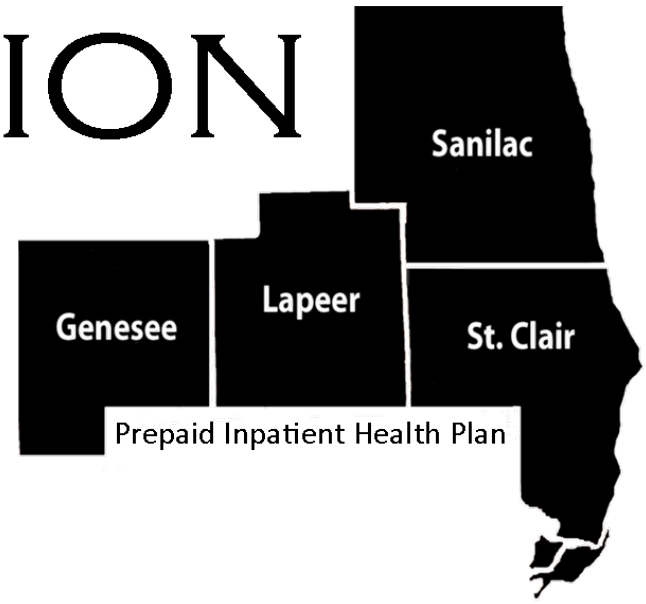
Region 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2023 – Annual Report

Quality Improvement Fiscal Year (FY) 2023 Work Plan (October 1, 2022 – September 30, 2023)

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure – Annual Evaluation	The goals for FY2023 Reporting Year are as follows: • Submit FY2022 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2022. 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.	Deidre Murch / Dena Smiley Quality Management Department QI Program Standing Committees	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **In order to provide staff with additional time to complete thorough evaluations, the deadline for annual evaluations was extended until October 14, 2022. Responsible staff evaluated the FY2022 goals and worked on completing the annual evaluations. The FY2022 Annual Report was presented to the Quality Improvement Committee (QIC) at the November meeting. QIC approved the FY2022 Annual Report as written. The FY2022 Annual Report was then presented to the Region 10 PIHP Board at the November meeting where it was also approved.** **<u>Q 2 (Jan-Mar):</u>** **The FY2022 Annual Evaluation was submitted timely to MDHHS ahead of the February 28, 2023 deadline.** **<u>Q 3 (Apr-June):</u>** **No activities took place during this quarter.** **<u>Q 4 (July-Sept):</u>** **Discussions took place at the Quality Improvement Committee (QIC) regarding the appropriate timeline going forward in relation to this goal. It was determined the FY2023 Program Evaluation be submitted to the QIC and PIHP Board in September.** **<u>Evaluation</u>: This goal has been met. The December 1, 2022 deadline was met for presentation and approval of the FY2022 Annual Evaluation by both the Quality Improvement Committee (QIC) and the Region 10 PIHP Board.**

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			<u>Barrier</u> <u>Analysis</u>: Uncertainty surrounding appropriate due dates. **<u>Next</u> <u>Steps</u>: Going forward, this goal will have a due date of the first day of the fiscal year. This is to allow staff to evaluate the prior year's activities before setting goals for the upcoming year. This goal will carry over into FY2024 with revised language regarding the date.**
QI Program Structure - Program Description	The goals for FY2023 Reporting Year are as follows: • Submit FY2023 QI Program Description and QI Workplan to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2022. o Review the previous year's QI Program and make revisions to meet current standards and requirements. o Include changes approved through committee action and analysis. o Include signature pages, Work Plan, Evaluation, Policies and Procedures, and attachments. • Develop the FY2023 QI Program Work Plan standard by 12/1/2022. o Present the work plan to committee by 12/1/2022. o Utilize the annual Evaluation in the development of the Annual Work Plan for the upcoming year. o Prepare work plan including measurable goals and objectives. o Include a calendar of main project goal and due dates.	Deidre Murch / Dena Smiley Quality Management Department QI Program Standing Committees	**Quarterly Update:** **The Health Services Advisory Group (HSAG) Compliance Review Final Report was received and reviewed by Region 10 PIHP in November. The FY2023 QI Program Description and QI Workplan were presented to and approved by the Quality Improvement Committee (QIC) and Region 10 PIHP Board in November. Updates were made to Responsible Staff designations for the following goals: QI Program Structure, Home and Community Based Services (HCBS), External Monitoring Reviews, Autism Program, Certified Community Behavioral Health Clinic (CCBHC) Demonstration, and 1915(i) due to staffing changes at Region 10 PIHP. Discussions continue regarding how to use the results of the HSAG Compliance Review Final Report to inform updates/changes to the QI Workplan.** **<u>Q 2 (Jan-Mar):</u>** **Updates were made to Responsible Staff designations for the following Components: Members' Experience, Provider Network, Autism Program, 1915(i) State Plan Amendment, Supports Intensity Scale, Verification of Services, and Credentialing / Privileging due to staffing changes at Region 10 PIHP. The Responsible Staff for the Components of QI Program Structure Annual Evaluation and Program Description and Integrated Health Care were updated to reflect current job**

