCUS MiFAST review, just as St. Clair CMH and Lapeer CMH have accomplished. The MichiCANS hard launch plans were discussed in terms of state and local preparation tasks and timeframes. CMH clinical leaders were encouraged to reach out to their leadership to put local hard launch plans into place.** **Q 3 (Apr-June):** **An updated Clinical Practice Guidelines (CPG) Policy draft has been submitted for posting.** **The Annual CPG Evaluation Report is in-process and on schedule.** **The Lapeer CMH MIFAST report on its IDDT program was shared, with informative discussion.** **A Certified Community Behavioral Health Clinic (CCBHC) Service Provision Survey was conducted, with findings due at the July meeting.**

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			Q 4 (July-Sept.): **The Annual Clinical Practice Guidelines (CPG) Evaluation Report is in-process and on schedule.** **The Certified Community Behavioral Health Clinic (CCBHC) Service Provision Survey report was presented, indicating CMH interest in compliance with Manual 1.9 service provision requirements. CMHs report referral pressures from contiguous County CMS taking advantage of the demonstration project service provision requirements.** **<u>Evaluation</u>: The Annual CPG Evaluation Report is in-process and on schedule for completion by September 30, 2024. The LOCUS implementation workplans are in place and on schedule for completion. The CPG policy has been updated. CMH evidence-based practice (EBP) MIFAST reports have been shared for discussion.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Review draft annual committee workplan goals.**
Employment Services	The goals for FY2024 Reporting Year are as follows: • Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC). Monitor quarterly ESC meetings designed to facilitate share and learn discussions on: o CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) o Standardized employment services data and report formats o In-service / informational materials o Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS])	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Lapeer CMHSP has completed the first-year implementation of its Individual Placement and Support (IPS) employment services program. St. Clair CMHSP presented its FY2023 IPS Performance Indicator (PI) report. Sanilac CMHSP and GHS are assessing their prospects for IPS implementation. Share and learn discussions took place regarding topics presented at the State Quarterly Competitive Employment Meeting, and the EOFY Michigan Mission-Based Performance Indicator System (MMBPIS) employment PI findings were also reviewed and discussed.** **Q 2 (Jan-Mar):** **The Lapeer CMH first-year MiFAST Individual Placement and Support (IPS) fidelity report was shared, and its fidelity findings and recommendations were discussed. Also highlighted were key first accomplishments and second-**

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			year systems improvement targets. GHS and Sanilac CMH indicated that this report was very informative as each considers pursuing IPS certification. Also, a share and learn discussion took place regarding the 2Q Celebrating Competitive Employment meeting. Success stories in working with Michigan Rehabilitation Services (MRS) were noted, and St. Clair shared its most recent annual IPS participation and employment rates. **Q 3 (Apr-June):** **Lapeer CMH discussed recent statewide initiatives in support of Direct Care Worker (DCW) wage increases and shared highlights of the May quarterly Competitive Employment meeting. Discussion also noted that certain functions of conflict-free access and planning (CFAP) are at variance with IPS as an EBP. Sanilac has recently put into place its capacity to bill for Supported Employment Services. GHS updated the group on its recent contacts with the state IPS consultant as it pertains to GHS plans to launch IPS programming.** **Q 4 (July-Sept.):** **The August quarterly meeting reviewed Individual Placement and Support (IPS) programming updates along with supporting GHS and Sanilac's interest in pursuing IPS implementation. Share and learn discussions have taken regarding MMBPIS work PI reports, quarterly state-wide supported employment meetings, community collaborative practices, and standardized employment services reports.** **<u>Evaluation</u>:** **The August quarterly meeting reviewed IPS programming updates along with supporting GHS and Sanilac's interest in pursuing IPS implementation. Share and learn discussions have taken regarding MMBPIS work PI reports, quarterly state-wide supported employment meetings, community collaborative practices, and standardized employment services reports. This annual goal is completed.** **<u>Barrier Analysis</u>: None**

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			<u>Next Steps</u>: Review draft annual committee workplan goals.
Home & Community Based Services	The goals for FY2024 Reporting are as follows: o Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure quality of clinical care and service. o Monitor network completion of the HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process o Monitor the provisional approval process	Deidre Slingerland / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP received three (3) provisional requests, one from St. Clair CMHSP, one from Lapeer CMHSP, and one from Genesee Health System. All three met the requirements and were approved. Additionally, St. Clair CMHSP had a consultation with MDHHS for a secured setting placement. This was also approved.** **Validation and remediation work for the FY2020 survey cycle concluded, with the PIHP submitting timely to MDHHS respective to the November 1 deadline.** **The PIHP HCBS Lead attended the CMHA Waiver Conference in November 2023. Information was presented about ensuring that documentation is in compliance with the HCBS Final Rule.** **Q 2 (Jan-Mar):** **As discussed in a pair of Leads meetings with MDHHS, the State is collecting information to form a database of all consumers in secured settings throughout Michigan. Additionally, in lieu of in-person site visits for FY2024, MDHHS plans to survey providers regarding the physical characteristics of their setting(s). The new survey is designed to overcome issues found with the previous version which caused a lot of confusion on the part of providers responding to the questions. The PIHP and respective CMHs began work assembling contact information for this task.** **The Centers for Medicare and Medicaid Services (CMS) hosted a webinar with information pertaining to Person-Centered Planning as it relates to HCBS documentation. The PIHP HCBS Leads were in attendance as well as others from the PIHP. Other states' frameworks were discussed as well as expectations for documentation within plans. This information was shared at IPLT in January**

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			and at a meeting with CMH Leads regarding the upcoming State Site Review. **The PIHP received 17 Provisional Approval Applications during the quarter, three (3) from GHS, two (2) from Lapeer CMH, five (5) from Sanilac CMH, and seven (7) from St. Clair CMH. Of these, 15 have been approved. One is awaiting attestation from the CMH and one requires MDHHS consultation as it is for a secured setting.** **MDHHS distributed revised Guidance Documents for the Provisional Approval process as well as updated applications for both Residential and Non-Residential Providers.** **Q 3 (Apr-June):** **The PIHP received six (6) Provisional Approval requests during the third quarter. All followed process and were subsequently approved; however, one from Lapeer CMH was not submitted far enough in advance of the move in date.** **MDHHS collected contact information for residential providers of HCBS and distributed a mandatory survey. The purpose of the survey was to identify which settings in the state have restrictive characteristics.** **MDHHS also requested copies of each CMH's and the PIHP's policies requiring an IPOS to be present on site at each provider for each person in services and ensuring that staff are adequately trained on the execution of those plans.** **The PIHP attended a Leads meeting hosted by MDHHS to receive updates on current activities. The information was then shared with CMH Leads in a meeting hosted by the PIHP the following week.** **MDHHS distributed a communication clarifying the State's position on restrictions and modifications in accordance with the Medicaid Provider Manual. The communication aligns with previous guidance requiring that full explanation of restrictions and modifications be in the individual's IPOS. The State is working with Michigan**

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			State University to develop training modules for case managers to ensure that all parties are understanding of the requirements. **Q 4 (July-Sept.):** **Four (4) Provisional Approval Applications were received during the quarter: one (1) from Lapeer CMH and three (3) from Sanilac CMH.** **PIHP Leads attended a meeting with MDHHS Leads. Topics included the recent CMS visit to Michigan, the completion of the Secured Settings Survey, and the upcoming training modules to aid case managers in HCBS compliance.** **MDHHS distributed an updated Joint Guidance Document regarding the HCBS Final Rule. The document was shared with the CMHs and it was requested that they share throughout their networks as well.** **MDHHS distributed survey responses from providers that participated in the Secured Settings Survey. No further direction was given regarding potential out-of-compliance responses.** **Subsequently, the PIHP met with the CMHSP Leads in a regular meeting to discuss updates provided by MDHHS.** **<u>Evaluation</u>: This goal has been met. The PIHP CMHSP compliance with all aspects of the Secured Settings Survey conducted by MDHHS. Over the course of the year, the PIHP met five times as a group with representation from each CMHSP. Validation and remediation work for the FY2020 survey cycle was completed with all providers demonstrating full compliance with the Final Rule. The PIHP received 30 provisional requests throughout FY2023 and had two (2) consultations with MDHHS regarding secured/Heightened Scrutiny settings. As part of the process, Region 10 takes into consideration how each provisional application aligns with the HCBS Final Rule, monitoring the use of the least-restrictive environment feasible for the individual's needs. The PIHP has worked with settings to ensure full understanding of and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			compliance with the Rule and has additionally monitored individual cases as necessary to ensure quality of care. This is done by review of the IPOS and any Behavior Treatment Plans for evidence of Person-Centered Planning and specifics regarding the individual's freedoms including community integration. **Barrier Analysis: A noted barrier in FY2024 relates to unclear guidance from MDHHS regarding the new assessment and consultation process.** **Next Steps: This goal will be carried over into FY2025. Although it is deemed complete, the goal is ongoing as monitoring will continue. The PIHP plans to develop a screening tool to be used across the region to help standardize the provisional on-site visit process for the CMHs. Additionally, follow up from the Secured Settings Survey will likely be deemed necessary and the PIHP will respond accordingly.**
Integrated Health Care	The goals for FY2024 Reporting are as follows: o 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.	Deidre Slingerland / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **A workgroup began in October focusing on identification and utilization of risk stratification criteria specific to the youth in foster care population. Efforts for the October session focused around identifying potential sub populations/diagnoses to include in future risk stratification. In November, it was decided that a technical assistance regarding use of CareConnect360 would be useful, and outreach was made to the State to that end.** **In the quarter, 42 cases were discussed. Nine (9) care plans were opened during the quarter and eight (8) were closed. Reasons for closing care plans included: all goals met, consumer moved out of catchment area, some goals met, and consumer was unable to reach or locate for several months.** **Q 2 (Jan-Mar):** **During the quarter, a total of eight (8) new care plans were opened and 15 were closed. Reasons for closing care plans included members losing coverage, all goals being met, and members being unable to locate for several months.**

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			The PIHP fully executed an agreement with HAP CareSource and was once again able to facilitate joint care meetings for shared members. **Q 3 (Apr-June):** **During the quarter, a total of 84 cases were discussed, including 36 new individuals. Of those 13 were opened and 8 were closed. Reasons to close care plans this quarter included goals being met, member death, and the member moving into long term care.** **Of note, there have been ongoing challenges during meetings with McLaren Health Plan due to their inability to were unable to disable AI transcription. Written updates were collected and distributed for open members. Upon fixing this issue, the McLaren hosted Zoom meeting was not able to receive phone calls.** **The PIHP/MHP Collaboration Workgroup met in May and held a special meeting in June to discuss the potential changes to the Performance Bonus initiatives in FY2025. A proposed change would add a benchmark to the joint care management process. Concerns were shared regarding the potential of disincentivizing discussion of members who may truly benefit from coordination but do not meet the current risk stratification criteria. The State is still hearing feedback on the proposed changes. The Workgroup also discussed the subgroup looking at adding youth to risk stratification. Decisions on this are expected in the next couple of months.** **Q 4 (July-Sept.):** **In the fourth quarter, a total of 59 cases were discussed including 23 new cases. Of those 22, five (5) were deemed appropriate to open care plans. Reasons to not open include already well-connected consumers and inability to contact for over a quarter. Four (4) care plans closed during the quarter. Two (2) had all goals met, one (1) was unable to reach, and had no goals met.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The issue with McLaren meetings has been resolved. The PIHP will now be hosting the meetings via Teams in alignment with the existing process for other health plans. **The PIHP/MHP Workgroup met twice to discuss updates being proposed by Optum that would allow for easier risk stratification for youth in CareConnect360. Additionally, the group discussed streamlining the process for joint care meetings across the state and revised a process document for this purpose. A final decision has not been reached on either of these topics.** **<u>Evaluation</u>: This goal is considered met. Over the course of FY2024, 34 Care Plans were opened in CareConnect360. This is a slight decrease over FY2023 which saw 37 Care Plans opening. Of the 34 Care Plans, 20 were from Genesee, one (1) from Lapeer, one (1) from Sanilac, and 12 from St. Clair. Throughout FY2024, 35 Care Plans were closed, a marked increase from FY2023 (25 closed Care Plans). Genesee closed 19 Care Plans, Lapeer closed two (2), Sanilac closed four (4), and St. Clair closed 10. 23% of these cases were closed due to determination that all goals had been met. The PIHP met internally and subsequently with the CMH Leads to discuss processes and ensure that shared members are receiving appropriate coordinated care. Care Plans were monitored in CareConnect360 monthly throughout the year to ensure timely and appropriate updates.** **<u>Barrier Analysis</u>: The PIHP identified a barrier of not always being able to find appropriate members for discussion from each MHP each month according to risk stratification criteria. To overcome this, the PIHP continued focus on the youth population. The PIHP utilizes a manual filter to search for children in foster care with marked ED use.** **<u>Next Steps</u>: This goal will be continued in FY2025. The PIHP will continue to work with the PIHP/MHP Collaboration Workgroup to develop a standardized statewide process to monitor risk for the child/youth population and ensure inclusion in joint care meetings when appropriate.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2024 Reporting are as follows: o To review and monitor the safety of clinical care. o Review CMH 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 CMH and SUD sentinel event review processes and ensure follow-up as deemed necessary. o Monitor CMH and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary. o Monitor CMH and SUD risk events review processes and ensure follow up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Two sentinel events are in the Sentinel Event Review Committee (SERC) review process, thus far noting CMHSP adherence to review and report standards. Network provider Risk Events/Risk Management (RM) reports were reviewed, and SERC regional analysis identified various levels of compliance to RM report standards, as well as noted marginal regional trends pertaining to emergency use of physical intervention (PI) and police responses. Committee feedback is being sent back to network providers to help ensure adherence to reporting standards, as this new RM reporting system moves forward. EOFY CMHSP Mortality Reports were reviewed, noting no significant service provision issues, although recommendations were made to help ensure reports cover all areas noted in the updated PIHP policy. Feedback to SUD providers to onboard their unexpected deaths reporting system also was discussed.** **Q 2 (Jan-Mar):** **One sentinel event review was continued for monitoring, and so far, all provider and committee review activities have been completed as appropriate and withing policy time frames. Monthly critical incident (CI) report monitoring revealed compliance to report timeframes and no concerning trends across report categories. The 1Q FY2024 CI report was reviewed, with discussion, and approved. No untoward trends were revealed, although close monitoring will continue regarding *Emergency Medical Treatment* across the CMH and SUD networks. The 2Q CMH Risk Events (RE) monitoring report was reviewed, with discussion. CMHs are completing track/trend activities across the required RE categories, along with other additional risk events. No emergent service systems issues are identified, but various prevention and proactive activities are taking place across the network. A time-limited SUD network workgroup has completed its task to inform SUD Risk Event and Risk Management (RM) reporting practices and processes. An aligned SUD network RM reporting system will begin next quarter.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **Monthly critical incident (CI) reports were reviewed along with the 2Q CI report. Emergency medical treatment (EMT) continues to be the most frequently occurring CI but thus far there are no concerning trends or service delivery issues. One sentinel event (SE) was closed, with all review standards and responses met by the program. One new SE was received, and one SE is in the monthly monitoring process, with both revealing program compliance to task time frames as appropriate. CMH 2Q Risk Events reports were reviewed with no concerning or service systems issues noted, other than SUD network reports are pending and will be reviewed next meeting in an updated report. Mid-Year provider program mortality reports were reviewed with no concerning trends or service systems issues noted.** **Q 4 (July-Sept.):** **Monthly critical incident (CI) reports were reviewed with no concerning trends noted along with the edited/completed second quarter CI report, which retained findings and recommendation reviewed by QIC in June. One sentinel event (SE) was closed, with all review standards and responses met by the program. One new SE was received, and one SE is in the monthly monitoring process, with both revealing program compliance to task time frames as appropriate.** **SUD second quarter Risk Events (RE) reports were reviewed with no concerning or service systems issues noted, other than to note two SUD program reports have still not been received. Outreach has been undertaken and these reports will be reviewed at the next meeting per an updated report.** **<u>Evaluation</u>: Monthly CI reports were reviewed with no concerning trends noted. One new SE monitoring report was reviewed and program compliance to task time frames as appropriate was noted. SUD 2Q Risk Events reports were reviewed with one program pending submission of periodic activities. Outreach has been undertaken. Otherwise, this goal has been completed.**

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<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td><u>Barrier Analysis</u>: One issue remaining regarding the SUD program RE reporting noted above.

<u>Next Steps</u>: Review draft annual committee workplan goals.</td></tr>
<tr><td>Michigan Mission Based Performance Indicator System (MMBPIS)</td><td>The goals for FY2024 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.
<table>
<tr><th></th><th>FY23 Q3</th><th>FY23 Q4</th><th>FY24 Q1</th><th>FY24 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>99.67%</td><td>100%</td><td>99.29%</td><td>100%</td></tr>
<tr><td>1.2 Adults</td><td>99.78%</td><td>99.89%</td><td>98.57%</td><td>99.77%</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. No standard</td></tr>
<tr><td>2a PIHP Total</td><td>54.23%</td><td>56.34%</td><td>48.76%</td><td>45.55%</td></tr>
<tr><td>2a.1 MI-Children</td><td>50.69%</td><td>57.58%</td><td>48.24%</td><td>43.41%</td></tr>
<tr><td>2a.2 MI-Adults</td><td>55.19%</td><td>54.86%</td><td>49.46%</td><td>48.24%</td></tr>
<tr><td>2a.3 DD-Children</td><td>55.32%</td><td>57.56%</td><td>45.95%</td><td>35.04%</td></tr>
<tr><td>2a.4 DD-Adults</td><td>64.00%</td><td>68.00%</td><td>50.00%</td><td>48.10%</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 persons with Substance Use Disorders. No standard</td></tr>
<tr><td>2b SUD</td><td>74.00%</td><td>78.17%</td><td>73.38%</td><td>74.59%</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. No standard</td></tr>
<tr><td>3 PIHP Total</td><td>81.62%</td><td>82.32%</td><td>78.01%</td><td>78.56%</td></tr>
</table></td><td>Lauren Campbell

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

Q 1 (Oct-Dec):
Performance indicators (PIs) for FY2023 fourth quarter were submitted to MDHHS on January 2, 2024. The PIHP did not meet the set performance standard for PI 4b. Sanilac CMH did not meet the set performance standard for PI 10-Children. St. Clair CMH did not meet the set performance standard for PI 4a-Children or PI 10-Children.

Throughout the quarter the PIHP PI Team worked on updating contract language to reflect the implementation of performance benchmarks/thresholds for indicators 2 and 3.

Q 2 (Jan-Mar):
CMH and SUD Contract Amendments regarding the new benchmarks for Indicators #2 and #3 were approved, with the benchmarks in effect beginning FY2024 Q1.

Performance indicators for FY2024 first quarter were submitted to MDHHS on March 29, 2024. GHS and St. Clair CMH did not meet the set performance standard for PI 4a for the children or adult population breakout.

Q 3 (Apr-June):
Performance indicators for FY2024 second quarter were submitted to MDHHS on June 28, 2024.

The PIHP did not meet the set performance standards for performance indicator #2. The PIHP did not meet the first performance standard for performance indicators #2b/2e and #3. The PIHP also did not meet the set performance standard for performance indicators #4a – Adults and 4b.</td></tr>
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<table>
<tr><td>3.1 MI-Children</td><td>80.38%</td><td>84.51%</td><td>78.64%</td><td>84.25%</td></tr>
<tr><td>3.2 MI-Adults</td><td>79.37%</td><td>79.33%</td><td>75.58%</td><td>76.50%</td></tr>
<tr><td>3.3 DD-Children</td><td>92.86%</td><td>90.05%</td><td>87.71%</td><td>76.64%</td></tr>
<tr><td>3.4 DD-Adults</td><td>81.54%</td><td>83.33%</td><td>80.00%</td><td>70.00%</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>94.57%</td><td>94.37%</td><td>91.43%</td><td>97.75%</td></tr>
<tr><td>4a.2 Adults</td><td>97.21%</td><td>97.94%</td><td>93.61%</td><td>94.82%</td></tr>
<tr><td>4b SUD</td><td>95.60%</td><td>94.74%</td><td>96.10%</td><td>91.14%</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>7.25%</td><td>14.78%</td><td>5.45%</td><td>8.80%</td></tr>
<tr><td>10.2 Adults</td><td>12.01%</td><td>12.79%</td><td>13.77%</td><td>12.02%</td></tr>
</table>
</td>
<td></td>
<td>For second quarter, Providers were asked to submit updates to the plans of improvement submitted in first quarter.

Q 4 (July-Sept.):
The PIHP received the FY2024 second quarter Consultation Draft Report from MDHHS. The PIHP Habilitation Supports Waiver (HSW) Coordinator was not able to match the information provided by MDHHS for performance indicator #6. Outreach was made to MDHHS to ask about MDHHS' logic for this indicator.

PIHPs learned MDHHS will be phasing out the Michigan Mission-Based Performance Indicator System (MMBPIS) and moving to standardized measures.

Performance indicators for FY2024 third quarter will be submitted to the PIHP by September 15, 2024.

<u>Evaluation:</u> During FY2024, the PIHP successfully reported indicator results to MDHHS, reviewed quarterly MMBPIS data, and provided status updates to relevant committees. However, the PIHP did not meet and exceed the performance standards each quarter. The PIHP started monitoring performance against MDHHS' established performance standards for indicators 2, 2b/2e, and 3. CMHs and SUD Providers were asked to provide an initial root cause analysis and plan of correction then quarterly updates.

<u>Barrier Analysis</u>: CMHs and SUD Providers reported challenges preparing root cause analyses and plans of correction due to person-driven reasons for noncompliance.

<u>Next Steps</u>: This goal will be continued for FY2025. The goal will be modified to include a planned activity to discuss and prepare for the transition from MMBPIS to standardized measures.</td>
</tr>
<tr>
<td>Members' Experience</td>
<td>The goals for FY2024 Reporting are as follows:
• Conduct assessments of members' experience with services.
o Conduct annual regional customer satisfaction</td>
<td>Deidre Slingerland</td>
<td>Quarterly Update:

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

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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 Form a workgroup consisting of members of the SUD Provider Network to gather feedback and share ideas to plan upcoming surveys. o Develop and implement action steps to address response rates / totals.	Quality Management Committee (QMC)	**The FY2023 Customer Satisfaction Survey Report was presented to the Quality Management Committee (QMC) on November 29, Quality Improvement Committee (QIC) on December 4, and the Region 10 Board on December 15.** **Some highlights from this Report include:** • **Survey response totals rose 282% for the Adult population from FY2022's survey. A total of 1,647 surveys were completed by adults in services.** • **Three of the four CMHs saw an increase in response totals, with Sanilac CMH's total dropping slightly.** • **The percentage of respondents indicating having experienced a barrier to services rose from 18% to 24% during the past year.** • **The most commonly stated barrier is transportation (24%) with the next most common being inconvenient appointment times (14%).** • **Recommend to streamline methodology in subsequent survey cycles throughout the network.** **The PIHP staff met to discuss potential incentives for persons served to participate in upcoming surveys.** **Q 2 (Jan-Mar):** **The FY2024 Quality Improvement (QI) Program and this goal on the Workplan were revised to remove references to the Recovery Self-Assessment (RSA) Survey. The Quality Management Committee (QMC) was notified on February 26th that PIHP members recommended the removal of the objective from the QAPIP. No objections were received. This change was subsequently approved by the Quality Improvement Committee (QIC) on March 7th and the Region 10 PIHP Board on March 15th.** **The PIHP met monthly with the SUD Survey Workgroup. Topics discussed included methodology, other surveys each provider participates in order to address any timeline issues, how findings of surveys and other assessments of satisfaction are shared with consumers and how their feedback is incorporated into analysis, how to properly carry out recommendations from the previous RSA survey,**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			and ideas for future survey growth in terms of response rates and totals. **Q 3 (Apr-June):** **The PIHP met throughout the quarter and finalized plans for the FY2024 Customer Satisfaction Survey. The decision was made to move to the standardized Mental Health Statistical Improvement Program (MHSIP) and Youth Services Survey for Families (YSS-F) for adults and youth respectively throughout the region. Surveys are to be administered in person to individuals presenting for services between July 22-August 9, 2024.** **Q 4 (July-Sept.):** **Materials were distributed to all network providers for the FY2024 Customer Satisfaction Survey. Packets were mailed to SUD providers on July 3 containing pre-printed surveys for their use as well as additional copies of the memo and instructions. The survey went live on July 22nd and ran through August 9th.** **<u>Evaluation</u>: This goal is considered met. The Customer Satisfaction Survey ran from July 22, 2024 – August 9, 2024 across the Region 10 Provider Network. Results from the FY2023 Customer Satisfaction Survey were reported throughout the network and the FY2024 data aggregation has begun. The Quality Management Committee (QMC) continues to discuss efforts aimed at increasing response totals for surveys. Totals for the Customer Satisfaction Survey are still being aggregated. In FY2023, a total of 1,627 surveys were completed by adults, 1,044 from those in CMH services and 603 from the SUD network. A total of 280 surveys were completed by families of children in CMH services.** **Additionally, the SUD Workgroup was formed to provide feedback from stakeholders in the SUD network. The results of these discussions are shared at QMC and helped inform the survey process throughout the FY.** **<u>Barrier Analysis</u>: Establishing a timeline for survey administration was difficult this year with various other activities taking place throughout the usual time period.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps</u>: This goal is ongoing and thus will be carried over into FY2025. Data is currently being aggregated from the FY2024 Customer Satisfaction Survey. It is expected that the findings will inform further action and discussion both internally and at each network provider.
State Mandated Performance Improvement Projects (PIPs)	The goals for FY2024 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 - First quarter implementation monitoring reports are in the process of aggregate analysis and providing program level feedback. PIP 2 - CMHSPs have completed their updated CY2023 improvement action plans, based on quality improvement / quality management consultative feedback provided by the Region 10 PIP team.** **Q 2 (Jan-Mar):** **PIP 1 End of (EO) Calendar Year (CY) 2023 implementation monitoring reports have been received, and the regional report and the program-specific reports have been sent to programs. Data and analysis output for re-measurement 1 has been received.** **PIP 2 EOCY2023 implementation monitoring reports and CY2024 systems improvement action plans were pended to the March QMC meeting and two CMHs have submitted their plans so far. FY2023 data analysis for the available (6 months) has been completed and shared. Full FY2023 data will be available by June.** **Q 3 (Apr-June):** **Performance Improvement Project (PIP) 1 annual analysis is in process and on schedule. PIP 2 annual analysis is underway. PIP 2 Calendar Year (CY) CY2023 implementation monitoring reports have been reviewed and edited for completeness and format consistency.** **Q 4 (July-Sept.):** **The Performance Improvement Project (PIP) 1 annual validation report was sent to the Health Services Advisory Group (HSAG) on time.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			PIP 2 annual analysis is completed and has been shared with the CMH QMC membership. PIP 2 CY2023 implementation monitoring reports and CY2024 systems improvement plans have been reviewed and edited for completeness and format consistency. **<u>Evaluation</u>: Performance Improvement Project (PIP) 1 annual validation report and follow up report were sent to HSAG on time. The Black / African American group Remeasurement 1 percentage (77.97%) was greater than the group's Baseline (68.12%) as well as its Remeasurement 1 target (76%). The White group Remeasurement 1 percentage (81.95%) was greater than the group's Baseline (73.18%) as well as its Remeasurement 1 target (76%). In addition to having conducted statistical testing between the measurement periods, statistical testing also was conducted to determine if the disparity between the White group and the Black/African American group had been eliminated. The Chi Square (X2 one-variable test of significance, two-sided confidence level) statistical test was used to compare for statistically significant differences. The p value significance level was set at = 0.05 (95 percent confidence level, $p < 0.05$) and was calculated and reported to four decimal places.** **The Chi Square achieved was 13.665 with a two-tailed P value equaling 0.0002, which is extremely statistically significant ($X2 (1) = 13.665$, $p = 0.0001$*). Therefore, although it was evident that both racial/ethnic groups demonstrated a significant increase in their rate of persons who received a face-to-face service for treatment or support from an SUD treatment program within 14 calendar days of a non-emergency request for service, the disparity between both racial/ethnic groups had not been eliminated. This negative result will be used to help inform systems improvement action planning, moving forward.** **PIP 2 annual analysis is completed and has been shared with the CMH QMC membership. Adult findings revealed a total of 1,599 FUH events, in which 1056 (66%) FUH events met the PIP criterion (Yes). This 66% rate exceeded the Baseline rate (62%) and the MMBPIS Minimum**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Target (58%), but it was below the Goal Target of 70%. CMHSP breakouts revealed that all CMHSP rates exceeded the PBIP Minimum Target of 58% (GHS 63%, Lapeer 75%, Sanilac 75%, St. Clair 69%), but only Lapeer and Sanilac exceeded the Goal Target of 70%. These results also indicated that, with the exception of Sanilac, all CMHSP rates exceeded their respective Baseline rates. Children findings revealed a total of 386 FUH events, in which 312 (81%) FUH events met the PIP criterion (Yes). This 81% rate exceeded the PBIP Minimum Target of 70%, but it was below the Goal Target of 89%. CMHSP breakouts revealed that all CMHSP rates exceeded the PBIP Minimum Target of 70% (Lapeer 91%, Sanilac 90%, St. Clair 89%), with the exception of GHS (76%). The results also indicated that all CMHSPs with the exception of GHS exceeded their respective Baseline rates. PIP 2 CY2023 implementation monitoring reports and CY2024 systems improvement plans have been reviewed and edited for completeness and format consistency. **All and all, this goal has been completed, though it is also noted that both PIPs are set for continuation during FY2025.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Review draft annual committee workplan goals.**
External Monitoring Reviews	The goals for FY2024 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW]: o Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions. o Ensure both Professional and Aide staff meet required qualifications. o Ensure compliance with person-centered planning and individual plan of service requirements, with	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Q1 was 547 of the PIHP's total 656 slots. There are currently four (4) pending applications. Slot utilization continues to be a struggle for the Habilitation Supports Waiver. Disenrollment numbers have increased, which is consistent across the State, due to the Appendix K flexibilities ending November 11, 2023.** **The PIHP HSW Lead has been holding monthly working sessions with the CMH leads to discuss slot utilization and strategize ways, as a region, to increase enrollment numbers. These meetings have been helpful in identifying**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	additional focus on areas identified as repeat citations. o Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. o Discuss and follow up on HSW slot utilization and slot maintenance.		**barriers to the program and discussing program expectations and needs. Additionally, the PIHP lead is scheduling a meeting with Finance to discuss the financial impacts of the decreased enrollment in the HSW program and explore reports to pull potential enrollees.** **In Q1, Region 10 updated Policy language which is now updated on the PIHP website. The policy reinforces timely documentation submission for the HSW program and slot utilization. The PIHP HSW Coordinator attended the 2023 Annual Home and Community Based Waiver Conference which took place in November.** **Another program improvement strategy the PIHP has adopted is at the monthly Quality Management Committee (QMC) meetings, the PIHP has asked the CMH representatives to speak to any outstanding items for the 1915(c) waivers and address any barriers. This oversight has been effective in getting outstanding items cleared up and will continue to be used. With continued oversight, communication, and target deadlines, Genesee Health System has been able to clean up all of the outstanding items for their Children's Waiver Program in Quarter 1.** **Q 2 (Jan-Mar):** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of the second quarter was 544 of the PIHP's total 656 slots. There are currently four (4) pending applications and two (2) pending disenrollments.** **The PIHP and CMH staff continue to discuss ways to increase enrollment numbers and have worked hard in the second quarter to complete reference tools created for the HSW Program to help staff and broaden program understanding.** **PIHP has met with CMH Site Review leads in the second quarter to help prepare for the MDHHS Site Review scheduled to take place this summer August- September. More meetings are being scheduled to meet with each CMH lead individually later this month.** **Q 3 (Apr-June):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The number of Habilitation Supports Waiver (HSW) enrollees at the close of Q3 was 539 of the PIHP's total 656 slots. In Q3, MDHHS approved nine (9) new pending applications and the PIHP received twenty-seven (27) new enrollee applications. There are currently nineteen (19) new enrollee applications in varying stages of approval. CMHs are working hard to push new enrollees for this program and increase these numbers. HSW new enrollment packets do continue to be pended back due to not being in compliance with the HCBS final rule, the PIHP HSW and HCBS teams continue to meet and collaborate on these cases. **In the Month of June, the PIHP Site Review team received a Draft Agenda, Audit sample selections, Cases chosen for the ARC interviews, Naming Conventions instruction, Final Review Protocol, Preparation PowerPoint, Staff Credentialing Worksheets and general review instruction. The PIHP sent the CMHSP Site Review leads these instructions and have requested for documentation submission July 17th to the PIHP. MDHHS has asked for all documentation and EMR access by August 2nd.** **Q 4 (July-Sept.):** **The number of Habilitation Supports Waiver (HSW) enrollees near the end of Quarter 4 was 539 of the PIHP's total 656 slots. In Quarter 4, MDHHS approved five (5) new pending applications and the PIHP received five (5) new enrollee applications. There are currently fourteen (14) new enrollee applications in varying stages of approval. CMHs are working hard to push new enrollees for this program and increase these numbers. HSW new enrollment packets do continue to go through the MDHHS Home and Community Based Services (HCBS) Team for review of compliance with the HCBS Final Rule before approval. The PIHP HSW and HCBS Team have created a review process for these new cases to streamline this process.** **In the fourth quarter, the PIHP Site Review Team received documentation from the CMHs for the State Site review on privileging and credentialing and training. This documentation was submitted to MDHHS. Also, on July**