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			tasks. The FY2023 Quality Improvement (QI) Program and Workplan were submitted timely to MDHHS ahead of the February 28, so 2023 deadline. **<u>Q 3 (Apr-June):</u>** **Updates were made to the Responsible Staff designations for the Home & Community Based Services and Opioid Health Home goals to reflect current job tasks.** **<u>Q 4 (July-Sept):</u>** **Updates were made to the Responsible Staff designations for the CCBHC Demonstration, 1915(i)SPA, Members Experience, and Verification of Services goals.** **Upon discussion at QIC, it was determined that this goal, in reflection upon changes to the previous one, will need an updated acceptable timeframe. The Annual Workplan should be submitted by November 1 of each year going forward.** **<u>Evaluation</u>: This goal has been met as the PIHP was able to meet the stated December 1, 2022 deadline.** **<u>Barrier</u> <u>Analysis</u>: No barriers identified.** **<u>Next</u> <u>Steps</u>: This goal will carry over into FY2024 with revised language regarding the dates.**
Aligned System of Care	The goals for FY2023 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.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The FY2022 Clinical Practice Guidelines (CPG) Annual Evaluation Report was presented and approved, and it has been submitted to the Quality Improvement Committee (QIC) for review and approval. The End of FY2022 Level of Care Utilization System (LOCUS) Implementation Plan Evaluation Report and the FY2023 LOCUS**

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	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). o Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan.		**Implementation Plan were presented and approved. A summary report of the DSM-V-TR was presented, highlighting relevant clinical updates. Members recognized Lapeer CMH's recent certification as an Individual Placement and Support (IPS) provider. Home and Community Based Services (HCBS) transition activities and Interactive Care Plan (ICP) activities are proceeding according to their annual plans. PISC quarterly meeting updates have also been shared and discussed.** **<u>Q 2 (Jan-Mar):</u>** **The service selection process has begun with the Improving Practices Leadership Team (IPLT) clinical leaders for the Clinical Practice Guidelines (CPG) Annual Evaluation Report. The latest status report from BHASA on Level of Care Utilization System (LOCUS) MIFAST assessment and consultation activities was reviewed, with a call for CMHSPs to determine appropriate next steps in connection with their respective LOCUS Implementation annual plans.** **<u>Q 3 (Apr-June):</u>** **The annual regional Evidence-Based Practice (EBP) update has been inserted into the draft Clinical Practice Guidelines (CPG) Biennial Evaluation Report. The CPG Annual Evaluation Report service selection process has been completed by the Improving Practices Leadership Team (IPLT) membership and report evaluation activities have begun as scheduled. The Level of Care Utilization System (LOCUS) mid-year evaluation report is completed; all CMHSPs are proceeding with implementation activities as planned. St. Clair CMH has just scheduled its LOCUS Michigan Fidelity Assistance Support Team (MiFAST) review for June.** **<u>Q 4 (July-Sept):</u>**

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			The Clinical Practice Guidelines (CPG) Annual and Biennial Evaluation Reports are proceeding as planned and will be completed as scheduled during October. A review/update of regional evidence-based practices (EBPs) has been completed and it has been integrated into the CPG Biennial Evaluation Report; Opioid Health Home (OHH) clinical monitoring has been added to the annual plan. Michigan Fidelity Assistance Support Team (MiFAST) and other best practices review information has been shared as available. All CMHs have followed through on their annual Level of Care Utilization System (LOCUS) implementation plans. **<u>Evaluation</u>: All goals have been met per their completed activities during this fiscal year. All goals are ongoing, as they apply year to year, and so should be continued.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Update the CPG policy contingent upon its the evaluation and recommendations generated by the CPG Annual and Biennial reports. Implement the FY2024 LOCUS annual implementation plan. Ensure share and learn presentations with CMH MiFAST fidelity reports as they become available. Continue committee goals for Y2024, to include OHH clinical monitoring.**
Employment Services	The goals for FY2023 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)	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Lapeer CMH recently obtained status as an Individual Placement and Support (IPS) provider. All members report progress expanding employment partnerships. GHS has standardized its medical necessity determination process for its skill development programs. All members report ongoing success in working on local opportunities to partner**

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	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]) o CMHSP successes addressing challenges in community-based employment (e.g., pandemic, community inclusion) o Centralized Utilization Management Redesign implementation		**with Michigan Rehabilitation Services (MRS) on specific cases.** **<u>Q 2 (Jan-Mar):</u>** **The February meeting Minutes were reviewed, and there was brief discussion in support of Individual Placement and Support (IPS)/progressive employment services practices supported by the Employment Services Committee (ESC). Michigan Rehabilitation Services (MRS) collaborations were also noted and materials from the quarterly Competitive Employment were shared.** **<u>Q 3 (Apr-June):</u>** **The Employment Services Committee (ESC) May meeting Minutes were reviewed, and supportive discussion took place regarding ESC participation in the MDHHS Recharging Competitive Employment quarterly meeting, expansion of Michigan Rehabilitation Services (MRS) partnered services, and post Public Health Emergency (PHE) community employer networks.** **<u>Q 4 (July-Sept):</u>** **Michigan Mission-Based Performance Indicator System (MMBPIS) employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) have been monitored for discussion. Standardized employment services data and report formats have been shared. In-service / informational materials have been shared. Community-based employment opportunities and collaborative practices with Michigan Rehabilitation Services (MRS) have been discussed. CMHSP successes addressing challenges in community-based employment (e.g., pandemic, community inclusion) have been discussed. As this goal pertains to the pandemic, it has been revised to align with the removal of the public health emergency (PHE). In**

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			connection to employment placement and skill development services authorization, the Centralized Utilization Management (UM) Redesign implementation has been forwarded into FY2024 due to delays in OASIS Redesign implementation. **<u>Evaluation</u>: All goals have been met per their completed activities during this fiscal year, except for centralized UM with skill building and employment services. All goals are either ongoing or should be forwarded for completion during FY2024, and so should be continued.** **<u>Barrier Analysis</u>: A barrier with delayed UM Redesign was encountered.** **<u>Next Steps</u>: Continue these goals for FY2024, with the deletion of activities pertaining to the pandemic. Discussion on the MMBPIS performance monitoring for competitive employment (indicator 8 community-based) and appropriate compensation (indicator 9 minimum wage or higher) will focus on encouraging CMHs to establish actionable performance targets.**
Home & Community Based Services	The goals for FY2023 Reporting are as follows: • Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure quality of clinical care and service. o Monitor network completion of the FY2022 HCBS survey process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process o Monitor the provisional approval process	Deidre Murch Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **During the first quarter, the PIHP received multiple requests for provisional approval. One setting was denied provisional approval due to being on heightened scrutiny in another region, but the CMH chose to use the COVID flexibility while the public health emergency continues.** **The PIHPs are still awaiting MDHHS' and CMS' determinations on whether settings can exit heightened scrutiny and continue with Medicaid funded HCBS services. When this information is received, the PIHP will work with CMHs to assist with transition planning.**

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			MDHHS provided lists of HCBS settings on heightened scrutiny for each CMH. CMHs were asked to review for any changes and, if there were any changes identified, update information within the Waiver Support Application (WSA). **During December, MDHHS provided additional information regarding the November 2020 survey cycle and the FY2023 first quarter survey cycle. CMH HCBS Leads have been asked to assist with data cleaning for the 2020 survey reports. Questions from the November 2020 survey requiring remediation and validation will be identified. The FY2023 first quarter survey will be disseminated to provisionally-approved settings and participants. CMH HCBS Leads have been asked to assist with providing information using a list of settings de-escalated from Heightened Scrutiny.** **The temporary PIHP HCBS Leads are scheduling meetings with the CMH HCBS Leads for January to discuss the survey cycles and requests for information.** **<u>Q 2 (Jan-Mar):</u>** **Region 10 received three (3) provisional requests, two (2) from Sanilac CMH and one (1) from St. Clair CMH. Two (2) followed protocols and were approved. One (1) required consultation from MDHHS who determined that this setting could be provisionally approved specifically for the individual placed there.** **MDHHS provided lists of settings that the State is recommending be removed from heightened scrutiny status. PIHPs are still awaiting CMS' final determinations on these settings. MDHHS also notified the PIHP that MDHHS requested a six-**

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			month extension from CMS for the Statewide Transition. That decision is still outstanding. **PIHP Home and Community Based Service (HCBS) Leads met with the CMH Leads individually twice throughout the quarter.** **CMH HCBS Leads completed data cleaning of the November 2020 survey reports, and that information was turned into MDHHS by the January 27th deadline.** **MDHHS met with HCBS Leads from the PIHPs for a bimonthly meeting. It was shared that with the ending of the Public Health Emergency on May 11, 2023, all persons receiving services under Covid flexibility would need their cases to be reexamined to determine whether it would be appropriate to seek a provisional approval again due to changes the setting has made, have a consultation with MDHHS, or transition the person into a new setting. No extensions apply when it comes to HCBS. This information was shared with the CMHs by the PIHP in order to begin appropriate planning.** **The FY2023 Q1 survey cycle opened on March 29th. This cycle covers waiver participants currently receiving services from settings that had previously been de-escalated from heightened scrutiny through no action of their own as well as those in settings provisionally approved since September of 2021.** **<u>Q 3 (Apr-June):</u>** **The PIHP received a total of ten (10) Provisional Requests throughout the third quarter: one (1) from GHS, three (3) from Lapeer CMH, two (2) from Sanilac CMH, and four (4) from St. Clair CMH. This total includes all Covid flexibility placements, which have successfully been either transitioned into**

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			new settings or undergone proper approval procedures to remain in their existing settings. **The FY2023 Q1 survey cycle closed on April 21st. Region 10 achieved a 100% response rate from Providers.** **The PIHP met with the CMH HCBS Leads for a pair of meetings to discuss ongoing practices.** **Validation and remediation work is underway for the FY2020 survey cycle.** **<u>Q 4 (July-Sept):</u>** **The PIHP met with the HCBS CMH Leads for a bimonthly meeting. The meeting focused on updates from the State as well as the upcoming October 1, 2023 deadline to submit Validation and Remediation documentation to the PIHP for the FY2020 survey cycle. All documentation is due to MDHHS November 1.** **Additionally, it was shared at the CMH Leads meeting as well as the Provider Network Committee and Improving Practices Leadership Team meetings that the PIHP is working on Policy edits to quantify a timely Provisional application. This has been noted to be an ongoing issue. The PIHP asked CMH Leads to send in license numbers of potential settings in advance so that Heightened Scrutiny checks can be done earlier in the process.** **MDHHS began discussions with PIHP Leads regarding proposed changes to the survey process. They will no longer contract with Qualtrics and plan to roll out an assessment program aimed at completing annual on-site physical assessments and biennial comprehensive assessments. Dialogue continues.**

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			The PIHP received six (6) Provisional applications in the fourth quarter. Two (2) from Genesee Health System, one (1) from Lapeer CMH, and three (3) from St. Clair CMH. **<u>Evaluation</u>: This goal has been met. The PIHP monitored the cleaning of the FY2020 survey data by the CMHSPs. Additionally, Region 10 achieved a 100% completion rate by Providers in the FY2023 survey cycle. Over the course of the year, the PIHP met twice with each CMHSP individually and five times as a group with representation from each CMHSP. Validation and remediation work for the FY2020 survey cycle is currently underway and running according to plan. Lastly, this program had a successful transition out of the Public Health Emergency with all Covid flexibility placements either being fully approved or transitioned into unsecured settings prior to the official end of the PHE on May 11, 2023. The PIHP received 22 provisional requests throughout FY2023 and had five (5) 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 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.** **<u>Barrier Analysis</u>: Noted barriers in FY2023 include ambiguity in State requirements, new staffing at both the PIHP and State level, and lack of specificity**