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			26th, Region 10 sent the ARC Review Team the demographics spreadsheet to start the interview portion of the Site Review. GHS had their teleconference session August 28th, with the other CMH teleconference sessions scheduled throughout September. These teleconferences provide opportunity for the CMH to review MDHHS' findings with the reviewers. **<u>Evaluation</u>: During the QMC meetings in FY2024, the PIHP Waiver Coordinator addressed 1915(c) Waiver outstanding items requesting updates on late and or missing case actions. Slot Utilization continued to be a struggle for the Habilitation Supports Waiver in FY24. Enrollment efforts remained a focus and the PIHP hosted quarterly workgroup meetings with the CMH Leads to discuss strategies to increase these numbers. Reference tools were created and distributed because of suggestions made in these workgroup meetings these will help broaden the understanding of this program and assist in training new staff members.** **With these additional efforts, enrollment in FY2024 has gone up 66% over the last fiscal year. In FY2024 third quarter, Region 10 had 21 new enrollment packets submitted, the total in FY2023. There is an additional barrier that was introduced in the third quarter. Initial Enrollment packets are being reviewed by the MDHHS HCBS team to confirm compliance with the HCBS Final Rule. Education has not officially been offered by MDHHS on what these standards should look like in an individual plan of service (IPOS), so cases have needed to be pended back due with questions and concerns which has slowed our efforts of increasing these program numbers.** **Additionally, in June the CMHs were asked to review enrollment numbers and project enrollment for the Habilitation Supports Waiver Program for Slot Utilization. MDHHS will be moving slots with the Waiver renewal for FY2025, and we were asked to anticipate our utilization. Region 10 requested to give up 29 slots for this program, effective October 1st.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The MDHHS State Site Review took place this Fiscal Year. Updates have been provided at quarterly Leads meetings and at the QMC meetings monthly. The PIHP Lead hosted a planning meeting for the State Site Review in February with the CMH Site Review leads to discuss expectations and begin planning. Meetings were also held with each CMH Lead in the third quarter to discuss outstanding Corrective Action Plans and further discuss the upcoming review. The review is in progress, follow-up and continued efforts will continue. Overall, this goal has shown improvement, with continued efforts into FY25. **<u>Barrier Analysis</u>: Enrollment packet submission has increased this fiscal year; however, Slot Utilization continues to be a barrier for the Habilitation Supports Waiver Program. There is now an additional review by the MDHHS HCBS Team for HCBS Final Rule compliance. With the slot allocation changes slot numbers will improve, but Region 10 will need to continue to increase the numbers for this program and continue to have a greater understanding of the HCBS Final Rule and what the expectations are within a beneficiaries IPOS to reduce initial submission PendBacks.** **<u>Next Steps</u>: This objective will be continued into the following fiscal year. To enhance oversight of Region 10's slot performance and program submissions, this goal will be discussed during QMC meetings and updates will be provided monthly by CMHs. Additionally, continued conversations will be had with each CMH to help address the challenges they are facing with slot performance and or any citations or findings from this year's Site Review. Finally, MDHHS has discussed education for CMH staff on the HCBS Final rule, which will help in understanding that barrier, and continued guidance and support will be provided by the PIHP team.**
Monitoring of Quality Areas	The goals for FY2024 Reporting are as follows: • To explore and promote quality and data practices within the region. o Monitor critical incident data and reporting. o Monitor risk event data and reporting. o Monitor emerging quality and data initiative / issues and requirements.	Lauren Campbell & Laurie Story-Walker Quality Management	**Quarterly Update:** **Q 1(Oct-Dec):** **BH TEDS MDHHS added H0038 as an excluded CPT code for Substance Use as it was reporting a missing BH TEDS record when the service can be provided prior to the treatment episode. The service can also be provided post discharge, however this was not impacted, because there**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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.	Committee (QMC)	**was a BH TEDS record in the warehouse. MDHHS worked with DTMB to correct some BH TEDS Errors.** **Completion Rates through 9/30/2023:** • **Mental Health – 99.44%** • **Q (Crisis records) – 98.65%** • **SUD – 99.68%** **CCBHC SUD claims have been paused as the PIHP works on updated requirements (email from Richard Carpenter 10/02/2023).** **MichiCANS - Sanilac CMH is a pilot site beginning in January 2024, along with others in the state. The pilot program will provide vital information on how the tool is working and allow for updates/enhancements to the tool and guidance document prior to the statewide go live which is expected for FY2025 (10/01/2024).** **Electronic Visit Verification (EVV) Collaboration and discovery meetings continue to occur with HHAX (vendor and MDHHS) they have also requested additional Provider information from each CMH to assist with the project development. On November 16, 2023, HHAX presented patient authorization, Provider Agency profile and Draft specifications. Proposed go-live date is 3/1/2024.** **DHHS – 2451A Income Only Determination (Ability to Pay) has been programmed into CHIP. Awaiting to hear from OASIS users and will be programmed in MIX for the SUD Providers. The goal for the new process is to have one (1) assessed ability to pay for all entities, mental health, SUD and CCBHC.** **Encounter Reporting – Genese Health System is working their PCE Project Manager to ensure the CCBHC T1040 is reporting with the qualifying CCBHC service. Lapeer CMH is reporting CCBHC services and Sanilac CMH is reviewing the data to ensure its accuracy before submitting the encounters. All have their EHR's programmed to**

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			attach the TF modifier, which identifies mild-to-moderate population using the LOCUS and CAFAs score. **The memo from Belinda Hawks was shared, adding Skill Building via telehealth to be provided in the home. The CMHSP/PIHP must guarantee the individual is not influenced or prompted for the service. It must be at the request of the individual.** **The October 2023 Encounter Data Integrity Team (EDIT) meeting minutes were shared highlighting agenda topics discussed.** **Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. All CMHs confirmed their numbers were accurate. Follow up continues to ensure critical incident remediations are addressed and submitted in the Customer Relationship Management (CRM) system.** **Additionally, the committee members submitted narratives for the regional Patient-Centered Medical Home narrative as part of the Performance Bonus Incentive Pool (PBIP) requirements. The narrative was submitted to MDHHS on November 13, 2023.** **Q 2 (Jan-Mar):** **BH TEDS comparison rates were reviewed and discussed with emphasis on reporting the Q Record promptly. Providers continue efforts with the dangling BH TEDS admission records that are missing an update or discharge. The EDIT meeting minutes and updates were shared with the workgroup members, along with the guidance on documenting the number of participants. All attendees are to be counted. Discussed the Electronic Visit Verification (EVV) upcoming launch and technical assistance provided by MDHHS and HHAX (Vendor for EVV project). Discussed the upcoming launch of the MichiCANS tool replacing the CAFAS/PECFAS for the those not involved in the pilot program and the upcoming training sessions. Staff should begin registering for a training session now, as there are upwards of 5000+ staff to train. Region 10's**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			CMHSPS are included in Cohort 1, beginning in April. We requested clarification from each CCBHC if they are reporting the coordination of benefit (COB) data as well as encountering services that were paid 100% by the primary payer regarding (e.g. Medicare/BCBS/Aetna, etc). GHS, Sanilac CMH, and St. Clair CMH will follow-up and provide an update. Lapeer CMH is submitting information for mental health and will follow-up on SUD services. Discussed the modifier TF cannot be added to SUD services because this is to identify the mild-to-moderate population for mental health. **Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. All CMHs confirmed their numbers were accurate. Follow up continues to ensure critical incident remediations are addressed and submitted in the Customer Relationship Management (CRM) system according to MDHHS' guidance.** **The committee was also made aware of an upcoming data validation activity for the Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) metric.** **Q 3 (Apr-June):** **The BH TEDS comparison rates, progress on the dangling admissions project and upcoming BH TEDS training on the FY25 changes were discussed. The CMHSPS were asked to report any encounter challenges or barriers to submitting data timely and accurately. The Electronic Visit Verification memo, assigned county ids, and provider survey were reviewed. The workgroup discussed the MDHHS memo related to V modifiers for the Hospital tiered Rate project. It was determined the process put in place would not be viable and MDHHS is seeking an alternate process. The MichiCANS training is underway for the CMHSPs that were not part of the soft launch, as this will take effect 10/01/2024. The FY24 period 1 EQI was completed and the FY24 P2 EQI began within the quarter. MDHHS is retiring the current Wraparound planning process and CPT code H2022 effective 10/1/2024. They are discussing the use of H2021 or T1017.**