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			in the Provisional Approval Process. Updates have been made in the process to address this issue. **<u>Next Steps</u>: This goal will be carried over into FY2024. Although it is deemed complete, the goal is ongoing as monitoring will continue. Also, the State is adopting a new assessment process to replace the old survey process, so increased oversight will be necessary for successful implementation.**
Integrated Health Care	The goals for FY2023 Reporting are as follows: • Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. o Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CareConnect360 (CC360) system.	Deidre Murch / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **All members are participating as per plan and meeting calendar. On average, over 30 cases have been reviewed monthly, with approximately four cases successfully closed.** **<u>Q 2 (Jan-Mar):</u>** **All members are participating as per plan and meeting calendar. On average, twenty-seven (27) cases are discussed each month. Over the course of this quarter, nine (9) new cases have been opened and seven (7) have been closed.** **<u>Q 3 (Apr-June):</u>** **All members are participating as per plan and meeting calendar. On average, 11 new cases were discussed each month during the third quarter. Over the course of the quarter, six (6) new cases have been opened and three (3) have been closed.** **<u>Q 4 (July-Sept):</u>** **The PIHP met internally and later with CMH Leads to discuss expanding our focus for joint care meetings as well as placing a greater emphasis on the need for care coordination. The PIHP added youth in foster care as a focus population in alignment with ongoing State discussions. The Interactive Care Plan team continues to review the Homeless Vulnerability Report as well for potential**

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			members to add to the Agendas. During the fourth quarter, an average of 16 new cases were discussed monthly and nine (9) were opened. **<u>Evaluation</u>: This goal is considered met. Over the course of FY2023, 37 Care Plans were opened in CareConnect360. This is an increase over FY2022 which saw 29 Care Plans opening. Of the 37 Care Plans, 17 were from Genesee, 1 from Lapeer, 4 from Sanilac, and 15 from St. Clair. Throughout FY2023, 25 Care Plans were closed, a marked decrease from FY2022 (35 closed Care Plans). Genesee closed 11 Care Plans, Lapeer closed zero (0), Sanilac closed three (3), and St. Clair closed 11. 32% of these cases were closed due to determination that all goals had been met. The PIHP met internally and subsequently with the CMHSP 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 added an additional focus on the youth population, specifically youth in foster care.** **<u>Next Steps</u>: This goal will be continued in FY2024. Additionally, new objectives have been proposed to enhance coordination with the PIHP/MHP Workgroup in order to more actively participate in discussed initiatives.**
Event Reporting (Critical Incidents, Sentinel	The goals for FY2023 Reporting are as follows: • 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.	Tom Seilheimer Sentinel Event Review Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **CMH and SUD critical incident (CI) reports, which also include unexpected deaths and risk events**

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Events & Risk Events)	○ Monitor CMH and SUD sentinel event review processes and ensure follow-up as deemed necessary. ○ Monitor CMH and SUD unexpected deaths review processes and ensure follow-up as deemed necessary. ○ Monitor CMH and SUD risk events review processes and ensure follow up as deemed necessary.		**categories, have been reviewed, noting adherence to timeliness of data and reporting standards, along with no concerning trends identified. Monitoring for unexpected deaths and risk events according to the updated system/process will be implemented upon posting of the updated CI Sentinel Event (SE) Policy.** **<u>Q 2 (Jan-Mar):</u>** **Monthly Aggregate Reports were reviewed, with no concerning trends noted. That said, GHS and St. Clair CMH systems issues were further discussed for regional response. In conjunction, the first quarter Critical Incident (CI) Report was reviewed and approved, with the advisory to recheck the data as needed. One SUD Sentinel Event (SE) Report was submitted for review, and committee feedback indicated program adherence to reporting standards and processes, and service delivery issues were ruled out.** **<u>Q 3 (Apr-June):</u>** **Critical incident (CI) reports were reviewed, with no concerning trends noted. GHS and St. Clair CMH have addressed their CI reporting issues. No sentinel events (SEs) were reported for review. The 2Q CI Report was reviewed and forwarded to the Quality Improvement Committee (QIC) for final review and recommendations.** **<u>Q 4 (July-Sept):</u>** **Monthly detail and aggregate reports were reviewed. Prospective service systems or reporting issues were ruled out or if identified were addressed. Follow-up assessment to potential critical incident findings identified were completed and discussed to rule out service systems issues. Semi-annual CMHSP Mortality Reports were reviewed to note that CMHSPs are generating service systems findings and recommendations. Risk events**

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			reporting has been pended to the posting of the Sentinel Events (SE), Critical Incidents (CI), and Risk Events Policy. **<u>Evaluation</u>: During the fiscal year, one SE was submitted within the SUD network, and zero SEs were submitted within the CMH network. Committee feedback indicated program adherence to SE reporting standards and processes, and service delivery issues were ruled out. Monitoring of CI detail, monthly aggregate, and quarterly monitoring reports identified either adherent or improved efforts to comply to reporting standards, and service-systems issues were ruled-out. All goals have been met per their completed activities during this fiscal year. All goals are ongoing, as they apply year to year, and so should be continued.** **<u>Barrier Analysis</u>: The revised CI SE Policy did not matriculate through the policy review/approval process until August.** **<u>Next Steps</u>: Forward current goals for FY2024, with revisions noted for Risk Events monitoring and for Unexpected Deaths (semi-annual mortality) reporting.**
Michigan Mission Based Performance Indicator System (MMBPIS)	The goals for FY2023 Reporting are as follows: • The goal is to attain and maintain performance standards as set by the MDHHS contract. o Report indicator results to MDHHS quarterly per contract. o Review quarterly MMBPIS data. o Improve performance with indicators without a set performance standard. o Ensure follow up on recommendations and guidance provided during External Quality Reviews o Provide status updates to relevant committees, such as the Quality Management Committee (QMC), PIHP CEO, PIHP Board.	Lauren Campbell Quality Management Committee (QMC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Performance indicators (PIs) for FY2022 fourth quarter were submitted to MDHHS on December 29, 2022. The PIHP did not meet the set performance standard for PI 4b. Sanilac CMH did not meet the set performance standard for PI 4a – Children. St. Clair CMH did not meet the set performance standard for PI 4a – Adults and PI 10 – Children. Lapeer CMH did not meet the set performance standard for PI 10 – Adults.**

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	FY22 Q4	FY23 Q1	FY23 Q2	FY23 Q3
Ind. 1 – Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%				
1.1 Children	99.57%	100%	100%	
1.2 Adults	99.89%	99.77%	99.89%	
Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. No standard				
2a PIHP Total	54.25%	54.99%	53.80%	
2a.1 MI-Children	57.62%	58.48%	54.75%	
2a.2 MI-Adults	54.39%	53.64%	53.35%	
2a.3 DD-Children	48.72%	50.00%	50.60%	
2a.4 DD-Adults	48.86%	61.64%	61.54%	
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				
2b SUD	64.75%	73.11%	73.26%	
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				
3 PIHP Total	86.26%	80.30%	81.97%	
3.1 MI-Children	87.47%	78.59%	83.37%	
3.2 MI-Adults	83.51%	80.16%	79.48%	
3.3 DD-Children	91.96%	85.82%	88.41%	
3.4 DD-Adults	94.03%	81.97%	88.24%	
Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%				
4a.1 Children	98.53%	97.30%	100%	
4a.2 Adults	95.71%	94.64%	95.21%	
4b SUD	90.67%	94.95%	91.01%	
Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less				
10.1 Children	8.51%	8.57%	8.93%	
10.2 Adults	8.87%	10.62%	11.60%	

PIHPs were informed MDHHS will implement performance standards for PIs 2 and 3. Data validation work will occur during January. It is anticipated the performance standards will be set in June for FY2024 PIs.

<u>Q 2 (Jan-Mar):</u>
Performance indicators (PIs) for FY2023 first quarter were submitted to MDHHS on March 31, 2023. The PIHP did not meet the set performance standard for PI 4a – Adults and PI 4b. GHS did not meet the set performance standard for PI 4a – Adults. Lapeer CMH did not meet the set performance standard for PI 4a – Children and PI 10 – Children. St. Clair CMH did not meet the set performance standard for PI 4a – Children and PI 10 – Adults. Sanilac CMH did not meet the set performance standard for PI 10 – Adults.

Cross-training continued among Region 10 PIHP Quality Management and Data Management staff on the review processes for performance indicators.

Regarding MDHHS' intent to implement performance standards for PIs 2 and 3, the PIHP did not receive a data file to validate and did not receive any updates regarding performance standards.

<u>Q 3 (Apr-June):</u>
Performance indicators for FY2023 second quarter were submitted to MDHHS on June 28, 2023. The PIHP did not meet the set performance standard for PI 4b. GHS did not meet the set performance standard for PI 4a – Adults.

Cross-training continued among Region 10 PIHP Quality Management and Data Management staff on the review processes for performance indicators.