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			Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. All CMHs confirmed their numbers were accurate. Follow up continues to ensure critical incident remediations are addressed and submitted in the Customer Relationship Management (CRM) system. **The PIHP presented the FY2023 Performance Bonus Incentive Pool (PBIP) award. Additionally, for PBIP, the data validation activity for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) metric was discussed. The PIHP will be preparing two different narratives as part of the FY2024 PBIP metrics. One narrative is related to social determinants of health and BH-TEDS data and the other narrative is related to joint care management processes.** **Q 4 (July-Sept.):** **The BH TEDS comparison rates and outstanding dangling admissions were reviewed. The CMHs were asked to report any encounter challenges or barriers to submitting data timely and accurately. The FY2024 period 2 Encounter Quality Initiative (EQI) initial data pull was completed, and staff are reviewing and correcting any data findings. The June 28, 2024, MDHHS memo removed the requirement for claim submission from the September 3, 2024, Electronic Visit Verification launch for Respite (T1005) and Community Living Services (H2015). The MichiCANS training continues for the CMHs that were not part of the soft launch, as this will take effect 10/01/2024.** **Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. All CMHs confirmed their numbers were accurate. If an incident was not submitted successfully, the CMH and PIHP representatives followed up. Follow up continues to ensure critical incident remediations are addressed and submitted in the Customer Relationship Management (CRM) system.** **The PIHP submitted two narratives to MDHHS as part of the FY2024 Performance Bonus Incentive Pool (PBIP)**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			metrics. One narrative was an analysis of BH-TEDS data and social determinants of health, and the other narrative covered joint care management processes. **<u>Evaluation</u>: The PIHP explored and promoted quality and data practices within the region. Discussion occurred during monthly QMC meetings, with additional information shared via email between meetings. Throughout the fiscal year, the CMHs and PIHP navigated the reporting method for critical incident data and submission of remediation responses. The committee monitored and addressed Performance Bonus Incentive Pool activities and indicators, changes to services codes, various regional data reports, and BH-TEDS. Regarding the planned activity to monitor emerging quality and data initiative / issues and requirements, committee members discussed new initiatives such as the implementation of the MichiCANS and electronic visit verification.** **<u>Barrier Analysis</u>: Early in the fiscal year, an identified barrier was understanding of the process for critical incident remediation entries within the CRM System. This barrier was addressed and the PIHP continues to oversee and facilitate collecting and submitting remediation responses.** **<u>Next Steps</u>: Continue this goal for FY2025 to continue exploring and promoting quality and data practices within the region**
Financial Management	The goals for FY2024 Reporting are as follows: • Establish consistent Region-wide finance reporting for the annual Certified Community Behavioral Health Clinic (CCBHC) Cost report. o Region 10 Chief Financial Officer (CFO) will provide quarterly training on specific aspects of the CCBHC cost report designed to inform and direct the CCBHC sites on how to gather and report the required financial information.	Richard Carpenter Finance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The first of the four quarterly trainings was completed on November 17, 2023 at the Lapeer County Country Club. This first training was designed as a financing overview for CCBHC Demonstration. CCBHC Finance Officers, administration staff, and Board members were all invited to participate in the training. Feedback regarding the training was positive.** **Q 2 (Jan-Mar):** **Identified date for the second quarter training. The training is currently scheduled for April 19th 12pm – 3pm.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **The next Certified Community Behavioral Health Clinic (CCBHC) training is being planned for July 2024.** **Q 4 (July-Sept.):** **The third Certified Community Behavioral Health Clinic (CCBHC) finance training was held on August 13th.** **Evaluation: This goal has been met.** **Barrier Analysis: No barriers identified.** **Next Steps: For 2025, there will be two more CCBHC trainings (November and January) as well as two trainings around the Encounter Quality Initiative (EQI) reporting (May and August).**
Utilization Management	The goals for FY2024 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).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Monthly crisis services utilization reports have been reviewed and no concerning trends have been identified.** **Q 2 (Jan-Mar):** **Review of monthly critical incident reports identified no service utilization issues.** **Q 3 (Apr-June):** **Monthly monitoring reports were reviewed and discussed, with no concerning trends evident.** **Q 4 (Jul – Sept.)** **Monthly monitoring reports were reviewed and discussed, with no concerning trends evident.** **Evaluation: Throughout the year, monthly monitoring reports were reviewed and discussed, with no concerning trends evident. This goal has been met.** **Barrier Analysis: No barriers identified.** **Next Steps: Review draft annual committee workplan goals.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Utilization Management	The goals for FY2024 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over restricted and intrusive behavioral techniques, emergency physical management use, 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).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **No service utilization or treatment issues are identified.** **Q 2 (Jan-Mar):** **As an administrative efficiency beginning 2Q, the review process changed to a desk review process as completed by the UMC Chair, for brief status and contingent discussion at the meeting. Review of these reports indicated no service systems issues or improvement opportunities.** **Q 3 (Apr-June):** **Quarterly reports were reviewed. Service systems issues were ruled out and providers are adhering to practice standards.** **Q 4 (July-Sept.):** **Quarterly monitoring reports were reviewed and discussed, with no concerning trends evident.** **Evaluation: Throughout the year, quarterly monitoring reports were reviewed and discussed, with no concerning trends evident. This goal has been met.** **Barrier Analysis: No barriers identified.** **Next Steps: Review draft annual committee workplan goals.**
Utilization Management	The goals for FY2024 Reporting are as follows: • Ensure regional Utilization Review (UR). o PIHP UM Department to conduct UR: ▪ UR on SUD network provider programs (annually) ▪ UR on CMHSP Optimal Alliance Software Information System (OASIS)-user affiliates (quarterly) o UMC to monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Annual SUD Utilization Review (UR) was completed as scheduled for the September meeting.** **CMH UR OASIS outlier/case finding reports are still in development with TBDS, and outreach has been maintained to encourage completion of these reports. CHIP CMH UR reports were reviewed in September as scheduled.** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Substance use disorder (SUD) utilization review (UR) planning activities began March and UR implementation activities will begin during 3Q. 2Q CMH UR reporting was completed at the March UMC meeting as scheduled. Reports revealed medical necessity in many cases along with clinical and service systems improvement opportunities communicated back to provider programs. **Q 3 (Apr-June):** **CMH utilization review (UR) for 3Q was completed and reports were reviewed at UMC. Service systems issues pertaining to person centered planning were noted, and supervision recommendations were made. Annual SUD UR will begin later in July.** **Q 4 (July-Sept.):** **4Q/EOY CMH utilization review (UR) is underway as scheduled. Annual SUD UR is completed.** **Evaluation: 4Q/EOY CMH utilization review (UR) is underway as scheduled. Annual SUD UR is completed. This goal has been met.** **Barrier Analysis: No barriers identified.** **Next Steps: Review draft annual committee workplan goals.**
Utilization Management	The goals for FY2024 Reporting are as follows: • Promote aligned care management activities across key areas of network operations. o Implement Centralized UM System (UM Redesign Project) ▪ Oversight of the OASIS Users Workgroup and Sub-Workgroup o Operate the MDHHS/Region 10 Phase I 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:** **Q 1 (Oct-Dec):** **OASIS / MIX demoing took place in early December, with plans to complete demoing in January. New Access clinical staff have been onboarded into the Indicia system. The Region 10 Chief Clinical Officer (CCO) participates in the statewide UM Directors Group and reports on the group's activities monthly at UMC.** **Q 2 (Jan-Mar):** **Utilization Management (UM) Redesign final task preparation is underway toward a 3Q launch of the project. The Milliman Care Guidelines (MCG) Indicia annual edition update is anticipated during 3Q. The UM**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Directors Group is helping coordinate state and vendor update activities and the contract renewal process. **Q 3 (Apr-June):** **The Utilization Management (UM) Redesign Project launch is now into its fifth week and by and large implementation is taking place as planned. The Milliman Care Guidelines (MCG) 27th Edition Indicia Inter-Rater Reliability (IRR) has been scheduled for late 4Q. UM Directors Group continues to meet monthly, and recently discussions have focused on COFR, IPU rates, IRR content.** **Q 4 (July-Sept.):** **The UM Redesign Project has been launched. Monthly UM Directors Group is meeting monthly as scheduled, with informational and problem-solving discussions held, such as pertaining to COFR, CFAP, and needs assessment tools. The annual IRR process has been implemented.** **Evaluation: The UM Redesign Project has been launched. Monthly UM Directors Group is meeting monthly as scheduled, with informational and problem-solving discussions held, such as pertaining to COFR, CFAP, and needs assessment tools. The annual IRR process has been implemented. This goal has been met.** **Barrier Analysis: No barriers identified.** **Next Steps: Review draft annual committee workplan goals.**
Utilization Management	The goals for FY2024 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 End of (EO) FY2023 Access Management System (AMS) Evaluation Report was completed and reviewed, and its findings and recommendations are being integrated into the Utilization Management (UM) Program Plan Evaluation Report, which will be forwarded to QIC for review/approval.** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The End of (EO) FY2023 Access Management System (AMS) Evaluation Report was submitted to the Quality Improvement Committee (QIC) at the March meeting as an attachment document to the FY2023 UM Program Plan Evaluation Report. **Q 3 (Apr-June):** **The mid-year report is rescheduled for review in July.** **Q 4 (July-Sept.):** **The M-Y AMS Report is completed, and the Annual AMS Report is on schedule for completion.** **<u>Evaluation</u>: The M-Y AMS Report is completed, and the Annual AMS Report is on schedule for completion. This goal has been met.** **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: Review draft annual committee workplan goals.**
Utilization Management	The goals for FY2024 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):** **Quarterly reports were reviewed with all CMHSPs successfully engaged in a broad range of activities.** **Q 2 (Jan-Mar):** **Review of quarterly reports identified a range of member engagement and education activities, along with a variety of community engagement activities.** **Q 3 (Apr-June):** **April quarterly reports were reviewed, with highlights discussed, such a wide range of community outreach and education activities, and extensive offerings for Mental Health First Aid training.** **Q 4 (July-Sept.):** **Quarterly reports were reviewed, with highlights discussed, such a wide range of community outreach and education activities, along with additional efforts to inform and reach out to families and youth.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation</u>: Quarterly reports were reviewed, with highlights discussed, such a wide range of community outreach and education activities, along with additional efforts to inform and reach out to families and youth. **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: Review draft annual committee workplan goals.**
Utilization Management	The goals for FY2024 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):** **The quarterly reports were reviewed, and no concerning trends were noted.** **Q 2 (Jan-Mar):** **As an administrative efficiency beginning this quarter, the review process has changed to a desk review process as completed by the UMC Chair, for brief status and contingent discussion at the meeting. Review of these reports indicated no service systems issues or improvement opportunities.** **Q 3 (Apr-June):** **Quarterly reports were reviewed, and no service systems issues were identified.** **Q 4 (July-Sept.)** **Quarterly reports were reviewed, and progress was noted in aligned reporting practices.** **<u>Evaluation</u>: Throughout the year, quarterly reports were reviewed, and progress was noted in aligned reporting practices. This goal has been met.** **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: Review draft annual committee workplan goals.**
Corporate Compliance	The goals for FY2024 Reporting are as follows: o Compliance with 42 CFR 438.608 Program Integrity requirements.	Jim Johnson	**Quarterly Update:** **Q 1 (Oct-Dec):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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).	Corporate Compliance Committee	**FY2023 Q4 OIG Program Integrity Report submission completed. PIHP Compliance staff members attended the Quarterly Statewide Compliance Officers Workgroup where contractual language changes and OIG Program Integrity Reporting were discussed. The FY2024 Corporate Compliance Plan was posted on the PIHP website and distributed to both PIHP staff and Network Providers. FY2023 Corporate Compliance Annual Report approved and endorsed by the Regulatory Compliance Committee. Received MDHHS PIHP Contract Amendment 1 which included two (2) new OIG Reports; notification provided to Network Providers.** **Q 2 (Jan-Mar):** **New MDHHS Office of Inspector General (OIG) Reports submitted (Annual Program Integrity Report, Annual Compliance Program Report). MDHHS OIG Report discussion scheduled for next month to review findings.** **Q 3 (Apr-June):** **The FY2025 Annual PIHP Corporate Compliance Plan drafted. Drafted new PIHP Policy specific to Program Integrity requirements defined in MDHHS / PIHP contract. Received Network Provider 2Q Program Integrity and Complaint data reports.** **MDHHS OIG meeting with the PIHP to discuss OIG findings from recent (new) Annual Compliance Program Report. MDHHS OIG process updates on Credible Allegations of Fraud (CAF) which impacts how PIHP reports information to the OIG as well as the AG Health Care Fraud Division (HCFD) / Medicaid Fraud Control Units (MFCU). Additionally, process updates may impact how PIHPs work with Network Providers on Medicaid Fraud Referrals.** **Ongoing discussion at MDHHS / PIHP Contract Negotiation meetings regarding recommended OIG contract language enhancements.** **Q 4 (July-Sept.):** **Received Network Provider 3Q Program Integrity and Complaint data reports. May 2024 Quarterly Program**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Integrity Report was submitted to MDHHS. Feedback was received from the OIG and provider outreach followed which included clarification on reporting requirements. August 2024 Quarterly Program Integrity Report was submitted to MDHHS with that feedback pending. **MDHHS-OIG met with PIHP staff multiple times during the past couple of months. Additional clarification is needed due to staffing changes.** **The draft FY2025 Annual PIHP Corporate Compliance Plan was voted on and approved by the Corporate Compliance Committee and PIHP Board of Directors, and then endorsed by the Regulatory Compliance Committee. The new PIHP Policy specific to Program Integrity requirements as defined in the MDHHS / PIHP contract was approved by the PIHP Board of Directors and finalized for implementation; Program Integrity 01.02.07.** **Conflict of Interest Attestation form and process was reviewed, and minor changes followed. Providers notified of annual requirement and of form revision.** **Evaluation: All reporting continued to be met throughout the year.** **Barrier Analysis: This goal, being administrative in nature, was impacted by staffing changes at Region 10.** **Next Steps: Goal achieved and anticipating similar goal for FY2025.**
Corporate Compliance	The goals for FY2024 Reporting are as follows: • Compliance with 45 CFR 164.520 Notice of Privacy Practices o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Jim Johnson Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP Compliance Team facilitated a consultation meeting with Health Services Advisory Group (HSAG) to ensure that PIHP process for Privacy Notice distribution aligns with federal regulations. Reviewed objectives for this goal including reviewing requirements, identifying and documenting responsible entities, and identifying and documenting supporting evidence / practice.** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Privacy Notice requirements reviewed, and responsible entities identified. PIHP Privacy Notice distributed. Discussion regarding Provider Privacy Notice federal requirements pertaining to both PIHP and Network Providers. Network Provider email communication shared regarding federal Privacy Notice and Notice distribution sent. PIHP Annual Contract Monitoring Tool performance standard updates completed. PIHP policy and contract updates drafted. **Q 3 (Apr-June):** **FY2024 PIHP Annual Contract Monitoring Tools finalized to include performance standards regarding Privacy Notice content and distribution.** **Q 4 (July-Sept.):** **FY2024 Contract Monitoring reviews occurred. Contract Monitoring shows Notice of Privacy content and distribution did not meet the contract standard for most providers.** **<u>Evaluation</u>: Significant progress made to privacy notice and distribution to network.** **<u>Barrier Analysis</u>: This goal, being administrative in nature, was impacted by staffing changes at Region 10.** **<u>Next Steps</u>: Providers will need to follow-up on their individual plan of correction regarding notices.**
Corporate Compliance	The goals for FY2024 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):** **Discussion of FY2023 Annual Contract Monitoring including ongoing Provider Plans of Correction.** **Q 2 (Jan-Mar):** **FY2024 Annual Contract Monitoring Tool performance standard and interpretive guidelines review, and updates completed.** **Q 3 (Apr-June):** **FY2024 PIHP Annual Contract Monitoring Tools developed. Annual Contract Monitoring Tools Corporate**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Compliance Domain significantly modified to align with federal and state regulations, PIHP / Network Provider contracts, and was condensed. **Q 4 (July-Sept.):** **Contract Monitoring results pending finalization.** **<u>Evaluation</u>: All provider contracts were assessed through contract monitoring.** **<u>Barrier Analysis</u>: This goal, being administrative in nature, was impacted by staffing changes at Region 10.** **<u>Next Steps</u>: Providers will need to follow-up on their individual plan of correction. PIHP will monitor plans of correction during the next fiscal year.**
Provider Network	The goals for FY2024 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.	Jim Johnson Provider Network Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Implemented enhancements to PIHP / CMH Contract Performance Objectives Attachment regarding Habilitation Support Waiver (HSW) and Autism Services. Successful enrollment of GHS Intensive Crisis Stabilization Services (ICSS) Program (Adult and Children) per recent GHS subcontract provider changes. Evaluation of ARPA Grant Proposals for SUD Recovery Community Organizations and selected providers to receive funding awards. Development and issuance of contracts to selected SUD Recovery Community Organizations related to the American Rescue Plan Act (ARPA) Grant.** **Q 2 (Jan-Mar):** **The PIHP received and reviewed information for five (5) providers who had submitted Interested Provider Registry Forms.** **The PIHP PNM and Quality Teams discussed enhanced collaboration across the PIHP and at the Committee level regarding identified gaps in Autism Services across the region.** **Service Capacity issues continue to be an identified Barrier for the Autism Program in the second quarter. CMH**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Leads have identified that there are individuals waiting for applied behavior analysis (ABA) services at St. Clair CMH, Lapeer CMH and Genesee Health System. The Quality Department received monthly updates from the CMH Autism leads and will continue to communicate progress and or barriers identified with the Provider Network team. **Q 3 (Apr-June): The PIHP received and reviewed information for three (3) providers, who had submitted Interested Provider Registry Forms.** **Q 4 (July-Sept.):** **The PIHP PNM and Quality Teams discussed options to further enhance communication with Providers regarding waitlists and barriers. The PIHP received and reviewed information for two (2) providers, who had submitted Interested Provider Registry Forms.** **<u>Evaluation</u>: The Provider Network Management Team, Quality Team and CMH Leads continue to have ongoing discussion of service capacity concerns or observations, noting barriers as well as improvements.** **<u>Barrier Analysis</u>: Providers have identified challenges in adequate staffing, including both lack of quantity of staff, lack of properly credentialed staff or lack of staff available for working after normal business hours or on the weekends.** **<u>Next Steps</u>: Progress continues toward this goal and the PIHP continues to work with Providers to identify areas in which additional support can be provided by addressing gaps and capacity concerns.**
Provider Network	The goals for FY2024 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.	Jim Johnson Provider Network Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Discussion with MDHHS on upcoming changes to Network Adequacy Standards. MDHHS will identify maximum time and distance standards by PIHP region with additional information forthcoming. Received MDHHS recommendations on maximum time and distance standards regarding Network Adequacy and reviewing for additional considerations on county designations within**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			network. Outreach made to Sanilac County CMH regarding capability to meet standards. **Q 2 (Jan-Mar):** **MDHHS new Network Adequacy Reporting template received and reviewed. Information requests sent out to PIHP SMEs and Network Providers.** **Q 3 (Apr-June):** **Discussion on upcoming FY2024 HSAG Compliance Review Network Validation Activity and FY2024 Annual MDHHS Network Adequacy Report submission.** **Service capacity issues continue to be identified with individuals requesting ABA treatment in St. Clair, Lapeer, and Genesee Counties. CMH Autism Leads continues to provide monthly updates on this, and the Quality department will continue to share efforts with the Provider Network team as progress or barriers are identified.** **The PIHP submitted the FY2023 Network Adequacy Report to MDHHS on May 30, 2024.** **Q 4 (July-Sept.):** **The PIHP participated in Network Adequacy Validation Review. The PIHP's logic for time and distance was approved.** **<u>Evaluation</u>: The PIHP successfully implemented use of the MDHHS Network Adequacy Reporting template.** **<u>Barrier Analysis</u>: Providers have identified challenges in the area of adequate staffing.** **<u>Next Steps</u>: Progress continues toward this goal and the PIHP continues to work with Providers to identify areas in which additional support can be provided. The PIHP will continue to solicit additional providers to fill any identified deficiencies within the provider network to maintain Network Adequacy standards.**

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

Provider Network	The goals for FY2024 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.
		Jim Johnson
		
		Provider Network Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Enhancement of PIHP process to review Provider Annual Contract Monitoring Plans of Correction. Initial Subject Matter Expert (SME) review of Provider Annual Monitoring Plans of Correction complete. Issued notification to Providers on any Plan of Correction non-acceptance with requests for additional follow up. Draft materials developed for planned FY2024 Annual Contract Monitoring Kick Off Meeting.
			
			Q 2 (Jan-Mar):
			The PIHP PNM Department has continued to work closely with PIHP subject matter experts (SMEs) and Network Providers to finalize Network Provider FY2023 Annual Contract Monitoring Plans of Correction. All FY2023 Network Provider initial Plan of Correction responses have been accepted. The PIHP PNM Department continues to discuss efficiencies and improvement opportunities in monitoring Network Provider Outstanding Plan of Correction items.
			
			Q 3 (Apr-June):
			FY2024 Annual Contract Monitoring Tools were finalized. Subject Matter Experts completed reviews and Providers submitted supporting documentation. Contract monitoring visits were conducted virtually via Microsoft Teams or on-site with each Provider.
			
			Q 4 (July-Sept.):
			Work continues with discussion of final reports and a timeline to complete the Contract Monitoring Aggregate Report.
			
			<u>Evaluation</u>: The Provider Network Management Department will continue to work with Subject Matter Experts to ensure that deficiencies are addressed thoroughly by the Plan of Correction process to improve the quality of health care and services for members.
			
			<u>Barrier Analysis</u>: None identified.

<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><u>Next Steps</u>: This goal is considered met for FY2024 and the goal will continue into FY2025. The Provider Network Management Department has requested input from the Subject Matter Experts and our network of Providers to identify opportunities for improvement in the contract monitoring process and will work toward making these improvements to the process on an ongoing basis.</td></tr>
<tr><td>Customer Service Inquiries</td><td>The goals for FY2024 Reporting are as follows:
To review and analyze baseline customer service inquiry data for the region for FY2024.
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 rowspan="2"></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>14</td><td>15</td><td>15</td><td>3</td><td>5</td><td></td><td>52</td></tr>
<tr><td>Lapeer</td><td>3</td><td>3</td><td>0</td><td>0</td><td>1</td><td></td><td>7</td></tr>
<tr><td>PIHP</td><td>7</td><td>2</td><td>2</td><td>0</td><td>0</td><td></td><td>11</td></tr>
<tr><td>Sanilac</td><td>1</td><td>0</td><td>1</td><td>2</td><td>0</td><td></td><td>4</td></tr>
<tr><td>St. Clair</td><td>5</td><td>3</td><td>6</td><td>0</td><td>2</td><td></td><td>16</td></tr>
<tr><td>SUD</td><td>4</td><td>6</td><td>5</td><td>2</td><td>4</td><td></td><td>21</td></tr>
<tr><td>TOTAL</td><td>34</td><td>29</td><td>29</td><td>7</td><td>12</td><td></td><td>111</td></tr>
<tr><th colspan="7">Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>12</td></tr>
<tr><td colspan="7">Grievance</td><td>6</td></tr>
<tr><td colspan="7">Referral to Access</td><td>14</td></tr>
<tr><td colspan="7">Rights Complaint</td><td>1</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>28</td></tr>
<tr><td colspan="7">Other</td><td>29</td></tr>
<tr><td colspan="7">Unable to Reach</td><td>17</td></tr>
<tr><td colspan="7">Pending</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 thirty-four (34) customer service inquiries in Q1. This is an increase from FY2023 Q1 which had nineteen (19).

Top Inquiry Dispositions:
Ten (10) of the inquiries resulted in a referral to a provider within the PIHP Network.
Five (5) of the inquiries resulted in an appeal.
Five (5) of the inquiries were closed due to being unable to reach the consumer for follow-up.
Q2 (Jan-Mar)
The PIHP had 29 customer service inquires in Q2, which is an increase from FY2023 Q2 which had 22.

Through FY2024 Q2 Top Inquiry Resolution Categories:
Nine (9) of the inquiries were listed in the other category.
Six (6) of the inquiries resulted in a referral to a provider within the PIHP Network.
Five (5) of the inquiries were closed due to being unable to reach the consumer for follow-up.
Q 3 (Apr-June):
There was a total of twenty nine (29) customer service inquiries in Q3, which is an increase from FY23 Q3 which had twenty seven (27).

Top Resolution categories:
11 (37.93%) resulted in the other category.</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>7 (24.14%) resulted in a referral to a provider.
5 (17.24%) were unable to reach.

Q 4 (July-Sept.):
Thus far in Q4 there have been nineteen (19) inquiries received. This is a decrease from July and August FY23 Q4, which had 29 inquiries. September's data will be reported in October.

<u>Evaluation</u>: This goal has been met. The Customer Service Department has tracked and reviewed trends related to customer service inquiries monthly. No critical issues were identified and therefore, no interventions were developed. Referrals to either the PIHP Access Center or a Network Provided resulted in the highest resolution categories at almost 38%. Inquiry volumes were comparable to the previous fiscal year with 113 in FY2023. However, this data includes the month of September.

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

<u>Next Steps</u>: FY2025 goals will be developed.</td></tr>
<tr><td>Appeals</td><td>The goals for FY2024 Reporting are as follows:
To review and analyze baseline appeals data for the region for FY2024.
To track and trend internally the appeals on a monthly basis.
Identify consistent patterns related to appeals.
Develop interventions to address critical issues within the Network.
<table>
<tr><th colspan="8">Reporting Period: FY</th></tr>
<tr><th rowspan="2"></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>5</td><td>2</td><td>2</td><td>0</td><td>2</td><td></td><td>11</td></tr>
<tr><td>Lapeer</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td>1</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>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td>2</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
</table></td><td>Katie Forbes

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

Q 1 (Oct-Dec):
There were six (6) appeals in Q1 which was an increase from FY2023 Q1 with one (1).

Top Reasons for Appeal:
Four (4) appeals were for service termination.
Two (2) appeals were for service denial.
Q 2 (Jan-Mar)
The PIHP had four (4) appeals in Q2, which is a decrease from FY2023 Q2 which had eight (8) appeals.

Trends:

Of the four (4) appeals three (3) were for service denial and one (1) was for service termination.

Q 3 (Apr-June):</td></tr>
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<table>
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<tr>
<td></td>
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<table>
<tr><td>TOTAL</td><td>6</td><td>4</td><td>2</td><td>0</td><td>2</td><td></td><td>14</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Service Denial</td><td>7</td></tr>
<tr><td colspan="7">Service Termination</td><td>6</td></tr>
<tr><td colspan="7">Service Reduction</td><td>1</td></tr>
</table>
</td>
<td></td>
<td>There was a total of two (2) appeals in Q3, which was a decrease from FY23 Q3 which had five (5).

Reasons for the appeal:
One (1) was for a service denial.
One (1) was for a service termination.

Appeal outcomes:

Of the two (2) appeals in Q3 the PIHP overturned the ABD notices, meaning services were reinstated.

Q 4 (July-Sept.):
Thus far in July and August Q4 there have been two (2) appeals. This in an increase from July and August FY 23 Q4 which had five (5). September's data will be reported in October.

<u>Evaluation</u>: This goal has been met. The Customer Service Department has tracked and reviewed trends related to appeals monthly. No critical issues were identified and therefore, no interventions were developed. The volume of appeals slightly decreased from twenty-one (21) in FY2023. However, this count includes the month of September.

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

<u>Next Steps</u>: Develop FY2025 goals.</td>
</tr>
<tr>
<td>Grievances</td>
<td>The goals for FY2024 Reporting are as follows:
• To review and analyze baseline grievance data for the region for FY2024.
o To track and trend internally the grievances on a monthly basis.
o Identify consistent patterns related to grievances.
o Develop interventions to address critical issues within the Network.
o Meet with CMHSPs quarterly to discuss procedures for the receipt and completion of grievances.</td>
<td>Katie Forbes

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

Q 1 (Oct-Dec):
There have been no grievances reported thus far in Q1.
The PIHP will not receive grievance data from the CMH Network until January 15th. This quarterly update will be provided in the February Quality Improvement Committee meeting with all data received.

Q 2 (Jan-Mar):
This far, there have been six (6) grievances in Q2. The PIHP will not receive grievance data from the CMH Provider Network until April 15th. This quarterly update will be provided in the May Quality Improvement Committee (QIC) meeting.</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><th colspan="8">Reporting Period: FY</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>34</td><td>22</td><td>20</td><td>n/r</td><td>n/r</td><td></td><td>76</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>1</td><td>n/r</td><td>n/r</td><td></td><td>1</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>1</td><td>n/r</td><td>n/r</td><td></td><td>1</td></tr>
<tr><td>Sanilac</td><td>1</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td></td><td>1</td></tr>
<tr><td>St. Clair</td><td>0</td><td>4</td><td>0</td><td>n/r</td><td>n/r</td><td></td><td>4</td></tr>
<tr><td>SUD</td><td>0</td><td>3</td><td>0</td><td>0</td><td>1</td><td></td><td>4</td></tr>
<tr><td>TOTAL</td><td>35</td><td>29</td><td>22</td><td>n/r</td><td>n/r</td><td></td><td>87</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Quality of Care</td><td>51</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>23</td></tr>
<tr><td colspan="7">Service Environment</td><td>3</td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td>0</td></tr>
<tr><td colspan="7">Other</td><td>4</td></tr>
<tr><td colspan="7">Interaction w plan or provider</td><td>6</td></tr>
</table>
</td>
<td></td>
<td>Q 3 (Apr-June):
The PIHP received FY24 Q3 data from the CMH Provider Network. There was a total of twenty-one (21) grievances. This was a decrease from FY23 Q3 which had thirty-six (36) grievances.

Q 4 (July-Sept.):
Thus far in July and August of Q4 the PIHP had one (1) grievance. However, the PIHP will not receive CMH Network grievance data until October 2024.

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

<u>Barrier Analysis:</u> The PIHP is unable to fully analyze grievance data during annual evaluation due to not having grievance data from CMH Network at the time of annual evaluation.

<u>Next Steps:</u> Develop FY2025 goals.</td>
</tr>
<tr>
<td>Credentialing / Privileging</td>
<td>The goals for FY2024 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</td>
<td>Lauren Campbell

Privileging and Credentialing Committee</td>
<td>Quarterly Update:

Q 1 (Oct-Dec):
Approval of five (5) existing Provider Organizational Applications.

Q 2 (Jan-Mar):
The PIHP has received and approved one (1) Organizational Provider Application during the quarter.

Q 3 (Apr-June):
In the 3rd quarter, discussion continued regarding submission of materials from St. Clair County CMH related to their Marine City locations and ASAM credentials. The PIHP received notice of a location change for GHS, and MIX information was updated timely in May. The CPI Flint location terminated their contract with</td>
</tr>
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Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Region 10 effective May 31st. The PIHP Contract Monitoring process began in June. **Q 4 (July-Sept.):** **In the fourth quarter, no credentialing applications were received for new or current Providers. The privileging and Credentialing (P&C) Committee membership was updated to reflect staff changes and a new Chairperson was designed. In August, MDHHS approved a request to transfer St. Clair CMH's ASAM Level of Care (LOC) between two locations. The St. Clair CMH Organizational P&C CMH Application was approved and work continues to complete the SUD application. The PIHP met with MDHHS in August for an overview of Universal Credentialing related to Organizational and Practitioner credentialing/ recredentialing applications. The tentative target for statewide implementation is April 2025.** **<u>Evaluation</u>: This goal was considered met. Six Organizational Applications for credentialing were approved in FY2024. Approval of one organizational application for a new location is still pending. One location change request was processed for GHS. One contract (CPI Flint location) was terminated.** **<u>Barrier Analysis</u>: Newly assigned staff continue to review and gain understanding of P&C policy and processes, as well as Universal Credentialing. Approval of one organizational application for a new location is still pending.** **<u>Next Steps</u>: Follow up with the provider with the pending organization application for an additional location. Gather more information about Universal Credentialing. The privileging and credentialing process is ongoing, and this goal will continue into FY2025.**
Credentialing / Privileging	The goals for FY2024 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):** **Approval of three (3) Access Center Practitioner Applications.** **Q 2 (Jan-Mar):**

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 o Review of all Access Center leased staff credentialing decisions from St. Clair County CMH.		**The PIHP has not received any Region 10 staff Practitioner Applications during the quarter.** **Q 3 (Apr-June):** **The P & C Committee approved a new Access clinician for hire with a start date of June 10th.** **Q 4 (July-Sept.):** **No new Access Center Practitioner Applications were submitted in the fourth quarter. Letters of Agreement (LOAs) were discussed at the August committee meeting as they relate to privileging and credentialing (P&C) review for contract monitoring. At that meeting, adjusting the Practitioner credentialing timelines for Region 10 staff to avoid overlap with Organizational credentialing timelines was proposed. The committee also approved finalized FY2025 goals with the addition of Universal Credentialing. In late August, the PIHP met with MDHHS for an overview of Universal Credentialing and is gathering information about how this will impact Practitioner credentialing.** **<u>Evaluation:</u> Region 10 approved a total of four applications this fiscal year. The Privileging and Credentialing Committee meets to review Region 10 staff applications on an ongoing basis. This goal is considered met for FY2024.** **<u>Barrier Analysis</u>: More information is needed about Universal Credentialing.** **<u>Next Steps:</u> Determine if those working with the PIHP under Letters of Agreement (LOAs) should be reviewed during contract monitoring. An adjustment to Region 10 clinician's recredentialing timeline was recommended to further streamline that process but is pending further information about the impact of Universal Credentialing.**
Credentialing / Privileging	The goals for FY2024 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.	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Discussion regarding updated MDHHS Credentialing Policy. Received information from MDHHS on Universal Credentialing upcoming training and notified Universal Credentialing activities paused. Discussion regarding**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Review for alignment between policy and applications. ▪ Revise and clarify language where needed.		**enhancements necessary to PIHP Annual Contract Monitoring of Provider credentialing records and performance standards.** **Q 2 (Jan-Mar):** **Committee members continue to review and discuss the current PIHP Credentialing and Privileging Policy for necessary updates and revisions.** **Q 3 (Apr-June):** **Updates to the P & C Organizational Application with revised instructions regarding SUD Recovery Housing/addition of MARR certification were presented at the May P & C Committee meeting. The revised applications are under review for posting on the Region 10 website.** **Q 4 (July-Sept.):** **Universal credentialing activities paused in the first quarter and were reactivated in Quarter 4. The tentative Region 10 training window was set for January 27 - February 14, 2025. Resulting changes to policy, contract language and implications on the credentialing application process are pending further information from MDHHS. Customer Relationship Management (CRM) system access will be necessary. Privileging and Credentialing (P&C) Organizational Application changes made in the third quarter are also paused. Potential changes to the contact monitoring tool and documentation will be considered once the process has completely wrapped up.** **Evaluation: This goal is considered met. Due to staffing changes, policies and processes are all being reviewed to gain more knowledge. Any changes to policy, contracts, and/or applications are paused as more is learned about Universal Credentialing** **Barrier Analysis: Further information is needed about Universal Credentialing processes and expectations.** **Next Steps: Gain access to the CRM system. Gather and review information about Universal Credentialing.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Autism Program</td>
<td>
The goals for FY2024 Reporting are as follows:

Reduce the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services, as measured by the number of persons on the overdue list and length of stay on the overdue list before beginning services.

Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form.
Compare submitted Autism Benefit Case Action Forms (ABCAFs) in Microsoft Teams with encounter data to identify cases active and cases not receiving services.

<table>
<tr><th colspan="2"></th><th>FY24 1Q</th><th>FY24 Q2</th><th>FY24 Q3</th><th colspan="3">FY24 Q4</th></tr>
<tr><th colspan="2"></th><th>Dec</th><th>Mar</th><th>Jun</th><th>July</th><th>Aug</th><th>Sept</th></tr>
<tr><td>Genesee</td><td>Overdue List Total</td><td>249</td><td>224</td><td>253</td><td>259</td><td>252</td><td></td></tr>
<tr><td></td><td>≥90 (Days)</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>30-59</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>0-29</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td>Overdue List Total</td><td>14</td><td>19</td><td>33</td><td>33</td><td>29</td><td></td></tr>
<tr><td></td><td>≥90</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>30-59</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>0-29</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td>Overdue List Total</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td></tr>
<tr><td></td><td>≥90</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td>
<td>Shannon Jackson

Monitored by Quality Improvement Committee (QIC)</td>
<td>
Quarterly Update:

Q 1 (Oct-Dec):
In Q1, St. Clair CMH and Genesee Health System signed on new Providers to help keep up with service capacity demands. This effort is not reflected in the numbers provided, however. All four CMHSPs have individuals eligible and not yet receiving services. CMHSPs have reported applications are being accepted for BCBAs and QBHPs along with Behavioral Technicians to help improve the demand for services.

Q 2 (Jan-Mar):
In the second quarter, it has been discovered that there was some misinterpretation with the requested data on the Autism Monthly Reporting form. The PIHP Autism Team is working on correcting this error and deciding the best way to continue to monitor overdue totals. At the close of March, Genesee Health System reported having 224 individuals waiting for ABA services, Lapeer CMH reported 20 individuals waiting for ABA services, and St. Clair CMH reported having 31 individuals waiting to begin ABA services.

The PIHP additionally has not been receiving initial evaluation information in the form of an ABCAF form from each CMHSP, which has made validating and confirming the overdue numbers provided very challenging. The PIHP Autism Team will be reviewing the current process of monitoring, which was modified last year when the WSA was decommissioned.

The Quality department will continue to coordinate with the PIHP PNM team to help communicate areas where contract requirements are not being met, along with progress/barriers to the ABA Provider Network Capacity.

CMH leads continue to have internal discussion on staffing issues and lack of workers in the community, they also report having continued discussions with 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.
</td>
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Component	Goal/Activity/Timeframe							Responsible Staff/Department	Status Update & Analysis
		60-89							**CMHs have reported applications are being accepted for BCBAs, QBHPs along with Behavioral Technicians to help improve the demand for services.** **A provider did reach out to the PIHP interested in servicing Lapeer County. The PIHP Provider Network staff connected them with the Lapeer team to discuss this further, this new provider could help the Region's network capacity struggles.** **A new Provider did reach out to the PIHP in the beginning of February interested in providing ABA services in St. Clair County, this information was shared with the Provider Network and St. Clair CMH.** **GHS reported having Request for Proposal (RFP) for ABA providers and CMHs have promoted job openings for BCBAs, QBHPS and Behavioral Technicians to help improve the demand for services.** **In the month of March St. Clair CMH reported that they are in the process of signing on with Blue Mind, a new ABA provider that will be opening a location in Fort Gratiot. This will hopefully help their current waitlist numbers.** **Q 3 (Apr-June):** **At the end of Q3 Genesee Health System, Lapeer CMH, and St. Clair CMH reported having individuals waiting to begin ABA services. Genesee reported having 253 individuals eligible and not authorized for service, Lapeer reported 33 individuals eligible and not authorized for services, and St. Clair CMH reported xx individuals eligible but not authorized for services.** **Genesee Health System did update the PIHP Autism lead that in Q3 they are finalizing a contract with Metro ES a new Provider and are looking at three (3) additional proposals for new ABA providers.** **Q 4 (July-Sept.):**
		30-59							
		0-29							
	St. Clair	**Overdue List Total**	**40**	**31**	**36**	**40**	**38**		
		≥90							
		60-89							
		30-59							
		0-29							

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Near the end of Q4, Genesee Health System, Lapeer CMH, and St. Clair CMH reported having individuals waiting to begin ABA services. GHS reported having 252 individuals eligible and not authorized for service, Lapeer CMH reported 29 individuals eligible and not authorized for services, and St. Clair CMH reported 38 individuals eligible but not authorized for services. **Genesee Health System did provide the PIHP with the update that they have now trained one of their new providers and are working on referrals for them. They are offering contracts with two additional new providers.** **The PIHP has started to receive denial letters due to the L Letter 24-23 issued by MDHHS regarding Physical, Occupational, and Speech-Language Therapy for Beneficiaries diagnosed with Autism Spectrum Disorder. The PIHP Autism team is working on creating a process to follow when we receive these letters.** **<u>Evaluation</u>: Throughout FY2024 there was not a consistent improvement in reducing the number of beneficiaries overdue to begin ABA services, so this goal was not met. The PIHP requires that the CMH leads complete a monthly reporting form to provide overdue totals every month, which provided this data. From the beginning of FY2024 to its end, there were fluctuations with these numbers and lots of efforts to improve with additional providers added. In FY24 Genesee Health System and Lapeer CMH, had an increase in individuals eligible but not authorized for services. St. Clair's August numbers were the same as they were reported in August FY23, so they did not show an increase, but also no major improvement.** **<u>Barrier Analysis:</u> CMH Leads continue to report challenges with staffing and ABA provider network capacity.** **<u>Next Steps</u>: The PIHP will continue to monitor overdue totals through this goal next Fiscal year. The PIHP asks for monthly updates to the ABA Network and the PIHP Autism Lead will collaborate with the new PIHP PNM**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Lead to help improve these efforts. In FY2024, CMH Autism Leads have become more consistent at submitting the Autism Monthly Form and communicating the appropriate data to monitor these numbers. It is recommended to remove the chart from this goal, as many details are no longer available without WSA information. Moving into FY2025, the PIHP will continue to monitor overdue totals with the data provided monthly on the CMH reporting forms and monthly numbers will be reported. It is also suggested to include communication/submission barriers within this goal.
Autism Program	The goals for FY2024 Reporting are as follows: o The documents and data submitted to the PIHP for Autism Benefit program enrollees will be complete and accurate. This will be evidenced by seamless use of Microsoft Teams by all CMHSPs, accurate submission of Autism Benefit Case Action Forms (ABCAFs) for initial and re-evaluation documents to the PIHP related to the Autism Benefit. o The CMHSPs will additionally submit an Autism Monthly Reporting Form to the PIHP by the 15th of each month to report data for the previous month. The PIHP will work with CMHSPs on understanding of timeframes for document and data submission, and accurate and timely processing of document submission by the PIHP.	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Sanilac CMH has continued to not submit ABCAF documentation to the PIHP since April despite numerous outreach attempts. Sanilac CMH has also not consistently been submitting the Autism Reporting Form. Communication has increased with the CMH Lead to address this issue along with communication with the Quality Management Committee (QMC) CMH representative as an outstanding item to follow up on. This has proven to be a helpful strategy with these continued efforts and communication has improved.** **Outreach has been made to remind CMH Autism Leads of the program expectations as the Autism Monthly Reporting Form continues to not be submitted timely. More monthly communication is being made to help gain greater program accuracy and knowledge.** **Q 2 (Jan-Mar):** **In the month of February, the PIHP received all the monthly Autism Reporting Forms timely. However, in March that was not the case. Overall, in the second quarter, the Autism Monthly Reporting Form was not received timely and consistently by Genesee Health System, Lapeer CMH, or Sanilac CMH.** **CMH Autism leads/designees have not been uploading initial ABCAF documentation into Microsoft Teams consistently in the second quarter. However, questions that have come up, have been addressed promptly as agreed upon in our Performance Objectives. These standards have**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			been reviewed once more with the CMHSP Autism Leads and will continue to be addressed if these standards continue to not be met. **Q 3 (Apr-June):** **Q3 did show overall improvement in timely submission of the Autism Reporting form from the CMHSP Autism Leads. June did have late documentation submissions, however, and contacting the CMHSP Contract contacts will need to be discussed again as this method was effective in receiving timely submissions.** **Q 4 (July-Sept.):** **In Q4, all Autism Reporting forms were submitted in a timely manner.** **<u>Evaluation</u>: Communication has improved for the Autism Program, and CMH Autism Leads have been submitting timely Monthly Autism Reporting forms. In Q4 of FY2023, CMH Autism Leads only submitted 66% of the Autism reporting forms, each quarter that has improved and in Q3 and Q4 of FY24 100% of these forms have been submitted to the PIHP in a timely manner. This goal has been met.** **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: The PIHP will discontinue this goal. This goal was established to help strengthen communication and complete a new form submission to the PIHP after the decommission of the WSA in FY2023. This goal helped successfully monitor reporting progress and this goal has shown great improvement. It is recommended to continue to monitor communication barriers in the previous goal listed and discontinue this goal.**
Customer Relationship Management (CRM) System	The goals for FY2024 Reporting are as follows: o 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.	Laurie Story-Walker Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Alcohol Information and Counseling Center's (AICC) name and address change request has successfully been completed; the change is reflected throughout the applications in the Customer Relationship Management (CRM) system.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ 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		**Additionally, all CMHSP Homebased Certifications have been approved by MDHHS and are effective until September 2026.** **The PIHP had a ticket open with MDHHS regarding our region's critical incident remediations no longer being visible in the system. This was resolved and the PIHP's Critical Incident team is able to view remediations in the CRM system.** **Q 2 (Jan-Mar):** **Designated staff participated in a MiCAL meeting regarding CCBHC functions within the system, such as adding a CCBHC Service Card.** **The PIHP had technical issues with the Critical Incident Remediation notifications. Staff were no longer being notified when a remediation was posted in the CRM. A ticket was submitted by MDHHS, as staff were shown to have an active subscription to the incidents. PIHP staff are now receiving Partner Portal notifications via email.** **Q 3 (Apr-June):** **In order to connect Michigan Crisis and Access Line (MiCAL) callers with services, MiCAL needs real time up-to-date information about the crisis and access services provided by each CCBHC.** **Additionally, CCBHCs must provide justification of meeting CCBHC criteria and upload supporting documentation verifying that standards have been met in the CRM system. The CCBHC Application opened on April 29th and is due on July 1, 2024.** **MDHHS will host the first monthly meeting on Tuesday, August 13, 2024f or critical incident reporting leads to discuss incident reporting requirements, upcoming changes, suggestions on ways to improve the CRM, documents revisions, trainings, system enhancements and testing. Lead staff have been identified and will attend the August 13th meeting.** **Q 4 (July-Sept.):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Due to a recent staff change, others are being trained in the Customer Relationship Management (CRM) system, currently for the ASAM Level of Care. **<u>Evaluation</u>: Efforts Continue with education of the CRM system and staff's knowledge of the application (ASAM Level of Care) is ongoing.** **<u>Barrier Analysis</u>: The CRM System is not user friendly.** **<u>Next Steps</u>: Continue goal as there is discussions with MDHHS that Universal Credentialling will be deployed in FY2025.**
Opioid Health Home (OHH)	The goals for FY2024 Reporting are as follows: o Continue development of the Opioid Health Home (OHH) model within Region 10. o Identify, enroll, and onboard potential Health Home Partner(s) (HHP). o Increase and manage enrollment of OHH 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 OHH program has increased the total number of HHPs from two (2) to five (5) and from two (2) locations from five (5) to seven (7) in the region. This has resulted in an increased number of beneficiaries during the quarter from 167 to 269 enrolled, a 61% increase. With one new HHP, Arbor Recovery, not enrolling yet due to staff capacity.** **Plans continue to add OHH services to the claims verification process. OHH Coordinator has begun tracking monthly services submitted for utilization of program. Monthly recoupment reports have shown a decrease in recoupments from 10% in October and November to 3% for December.** **Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released in CC360 for June 30th, 2023. The latest FY2023 data reflects Programs total rate has continued to exceed Michigan and Region 10's rate for Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge (FUA-7); Michigan 27.45, Region 10 26.99, and Program total 60.81. Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14); Michigan 36.79, Region 10 38.38, Program total 76.8, and Region 10 Program 100.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 2 (Jan-Mar): **During this quarter, all providers contracted as Health Home Partners (HHPs) have been referring beneficiaries to the PIHP. This has resulted in an increased number of beneficiaries during the quarter from 266 to 450 enrollees, a 69% increase. HHPs received guidance and support throughout the quarter at monthly meetings relating to transfer issues among the different providers, extra support on Care Plan requirements and training on Sexual Health and Recovery.** **Recoupments in Region 10 remained lowest in the State for the quarter. Quality Metrics tracked by MDHHS were released in CareConnect360 (CC360) for September 30th, 2023. The FY2023 data reflects that the OHH program for Region 10 has continued to exceed the State's and Region's rate in the areas of Follow-up within 7 days after discharge (FUA-7) and Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14).** **Additionally, P4P must be finalized by the State before being released to the PIHPs.** **MDHHS met with pertinent Region 10 staff to discuss the plan of transition from OHH to SUD Health Homes starting in FY2025. This transition will include 2 more qualifying diagnoses, Stimulant Use Disorder and Opioid Use Disorder. The tentative timeline for a draft of the updated Handbook is set for May/June, with a SUD Health Home kick-off in August.** **Q 3 (Apr-June):** **During this quarter, all providers contracted as HHPs have been referring beneficiaries to the PIHP. There have been periods of high disenrollments, due to newer HHPs learning appropriate identification and proper engagement of beneficiaries. This caused fluctuation over the quarter, with a 5% increase from 449 to 465 enrollees. Additionally, all HHPs participated in the Case to Care Training, funded by MDHHS and have been engaged in Contract Monitoring.** **Recoupments in Region 10 remained lowest in the State during the whole quarter and Region 10 ranks 3rd for**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			highest enrollment number for the past 2 months. Quality Metrics tracked by MDHHS were released in CC360 for December 31st, 2023. The data reflects that the OHH program for Region 10 has continued to exceed the State's and Region's rate in the areas of Follow-up within 7 days after discharge (FUA-7) There was no data for the Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14) for OHH program in Region 10. P4P was sent out to each PIHP. **Q 4 (July-Sept.):** **During the last quarter of the FY, there was a 13% increase in enrollment from 465 to 527. All Health Home Partners (HHPs) engaged in PIHP requested meetings. All HHPs have increased their OHH Care Team staff during the last quarter to address the anticipated increasement of enrollees for FY2025.** **Recoupments within the region rose from 3% to 20% in the State for the last month in the quarter. and Region 10 remained ranked 3rd for enrollment numbers. Discussions have been held with the two (2) HHPs that had the highest recoupment rates for the quarter.** **Current enrollees for Region 10 are 527 (Arbor Recovery 203, BioMed 94, Flint Odyssey House 45, New Paths 76, SHRC Flint 48, SHRC Port Huron 22, SHRC Richmond 39).** **<u>Evaluation:</u> All goals were met for FY2024 by expanding the OHH program with addition of three new HHPs in Genesee County, Arbor Recovery, Flint Odyssey House and New Paths Inc. Utilization of OHH services in the region has shown an increase for engagement of services from 1264 units to 4127 units claimed, a 39% increase. The total approved OHH enrollees for Region 10 PIHP at the end of FY2024 stands at 527 beneficiaries, which is an increase of 215% from end of FY2023 at 167 beneficiaries enrolled. HHP provider support was improved with consistent monthly group and one-on-one meetings, TA assistance and two (2) trainings were held for quality improvement of services during FY2024. Two (2) of three (3) Quality Metrics tracked by MDHHS were met during**