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP PI Leads reviewed FY2023 first quarter performance indicator plans of correction and plans of improvement from providers. Outreach was made to the Providers with repeat plans of improvement and plans of correction. **Also, a meeting was scheduled with PIHP SUD Team staff to discuss performance on indicators 2b and 4b.** **The PIHP PI Leads are preparing to learn more from MDHHS regarding the development and implementation of standards for PIs 2a, 2b, and 3.** **<u>Q 4 (July-Sept):</u>** **Performance indicators for the current reporting period are being calculated and will be reported to the PIHP by September 15, 2023 for aggregate reporting to MDHHS.** **The PIHP PI Team began planning for the implementation of performance benchmarks/thresholds for indicators 2 and 3.** **<u>Evaluation</u>: During FY2023, the PIHP successfully reported indicator results to MDHHS, reviewed quarterly MMBPIS data, and provided status updates to relevant committees. However, there was not consistent improved performance with indicators without a set performance standard. For indicator 2a, performance slightly dropped from FY2022 second quarter (54.88%) to FY2023 second quarter (53.80%) while the number of requests for services increased. For indicator 2b, performance improved from FY2022 second quarter (66.87%) to FY2023 second quarter (73.26%) but the number of requests for SUD services decreased. For indicator 3, performance dropped from FY2022 second quarter (84.79%) to FY2023 second quarter (81.97%), and the number of events increased.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: Barriers identified during root cause analyses for indicators 2a and 3 included limited staff capacity, individuals not showing for appointments or rescheduling appointments, unsuccessful outreach attempts to engage individuals in services, and transportation. One CMHSP also reported many individuals chose not to present for intake after a walk-in intake process was implemented. **<u>Next Steps</u>: This goal will be continued for FY2024. Because there will be performance benchmarks established for indicators 2 and 3, the goal will be updated to include achieving and exceeding performance indicator standards and benchmarks.**
Members' Experience	The goals for FY2023 Reporting are as follows: • Conduct assessments of members' experience with services. o Conduct annual regional customer satisfaction survey. o Conduct the Recovery Self-Assessment (RSA) 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.	Deidre Murch Quality Management Committee (QMC)	**Quarterly Update:** **The FY2022 Customer Satisfaction Survey Report was completed and presented during the November QMC Meeting where feedback was obtained and incorporated into the final draft report. Survey data obtained by the PIHP on behalf of SUD providers was also shared with SUD providers along with contact information for consumers requesting follow up. The final draft report was presented during the December QIC meeting and Region 10 Board meeting, where the report was approved and feedback for future surveys was obtained. The FY2022 Customer Satisfaction Survey Report has been posted to the Region 10 website and sent to all providers to share with individuals served, practitioners, providers, and governing bodies.** **Work has begun for the planning of the FY2023 Recovery Self-Assessment (RSA) Survey. Recommendations for survey administration were presented during the December QMC meeting, including increasing the survey administration period in order to increase the number of responses**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			received. CMH representatives were encouraged to provide feedback and ideas regarding the survey administration process. **<u>Q 2 (Jan-Mar):</u>** **The FY2022 Customer Satisfaction Survey Report was presented at the SUD Provider Network meeting on January 26th.** **The PIHP met internally to discuss ongoing survey activities and share ideas to increase participation for both the Customer Satisfaction Survey and the Recovery Self-Assessment (RSA) Survey in 2023.** **The RSA survey went live on February 27th. There were three (3) different versions: one for those with a Serious Mental Illness (SMI) diagnosis and the Substance Use Disorder (SUD) population, a second for direct providers of services and a third for administrators. The survey ran through March 17th. A total of 1,082 surveys were completed: 862 from persons served, 147 by direct service providers, and 73 from administration.** **<u>Q 3 (Apr-June):</u>** **The FY2023 Recovery Self-Assessment was presented to the Quality Management Committee (QMC) and approved by the Quality Improvement Committee and the Region 10 Board. It has been shared with Providers and posted to the Region 10 website.** **Planning is underway for the FY2023 Customer Satisfaction Survey. Instructions have been drafted and the survey will include Medicaid beneficiaries visiting a CMH or SUD Provider in the Region 10 network during the month of August.** **<u>Q 4 (July-Sept):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The FY2023 Customer Satisfaction Survey ran from July 31st – September 1st throughout the CMHs and will and August 7th – August 18th across the SUD Provider Network. Region 10 distributed paper copies of surveys to each SUD provider for their distribution. These were then returned to the PIHP for keying into Survey Monkey. Because the CMHs add questions to their surveys, are finalizing their own versions and do their own data entry. The PIHP met internally to discuss potential changes to the survey in the next fiscal year, including how to best integrate the SUD Provider Network into discussions and decisions regarding survey content and administration. **<u>Evaluation</u>: This goal is partially met. The Customer Satisfaction Survey ran from July 31, 2023 – September 1, 2023 in the CMHs and from August 7, 2023 – August 18, 2023 in the SUD Provider Network. The Recovery Self-Assessment (RSA) Survey ran from February 27, 2023 – March 17, 2023 throughout the Region 10 Provider Network. Results from this survey as well as the FY2022 Customer Satisfaction Survey were aggregated during FY2023 and reported throughout the network. The Quality Management Committee (QMC) continues to discuss efforts aimed at increasing response totals for surveys. In FY2023, Region 10 saw a total of 1,082 Recovery Self-Assessment surveys: 862 from persons served, 147 by direct service providers, and 73 from administration. This was a 150% increase in response from persons served over FY2022. Totals for the Customer Satisfaction Survey are still being aggregated.** **<u>Barrier Analysis</u>: Staffing shortages at the Provider level have affected the ability to administer surveys. The PIHP keyed the SUD surveys from the Customer Satisfaction Survey in order to lessen the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			burden on Providers. It has also been identified that survey wording may not be clear, which will need to be addressed in FY2024. **<u>Next Steps</u>: This goal is ongoing and thus will be carried over into FY2024. In order to get more involvement from the SUD Provider Network, a proposed objective of creating a workgroup comprised of representatives from SUD Providers is being discussed. Region 10 PIHP wants to ensure that all Providers are part of the survey process from planning to administering and reporting. Discussions will take place in FY2024 regarding the content and presentation of survey questions.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