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			each quarter, Follow-up within 7 days after discharge (FUA-7) and Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14). The majority of the P4P being awarded and distributed to Scared Heart and Biomed, based on a logic model, approved by MDHHS. **<u>Barrier Analysis:</u> No barriers identified** **<u>Next Steps:</u> This goal will be discontinued as the program is transitioning to SUDHH for FY2025**
Substance Use Disorder (SUD) Health Home	The goals for FY2024 Reporting are as follows: • Engage in the strategy to transition the Opioid Health Home (OHH) model to the Substance Use Disorder (SUD) Health Home model. o Develop a workplan with specific action steps and timelines. o Review the Draft SUD Health Home Handbook upon release by MDHHS. o Meet with pertinent PIHP staff for review of the Draft SUD Health Home Handbook.	Jacqueline Gallant Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 3 (Apr-June):** **Findings of the review of the draft of SUD Health Home Handbook show minor changes with language and timelines, but overall program process and management will remain the same.** **Draft will be provided to HHPs mid-July for feedback to MDHHS.** **Q 4 (July - Sept):** **During this quarter, a second draft of SUD Health Home (HH) Handbook was released and shared with PIHPs and Health Home Partners (HHPs). Feedback and recommendations were shared with MDHHS. SUDHH Kick-Off presentations and Care Plan training was attended by all HHPs and LEs across the state.** **Updated process documents and provider documents are completed to begin use at the program implementation, the beginning of FY2025. Contract language has been approved and the policy update is ready for review, being on track to be ready at program implementation.** **<u>Evaluation</u>: All goals were met for FY2024, focusing on preparation for program transition to SUDHH from OHH program. Updated internal process documents have been completed. Updated contract language has been prepared. Additional PIHP SUDHH support staff is being trained on the program.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: No barriers identified **<u>Next Steps</u>: Implementation of transitioned program for beginning of FY2025.**
State Opioid Response (SOR) Grant	The goals for FY2024 Reporting are as follows: • Ensure the Government Performance and Results Act (GPRA) assessment is completed for all applicable SOR-funded treatment services. o Define specific criteria for GPRA assessment 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 assessments at the necessary intervals for relevant cases. o Establish a streamlined process to communicate the mandatory completion of GPRA assessments for relevant intake referrals. o Develop a protocol to guarantee ongoing communication of the necessity for GPRA assessment as individuals served transition to alternate providers.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 3 (Apr-June):** **During this quarter a new QIC goal was implemented for the SOR Grant and a new SOR Coordinator transferred into the role. A request for GPRA rates was sent out to treatment and recovery housing providers in early May. The PIHP has received GPRA rates from SOR eligible providers and SOR contract language has been sent out to the PIHP's eligible providers.** **Q 4 (July-Sept.):** **During the last quarter of FY2024, the Data Manager and SUD Director implemented State Opioid Response (SOR) Insurance Policy Funding Source and Government Performance and Results Act (GPRA) Process Document. The process improvement has added new functionality in MIX to add SOR Insurance Policy (Fund Source) and to enter Initial and Discharge GPRA data. These updates are intended to facilitate tracking of GPRA surveys related to SOR funding. Memos were sent to our SOR funded Treatment and Recovery Housing Providers, which outlined the PIHP's requirements for the new GPRA process. These providers were also given information pertaining to the next Wayne State University GPRA Training which will be held on September 19, 2024. Providers were directed to have staff requiring GPRA training attend this event.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation</u>: Since the implementation of the SOR QIC goal most of the activities have been completed. The uncompleted activities will be added to the FY2025 QIC goals. **<u>Barrier Analysis</u>: Providers lack of understanding of GPRA requirements and PIHP process improvements continue.** **<u>Next Steps</u>: Carry over uncompleted activities in FY2025 to ensure providers receive support on adhering to compliance.**
State Opioid Response (SOR) Grant	The goals for FY2024 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 assessments 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 assessments are necessary. o Institute clear benchmarks for evaluating provider performance and adherence to Region 10's SORT/GPRA criteria. o Implement a structured approach for identifying and addressing data disparities, particularly focusing on referrals necessitating GPRA assessments with no corresponding data in Qualtrics.	Heather Haley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 3 (Apr-June):** **During this quarter a new QIC goal was implemented for the SOR Grant and a new SOR Coordinator transferred into the role. The SOR Coordinator is working with Wayne State University to ensure that monthly GPRA reports include PIHP client ID. SOR Coordinator and Wayne State have reached out to clinicians to ensure the PIHP client ID is entered in monthly Qualtrics submissions to allow for accurate data tracking.** **Q 4 (July-Sept.):** **During the fourth quarter of FY2024, the State Opioid Response (SOR) Coordinator continues working with Wayne State University to ensure that monthly Government Performance and Results Act (GPRA) reports include PIHP client ID. SOR Coordinator and Wayne State have reached out to clinicians to ensure the PIHP client ID is entered in monthly Qualtrics submissions to allow for accurate data tracking.** **<u>Evaluation</u>: Since the creation of the SOR goal, a plan has been constructed on how to achieve an appropriate and streamlined procedure that will allow the PIHP the ability to monitor and analyze the data efficiently. WSU will be taking over the 6 month follow up GPRAs in FY2025. SOR Coordinator is in communication with WSU on how this change will affect providers discharge GPRAs.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: Due to ongoing provider training and support SOR Coordinator has not implemented a structured approach for identifying and addressing data disparities. **<u>Next Steps</u>: Carry over uncompleted activities in FY2025 to ensure compliance.**
Certified Community Behavioral Health Clinic (CCBHC) Demonstration	The goals for FY2024 Reporting are as follows: o 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. 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. o Adjust processes as needed to accommodate the increased capacity expected as a result of the expansion of the CCBHC Demonstration.	Dena Smiley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP Certified Community Behavioral Health Clinic (CCBHC) Team continues to review quality measures, manage the Waiver Support Application (WSA), Electronic Grants Administration & Management System (EGrAMS) non-Medicaid ARPA Grant reporting, and other CCBHC functions.** **Medicaid Bulletin MMP 23-56 was reviewed.** **A process document was developed and distributed to all the CCBHC Demonstration Sites to help assist them with Waiver Support Application (WSA) case actions.** **The new demonstration sites continue to use the CCBHC FAQ Tracker and submission channel that is used as a central location for the PIHPs and CCBHCs to submit and ask questions for the MDHHS Program team to respond to and track.** **The new CCBHC Demonstration CMHs reported that their CHIP and OASIS systems were set up and ready to submit encounters with the T1040 code and TF modifier.** **The Quality Management Team has met to discuss the overlap and review process with 1915 (i)SPA/ CCBHC.** **At the close of first quarter, there were approximately 70 CCBHC cases remaining in the PIHP work queue waiting for assignment. 30 of the outstanding cases are being reviewed by the state for WSA system issues or errors.** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			At the close of March, there were around 10,000 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 784 cases in our queue to process. **MDHHS has requested that the PIHP submit a CCBHC Supplemental Data Request template for Designated Collaborating Organization (DCO) and Child And Adolescent Functional Assessment Scale (CAFAS) information for each CCBHC. This request includes SFY 2023 member-level and encounter-level information specific to each CCBHC, as reflected in the MDHHS data warehouse as of February 3, 2024. PIHPs have passed these data templates along to the CCBHCs for completion. The template for St. Clair CMH was submitted by the March 31st due date. The remaining sites must be submitted to the state by April 16th.** **MDHHS has currently updated the CCBHC Demonstration Handbook with further clarification and changes made during the fiscal year and is scheduled to be published after April 1st.** **New certification criteria for next recertifications were shared in the CCBHC Bi-Monthly meeting with MDHHS.** **Work continues on the bidirectional electronic medical record (EMR) and WSA project. The go live date is currently set for the end of August 2024.** **Region 10 provided clarification the PIHP does not have a requirement for an individual to be assigned in the WSA before the T1040 code can be reported.** **The PIHP hosted a CCBHC WSA Bi-Monthly meeting in March. MDHHS updates were shared with all CCBHC demonstration sites. Next meeting is scheduled for May 29, 2024.** **The PIHP and CMHs worked on recommending and assigning cases within the WSA. Additional discussion occurred and guidance was provided regarding expectations for the MDHHS 5515 Consent Forms.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **At the close of June, there were around 14,073 cases assigned in the Waiver Support Application (WSA). Region 10 has approximately 34 cases in the PIHP work queue to review and assign.** **Region 10 attended three MDHHS CCBHC TA Sessions in the month of June.** **MDHHS Actuarial and the CCBHC program team have finalized the FY 2025 Cohort 2 (started demonstration on October 1, 2023) PPS rebasing schedule.** **FY 2026 will likely look similar to FY 2025.** **MDHHS will share the FY 2026 rebasing timeline with this group when it's finalized.** **The next bi-monthly WSA/CCBHC meeting will be held on July 17th between Region 10 & CMHs.** **Q 4 (July-Sept.):** **During fourth quarter, PIHP staff continued to review and assign cases in the Waiver Support Application (WSA). MDHHS posted CCBHC V1.8 Handbook to their website and distributed V1.9 to PIHPs and CCBHCs at the beginning of August with a 30-day review window. The FY2025 Handbook is expected to be finalized with an October 1st start date.** **The PIHP received new FY2025 MDHHS/PIHP Contract language regarding the CCBHC Demonstration. Region 10 submitted feedback to MDHHS.** **The Final Demonstration Year (DY) 2 Quality Bonus Payment (QBP) was distributed by MDHHS. St. Clair CMH did not meet the benchmark for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) measure nor the Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) measure and thus did not earn back the original withhold amount. However, St.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Clair CMH did receive an award from redistributed funds not earned through the state. **PIHP staff reviewed the latest quarterly CCBHC Quality Measures report submitted by each CCBHC. The PIHP Team is planning to meet with each CCBHC to address findings.** **Through the FY2025 Re-Certification process, MDHHS granted GHS, Sanilac CMH, and St. Clair CMH Full CCBHC Certification. Lapeer CMH also received Full Certification, but with a Corrective Action Plan (CAP). The MDHHS Team will provide additional information regarding the CAP needed to address the application deficiencies.** **As part of the CCBHC annual contract monitoring, the PIHP scored one CMH as Not Met for one of the performance standards due to not listing Region 10 and the correct address on the 5515 Consent Forms.** **<u>Evaluation</u>: This ongoing goal is considered partially met for FY2024. Throughout the fiscal year, the PIHP monitored quality measures, oversaw case enrollment within the WSA, and maintained communication with CCBHC staff including training for the three additional CCBHC sites in the Region. However, St. Clair CMH did not meet the benchmark for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) quality measure. The set benchmark for the SAA measure is 58.5%. MDHHS' final findings show a rate of 56.9% for St. Clair CMH. This is the second year the benchmark for this metric was not met. Additionally, St. Clair CMH did not meet the benchmark of 23.9% for Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C), reaching only 12.1%. Additional follow-up should occur to improve performance. As Quality Bonus Payments (QBPs) were awarded by an all-or-nothing standard, St. Clair did not receive their originally withheld amount. Monitoring for the other three (3) CCBHCs in Region 10 is also ongoing for metric performance.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: As identified by St. Clair CMH, there continues to be discrepancies for metric data between what is reported from MDHHS and what is found using EHR data. **<u>Next Steps</u>: This goal should be carried forward into FY2025. All four CMHSPs in the region will continue to participate in the CCBHC Demonstration and it is expected additional oversight in this area will be necessary. Additionally, the PIHP should work closely with the CCBHC sites to ensure benchmarks are achieved for quality measures.**
1915(i) State Plan Amendment	The goals for FY2024 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 Review and share reports to maintain timely submission of updated Re-evaluations. 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):** **The 1915(i)SPA went live on October 1, 2023. As of December 28th, there were 3,174 iSPA cases open in the Waiver Support Application (WSA); five (5) new cases to enroll; 521 past due re-evaluations; and 19 re-evaluations coming due in the next 30 days. The primary focus in the first quarter was identifying new beneficiaries for enrollment and processing timely re-evaluations. The PIHP met monthly with the CMHSPs to monitor processes, discuss enrollment barriers and WSA issues, and share MDHHS updates. Additional MDHHS guidance was needed on expectations for enrollment when services between the iSPA and CCBHC overlap. PIHP Leads attended the Waiver Conference in November, including informative sessions on the 1915(i)SPA and the site review process. Information was shared at debriefing meetings with the PIHP Quality Department, Data Department, and CMH Leads, and will be used to guide planning for 2024 site reviews. In December, the PIHP participated in a technical assistance (TA) call with MDHHS for further clarification, particularly on processing adoption cases; notice required for Disenrollments; and CCBHC enrollment/disenrollment as it relates to iSPA enrollment. These topics required further investigation by MDHHS with a response anticipated in early 2024.** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Focus for the 1915(i)SPA remains on enrollment and submission of timely Re-evaluations. In March, the PIHP hired a new Administrative Technician who is awaiting WSA access to assist with processing cases. The end of March WSA report showed 3,121 open cases; seven cases to enroll; and 1,138 Re-evaluations or disenrollments to process. The PIHP has requested further MDHHS guidance around notice required for disenrollments due to change in Authority. **At the March Leads meeting, MDHHS notified the PIHPs of a new understanding of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Authority as it applies to the iSPA. Beneficiaries requiring any of the four services previously thought to be covered under EPSDT must now be enrolled under the iSPA if not covered under any of the individual's other programs or Waivers. MDHHS sent a spreadsheet of potential enrollees for validation based on the change which the PIHP submitted by the March 27th deadline. The projected time frame for Region 10 to enter and submit those cases is April 22nd – June 5th.** **Lapeer CMH and Sanilac CMH are still working out the best method to best identify new enrollees. Use of the Coming Due/Past Due reports has been encouraged for timely processing of cases for re-evaluation. Specific guidance from MDHHS regarding notes needed for untimely cases and the issue and process around incorrect initial dates entered was discussed at the March CMH Leads meeting, along with MDHHS-suggested PIHP Technical Assistance. In February, guidance was provided regarding disenrollment of cases due to no iSPA services received in the past 90 days. The CMHs are developing reports to monitor for this, which the PIHP can validate utilizing a report created by the Region 10 Data Management Department.** **The current Site Review Report tool and a preparation session was held in February, and monthly updates have been provided in preparation for a Fall review.** **Q 3 (Apr-June):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The third quarter ended with 3,212 iSPA cases open for Region 10. Focus remains on processing new cases and timely re-evaluations. There were 766 re-evaluations or disenrollments in the CMH queues, and there has been discussion with the CMHs about their related processes and the level of detail needed in Comments for untimeliness. CCBHC assignment continues to impact the iSPA as disenrollment is needed if there is service overlap. There has been ongoing conversation about disenrollment notice requirements and due to no services within 90 days. **Earlier this quarter, Region 10 processed 269 EPSDT cases for individuals under age 21 to receive iSPA services after MDHHS discovered those services did not fall under EPSDT Authority. Validation of an MDHHS HCBS spreadsheet identifying potential iSPA enrollees was completed in April. Cancellation of the June monthly MDHHS iSPA Leads meeting resulted in cancellation of the PIHP-CMH Leads meeting due to lack of updates. MDHHS is addressing communication issues between CHAMPS and the WSA as accurate determination of Medicaid eligibility is needed to process cases. EMR integration work continues toward October implementation, and progress was made on enhancing the PIHP iSPA Data Pull report.** **The PIHP held May Site Review Prep meetings with the CMHs and joined MDHHS for a TA call in June in advance of the review period August 12th-September 30th. Timelines, sample cases, conference schedules, and other information from MDHHS are being shared with the CMHs.** **Q 4 (July-Sept.):** **Region 10 had 2,903 open iSPA cases at the close of the 4th quarter. Enrollment numbers continue to reflect the impact of CCBCH assignment as service overlap results in iSPA disenrollment. Medicaid eligibility, at least in part due to communication issues between CHAMPS and the WSA, is also impacting enrollment. Additionally, this contributes to the number of past due re-evaluations totaling 575 cases for the CMHs to process. Efforts to**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			resolve this issue include monthly monitoring, iSPA Data Pull report validation, and individual CMH outreach. **During this quarter, MDHHS submitted and received feedback from CMS related to the Waiver Renewal and 1915(i) State Plan Amendment. Depending on the timeline for revisions, October 1st implementation for both may be delayed. At the August MDHHS-PIHP meeting, Office of Recipient Rights (ORR) reporting requirements were discussed as data collection and/or submission may become a PIPH responsibility. The PIHP collected and submitted documentation to MDHHS for Site Reviews running August 12th - September 30th. Teleconference dates are scheduled, and feedback has currently been received on GHS and St. Clair CMH submissions.** **<u>Evaluation</u>: The 1915(i)SPA went live nearly one year ago. Understanding of services covered and MDHHS expectations has evolved over time. Enrollment has leveled off at around 2,900 cases. The PIHP continues to support the CMHs in accurate and timely processing of cases for enrollment, re-evaluation, and disenrollment, adhering to MDHHS guidelines and updates. Monthly PIHP-CMH meetings and information sharing keep everyone informed of changes and requests. This goal is considered met but will continue into FY2025 to include a tracking grid for timely re-evaluations to demonstrate progress.** **<u>Barrier Analysis:</u> Medicaid eligibility issues, timely processing of re-evaluations and disenrollments, and changing MDHHS expectations continue to be barriers.** **<u>Next Steps</u>: Monitor untimeliness, provide CMH support, and share MDHHS guidance. Develop a tracking grid for timeliness reporting. Continue this goal into FY2025.**
Verification of Services	The goals for FY2024 Reporting are as follows: o 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.	Deidre Slingerland Quality Management & Data Management Departments	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP completed review of FY2022 Q3 claims and submitted final letters to providers initially found to be in compliance on November 28 – 30. Final letters were prepared for those initially found to be out of compliance and are under review.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. ○ Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. ○ Send Explanation of Benefits (EOB) letters biannually during the fiscal year. ○ Send EOB letters to more than 5% of consumers receiving services.		**A new guidance document was drafted for use with the next request for documentation to aid providers in selecting the correct documents to send.** **Explanations of Benefits (EOBs) were sent in December. 905 letters were sent to consumers of GHS, 140 to consumers of Lapeer CMH, 88 to Sanilac CMH consumers, 424 to consumers of St. Clair CMH, and 96 letters sent to consumers in the SUD Provider Network. This equates to approximately 8.7% of consumers.** **The Claims Verification Annual Report was drafted.** **Q 2 (Jan-Mar):** **Final letters were sent to Providers following review of FY2022 Q3 claims. Of those, three (3) appeals were received by the PIHP. Two (2) appeals were accepted, and one (1) still resulted in a reconsideration.** **PIHP staff met to discuss timeframes and methodology in Claims Verification reviews.** **Q 3 (Apr-June):** **No updates.** **Q 4 (July-Sept.):** **Follow up continued for Providers with outstanding voids and reconsiderations from the most recent review.** **Staff at the PIHP met to discuss plans for upcoming Claims Verification reviews.** **<u>Evaluation</u>: This goal is partially met. The PIHP continued reviews with the increased sample size to encompass claims from each Provider. The Annual Report was submitted timely at the end of CY2023 to reflect the previous fiscal year's activities. The PIHP has not yet reviewed and updated the Claims Verification Policy. EOBs were sent during both Q1 and Q3 into Q4 of FY2024, satisfying the biannual objective. Surpassing the 5% benchmark, they were sent to 9% of those in services.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: The need for training at the PIHP and providers related to the Claims Verification process was the largest barrier this year. **<u>Next Steps</u>: This goal will be carried over into FY2025. The Claims Verification process will need to be reviewed and the current team will need to be trained. Additionally, the Claims Verification Policy will be reviewed and updated as necessary in FY2025.**
Long-Term Services and Supports	The goals for FY2024 reporting are as follows: o 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 o 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 o At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.	Tom Seilheimer / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **No utilization reviews of case records were completed during the first quarter of FY2024. 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.** **Clinical case record reviews for 1915(c) Waiver enrollees and individuals receiving Applied Behavior Analysis services are scheduled to occur during Annual Contract Monitoring.** **Claims verification reviews continued for the random sample of FY2022 Q3 claims. Following the administration of the FY2023 Customer Satisfaction Survey, the PIHP aggregated responses to prepare a report with findings.** **Through the person-centered planning process, the PIHP ensures the CMHSPs conduct initial and annual biopsychosocial assessments, and other assessments as needed.** **Q 2 (Jan-Mar):** **The PIHP Chief Clinical Officer, Customer Service Manager, and Quality Manager met to review the definition of LTSS. A document from the Statewide Customer Service Workgroup provides specific services and service codes to be considered LTSS.** **Utilization reviews are scheduled for March. Periodic reviews of plans of service continue per person-centered**