State Mandated Performance Improvement Projects (PIPs)	The goals for FY2023 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. o QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The PIP 1 Barrier Analysis findings were presented for additional program SME feedback from each of the five participating SUD programs. PIP improvement action planning is underway for scheduled implementation in early January. PIP 2 improvement activities continue to take place as per annual implementation plans.** **<u>Q 2 (Jan-Mar):</u>** **The Quality Management Committee (QMC) provided additional feedback in support of current Performance Improvement Project (PIP) 1 service systems improvement action planning. CMHSPs completed their PIP 2 calendar year (CY) 2022 systems improvement action plan implementation monitoring reports. CareConnect360 encounter data gathering continues to lag, and the prospect remains that a full CY database may not be available until early June. In the meantime, provisional analysis reports are being generated.** **<u>Q 3 (Apr-June):</u>** **Performance Improvement Project (PIP) 1 systems improvement action plans were completed during May, in preparation for the July 1st launch. The full calendar year (CY) 2022 data set for PIP 2 was finally made available and provisional analysis reports were completed and shared with the CMHSPs. The formal/annual update reports for both PIPs are in process per the mid-July completion date.** **<u>Q 4 (July-Sept):</u>** **Performance Improvement Project (PIP) 1 implementation activities are underway as per plan. Improvement activities were fully in place as of July, and quarterly implementation monitoring and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			outcomes data analyses will be conducted to help inform first-year efforts to achieve first year targets. The Health Services Advisory Group (HSAG) Validation Report on PIP 1 noted a compliance score of 100%. **Performance Improvement Project (PIP) 2 calendar year (CY) 2022 Re-measurement 2 data were analyzed and discussed at the August Quality Management Committee (QMC) meeting.** **<u>Evaluation</u>: PIP 1 goals have been met per the completion of all activities as scheduled during this CY. For PIP 2, outcomes analyses indicated significant achievement in all areas, above the bonus-minimum targets and baselines, but were below remeasurement 2 goals. Remeasurement 2 findings for PIP 2 show performance for Adults at 64%, which exceeds the benchmark (58%) but does not meet the remeasurement 2 goal (70%). For Children, remeasurement 2 findings show performance at 88%, which exceeds the benchmark (70%) and equals the remeasurement 2 goal (88%). September QMC will address in detail necessary updates to the current systems improvement action plans. For both PIPs, all goals and activities are ongoing, as they apply to these multi-year PIP plans, and so should be continued.** **<u>Barrier Analysis</u>: No barriers were encountered, except for the PIP 2 data lag experienced with the CareConnect360 claims data file. Quarterly data gathering and analysis will continue through CY2024, to help inform CMH implementation of their service systems improvement action plans.** **<u>Next Steps</u>: Continue these goals for FY2024.**
External Monitoring Reviews	The goals for FY2023 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's	Shannon Jackson	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	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. o Ensure both Professional and Aide staff meet required qualifications. o Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. o Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. o Discuss and follow up on HSW slot utilization and slot maintenance.	Quality Management Committee (QMC)	**The 1915(c) HCBS Waivers and Substance Use Disorder Site Review Reports were received from MDHHS. The PIHP submitted CMH and PIHP corrective action plans to MDHHS in response to findings from the 2022 MDHHS 1915(c) Waiver Site Review. At the end of November, MDHHS approved the PIHP and CMH corrective action plans. 90 days after MDHHS' approval of the corrective action plans, MDHHS will follow up with the PIHP to ensure corrective action plans were implemented.** **Additionally, during the December QMC meeting, GHS and Lapeer CMH reported conducting quarterly reviews of Waiver cases. Following the meeting, St. Clair CMH reported they conduct quarterly reviews as well.** **<u>Q 2 (Jan-Mar):</u>** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of second quarter was 583 of the PIHP's total 656 slots. There is currently one (1) pending application and two (2) pending disenrollments.** **On March 15th, the PIHP received the Approval Memo for the FY2022 90-day Corrective Action Plans for the State Site Review. MDHHS conducted a 90-day follow-up review February 24th through March 14th in which the PIHP provided clarification and detailed documentation of the effective remediation to the findings from the full site review which took place August 15th through Sept 30th. MDHHS review determined the actions taken by Region 10 were effective.** **<u>Q 3 (Apr-June):</u>** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of third quarter was 572 of the PIHP's total 656 slots. There is currently two (2) pending application and two (2) pending**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			disenrollments. Slot utilization continues to be a struggle for the Habilitation Supports Waiver which is consistent across the State. **During the HSW Coordinators Meetings with MDHHS this quarter, the unwind of the Public Health Emergency and major clean-up efforts were the focus of discussion. The State plans on cracking down on more timely submissions, specifically recertifications, pendback cases. After further discussion on timely submissions to MDHHS it was suggested to potentially re-evaluate policy language to aid in these efforts.** **The PIHP Quality Team is wrapping up the FY2023 Annual Contract Monitoring case record reviews, site visits were conducted in the month of June and final paperwork is being completed and submitted. PIHP Quality staff conducted clinical case record reviews for a sample of Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Children with Serious Emotional Disturbances Waiver (SEDW) cases.** **A Plan of Correction request was sent on June 26th to Genesee Health System to address Children's Waiver Program paperwork submissions for timely recertifications, new enrollees, and disenrollments within the WSA. Additionally, submission barriers and updates for the 1915(c) Waivers, were introduced at the May Quality Management Committee (QMC) meeting as an area of concern and at the June meeting, representatives were asked to speak to their CMHSPs progress. The purpose of this request is to help prompt timely submissions and assist in the State's efforts for clean-up.** **<u>Q 4 (July-Sept):</u>** **The number of Habilitation Supports Waiver (HSW) enrollees as of 9/7/23 HSW had 564 enrollees**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			of the PIHP's total 656 slots. There are currently two (2) pending applications and two (3) pending disenrollments. Slot utilization is a struggle for the Habilitation Supports Waiver, which is consistent across the State. **The Behavioral Health 1915(c) HCBS Waiver Renewal is in progress. The Waiver expiration is September 30, 2024. MDHHS has set up several Feedback sessions in August and September to help improve these programs.** **MDHHS presented guidance on enforcing timely recertifications, new enrollment and disenrollment submission within the Waiver Support Application (WSA). This guidance is now being enforced and has been successful in completing outstanding items. The PIHP is in the process of updating Policy language to reflect these changes.** **On August 24th, the PIHP Waiver Coordinator traveled to Sanilac CMH and presented on the HSW and writing Habilitative goals. The PIHP Waiver Coordinator received positive feedback from this session. The PIHP Waiver Coordinator is hopeful this will improve the quality of goals submitted on Individual Plan of Service (IPOS) documents and increase enrollment numbers. The PIHP Lead is scheduling educational sessions with all of the CMHs.