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			planning principles, but the reviews of these plans are pended to the utilization review case record review process. **Clinical case record reviews for 1915(c) Waiver enrollees and individuals receiving Applied Behavior Analysis services are scheduled to occur during Annual Contract Monitoring. The PIHP and CMHs are also preparing for an MDHHS Site Review for the 1915(c) Waivers and the 1915(i) State Plan Amendment (SPA).** **Claims verification reviews were completed for the random sample of FY2022 Q3 claims. The claims verification processes and policy are being revisited.** **Through the person-centered planning process, the PIHP ensures the CMHSPs conduct initial and annual biopsychosocial assessments, and other assessments as needed. PIHP Clinical and Quality staff started meeting to discuss the person-centered planning process and expectations, especially for individuals receiving home and community-based services.** **Q 3 (Apr-June):** **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. CMH utilization review (UR) for 3Q is underway. Annual SUD UR is in the preparation phase.** **The claims verification processes and policy are being revisited.** **Clinical case record reviews for 1915(c) Waiver enrollees and individuals receiving Applied Behavior Analysis services are scheduled to occur during Annual Contract Monitoring.** **The PIHP and CMHs are also preparing for an MDHHS Site Review for the 1915(c) Waivers and the 1915(i) State Plan Amendment (SPA).** **The PIHP met internally to discuss planning for the FY2024 Customer Satisfaction Survey.**

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			Through the person-centered planning process, the PIHP ensures the CMHSPs conduct initial and annual biopsychosocial assessments, and other assessments as needed. PIHP Clinical and Quality staff continued to share information regarding person-centered planning process and expectations for individuals receiving home and community-based services. **Q 4 (July-Sept.):** **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. CMH utilization review (UR) began in August. Annual SUD UR began in July and will continue into September.** **The claims verification processes and policy are being revisited.** **Clinical case record reviews for 1915(c) Waiver enrollees and individuals receiving Applied Behavior Analysis services occurred as part of FY2024 Annual Contract monitoring.** **The PIHP and CMHs prepared documentation for the MDHHS Site Review for the 1915(c) Waivers and the 1915(i) State Plan Amendment (SPA).** **The FY2024 Customer Satisfaction Survey is underway.** **Through the person-centered planning process, the PIHP ensures the CMHSPs conduct initial and annual biopsychosocial assessments, and other assessments as needed. PIHP Clinical and Quality staff continued to share information regarding person-centered planning process and expectations for individuals receiving home and community-based services.** **<u>Evaluation</u>: The PIHP and the provider network assessed the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS using periodic reviews of plans of service, utilization**

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			reviews, claims verification reviews, clinical case record reviews, and customer satisfaction surveys. The PIHP and provider network also assessed each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring using biopsychosocial assessments and ancillary assessments. The PIHP conducted quarterly utilization reviews, but implementation of the utilization review form in the PCE system is in the PCE Project Manager's queue. **<u>Barrier Analysis</u>: No barriers were identified.** **<u>Next Steps</u>: Continue this goal for FY2025 to continue monitoring and oversight of these activities.**
External Quality Review Corrective Actions	The goals for FY2024 Reporting are as follows: o Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. Following the SFY2023 Compliance CAP Review of Region 10 PIHP, designated Standard Leads will address any outstanding findings and CAPs from SFY2021 and SFY2022 Compliance Reviews. Per the 2023 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended: o Region 10 and the CMHSP expand upon their performance indicator validation checks to ensure any manually entered dates as a result of system overrides are reviewed for accuracy.	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation:** Lauren Campbell	**Quarterly Update:** **Q 1 (Oct-Dec):** **The final 2023 Performance Measure Validation (PMV) Review Report was received from HSAG. The report was presented to the Quality Management Committee, Quality Improvement Committee, and PIHP Board. The identified weakness and recommendation were highlighted with the committee members. The PIHP will plan for additional follow up in the future to ensure CMHs have expanded validation checks for performance indicator events with any manual entries or overrides.** **The PIHP also received the SFY2023 Compliance Review Report with final findings. All but two corrective action plans were found to be complete. However, no technical assistance sessions were needed. The External Quality Review Team asked Standard Leads for responses to the recommendations provided in the SFY2023 Compliance Review Report.** **The External Quality Review Team hosted a kick-off meeting to prepare for the SFY2024 Compliance Review. Standard Leads were asked to begin reviewing Standards and consider needed evidence documents. Additionally, HSAG scheduled the SFY2024 Compliance Review and provided key dates for the review. The SFY2024 Compliance Review is scheduled for September 16, 2024.**

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			Q 2 (Jan-Mar): **Work continued to address recommendations provided during the 2023 Performance Measure Validation (PMV) Review and the SFY2023 Compliance Corrective Action Plan (CAP) Review. Standard Leads were prompted to add updates to the PIHP-developed Recommendation Tracking Template documents.** **The PIHP External Quality Review (EQR) Team continued planning for the SFY2024 Compliance Review. The External Quality Review Team hosted working sessions to continue preparing for the SFY2024 Compliance Review.** **The PIHP received the SFY2023 Encounter Data Validation (EDV) Aggregate Report. The PIHP EDV Team met to review the findings. A Recommendation Tracking Template document will be used to track the findings and actions taken to address the Region 10-specific recommendations.** **The PIHP also learned there will be a SFY2024 EDV activity and a SFY2024 Network Adequacy Validation (NAV) activity.** **Q 3 (Apr-June):** **Work continued to address recommendations provided during the 2023 Performance Measure Validation (PMV) Review, the SFY2023 Compliance Corrective Action Plan (CAP) Review, and the SFY2023 Encounter Data Validation (EDV) activity. Standard Leads were prompted to add updates to the PIHP-developed Recommendation Tracking Template documents.** **The PIHP External Quality Review (EQR) Team continued planning for the SFY2024 Compliance Review. The External Quality Review Team hosted working sessions to continue preparing for the SFY2024 Compliance Review.** **Materials for the SFY2024 Compliance Review were received. The PIHP External Quality Review (EQR) Team hosted a Kickoff Meeting 2.0 with Standard Leads.**

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			The PIHP received the sample files and tracking worksheets for the SFY2024 EDV activity. Designated PIHP EDV Team members continued reviewing sample files and preparing files for submission to HSAG. **Materials for the 2024 PMV and Network Adequacy Validation (NAV) Review were received. The PIHP and CMHs began completing the Information Systems Capabilities Assessment Tool (ISCAT) and collecting supporting documents. The ISCAT and supporting documents were submitted to HSAG on June 14, 2024.** **Q 4 (July-Sept.):** **For the SFY2024 Compliance Review, Compliance Review Tools, Checklists, and supporting evidence documents were submitted to HSAG on July 12, 2024. The SFY2024 Compliance Review is scheduled for September 16, 2024.** **On July 12, 2024, the PIHP submitted proof of service documents for the sample cases selected for primary source verification for the 2024 PMV Review. On July 31, 2024, the PIHP participated in the 2024 PMV and NAV Review with the Health Services Advisory Group (HSAG). The PIHP and CMHs worked on follow-up items after the review. The draft report has not yet been received.** **Evaluation: Responsible staff for the Compliance Review Recommendations Tracking Templates changed throughout the fiscal year. Recommendations Tracking Templates documents were not always updated. The recommendation from the 2023 Performance Measure Validation review was addressed. A Recommendation Tracking template was prepared for the findings from the SFY2023 Encounter Data Validation (EDV) activity.** **Barrier Analysis: Responsible staff for the Compliance Review Recommendations Tracking Templates changed throughout the fiscal year. Comprehensive updates were not always added to Recommendations Tracking Templates documents.**

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			<u>Next Steps</u>: The External Quality Review Team will review the Recommendations Tracking Templates and will follow up with responsible staff to ensure recommendations and deficiencies are addressed. Continue this goal for FY2025 and modify to address any findings, corrective action plans, and recommendations from the FY2024 external quality review activities.

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As of 09.05.2024