** **During the fourth quarter, the PIHP completed training and privileging and credentialing reviews as part of the annual contract monitoring process for staff working with a sample of 1915(c) Waiver enrollees. Necessary evidence documents were not found for all staff. Recommendations were provided to CMHSPs.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation</u>: During QMC meetings, PIHP Waiver Coordinator addressed Habilitation Supports Waiver (HSW) slot utilization, the unwind efforts of the End of the Public Health Emergency, the MDHHS Waiver Reviews, and the FY2023 Annual Contract Monitoring cycle. **Slot utilization continues to be a struggle for HSW and continues to be addressed with CMH Waiver Leads during quarterly Leads Meetings. At the beginning of the Fiscal year Region 10 was at 91.2% slot utilization, at the close of FY2023 Region 10 is at 86%. MDHHS slot Utilization benchmark is 95% or higher. Barriers for enrollment continue to be discussed.** **In efforts to improve Region 10's performance, the PIHP Waiver Coordinator has prepared an educational presentation to be used as a resource to help inform and educate CMH staff on writing Habilitative Goals and provide an overview of the program. On average in FY2023, 31.7% of the monthly recertifications have been pended back to the CMH for corrections. Education with CMH staff will help with this moving into FY2024 and provide a greater respect and interest in the program.** **The Waivers support community integration and help individuals remain in the community by providing essential support to the beneficiaries and their families. Promoting this program is important in the success of these waivers. Further discussion has also been suggested on updating HSW advertising/outreach methods for this program at each CMH.** **Throughout FY2023, this goal was not met as there were not consistent improvements on Slot Utilization for the HSW Program. Additionally, follow-up has been needed monthly with CMH leads to discuss ensuring compliance with timely submissions for the HSW, CWP and SEDW**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			programs. Regarding training and privileging and credentialing record reviews, the PIHP did not find needed evidence for all selected staff. Performance activities will continue to be monitored in FY2024. **<u>Barrier Analysis</u>: Slot Utilization for the HSW Program decreased every month during FY2023. There have not been timely documentation submissions for Waiver cases.** **<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 CMH representatives. Additionally, continued conversations will be had with each CMH to help address the challenges they are facing with slot performance. More stringent guidelines are being added to the PIHP policy language to help CMH staff ensure compliance. Additionally Educational outreach will continue to help CMH staff learn more about the HSW Program and be more successful and confident in writing Habilitative goals. Regarding training and privileging and credentialing record reviews, the PIHP will provide more detail to CMHSPs regarding needed evidence to ensure all Professional and Aide staff meet required qualifications. The PIHP will also reevaluate the process for conducting these record reviews.**
Monitoring of Quality Areas	The goals for FY2023 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 Committee (QMC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The PIHP confirmed with membership the receipt of handouts, discussed any challenges or barriers the CMHSPs experienced reporting encounters and the FY2022 Period 3 Encounter Quality Initiative (EQI) timeline and comparison efforts.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Monitor and address Performance Bonus Incentive Pool activities and indicators. o Monitor and address changes to service codes. o Review / analysis of various regional data reports. o Review / analysis of Behavioral Health Treatment Episode Data Set (BH TEDS) reports.		**Monthly critical incident reports were reviewed. It was identified that only two CMHs have successfully reported critical incident events using the new PCE module for events occurring after October 1, 2022. Performance Bonus Incentive Pool (PBIP) activities were also discussed. The PIHP submitted the narrative on patient-centered medical home efforts.** **<u>Q 2 (Jan-Mar):</u>** **FY2022 and FY2023 Behavioral Health Treatment Episode Data Set (BH TEDS) Completion Rates were reviewed noting the FY2023 Q records are below 95%. CMHSPs are working to complete the missing Q records and working on improvement opportunities. The dangling admission report (BH TEDS admission record with no reported encounters for one year) MDHHS will send report after the completion of the SUD review which is scheduled for March 31, 2023.** **Each month, the CMHSPs report on barriers/challenges related to encounter reporting. The PIHP and CMHSPs completed comparison reviews of the FY2022 Period 3 data and submitted the reports to MDHHS February 28, 2023. The DHHS-2451A Income only determination, is pending the outcome of the statewide workgroup and how it will be applied to the various programs. The workgroup includes a Region 10 and St. Clair CMH representative. The MDHHS Employment and Modifier document was shared with Committee Members. The group discussed the change to the MDHHS Peer Recovery Coach certification which now includes a requirement for Continuing Education Units (CEU) and certification expiry date, good for two years beginning in 2023.** **The workgroup reviewed the Memo regarding Temporary Waiver of Child Mental Health Provider Qualification, the MSA bulletin 23-08 CPT/HCPC Code changes, the MSA bulletin 23-10 changes to telehealth services at the end of the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			public health emergency (PHE) which takes effect May 12, 2023 and the March 15, 2023, memo regarding Rounding Rules for Behavioral Health Services after COVID-19 Crisis. **Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. During second quarter, Lapeer CMH reported missing one Non-Suicide Death for October 2022, reported on December 20, 2022. St. Clair CMH followed up on the data exchange to the new Critical Incident module. Errors were noted with GHS' critical incidents. The committee also briefly discussed the process for remediation for critical incident reporting.** **<u>Q 3 (Apr-June):</u>** **Behavioral Health Treatment Episode Data Set (BH TEDS) Completion Rates were reviewed during the quarter, along with the changes to the Public Health Emergency end. The CMHSPs completed their annual renewal for Home Based services in the Customer Relationship Management (CRM) system where the PIHP reviewed and submitted to MDHHS for review and approval. The annual DHIP reports, and narrative were submitted to MDHHS. A Crisis coding survey was completed to assist MDHHS in aligning the reporting of the service code for Adults and Children. MDHHS is working on the Electronic Visit Verification (EVV), currently reviewing encounter companion guides.** **Critical incident numbers were reviewed by the committee. Two CMHs reported issues with reporting critical incidents. These CMHs were directed to follow up with PCE. Outside of the committee meetings, the PIHP worked with CMH contacts to address critical incident remediation required in the Customer Relationship Management (CRM) system. PIHP Quality and Data staff**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			continue to review and develop processes for critical incident reporting. **<u>Q 4 (July-Sept):</u>** **Behavioral Health Treatment Episode Data Set (BH TEDS) FY2024 Error Descriptions, Completion Rates, and upcoming training for staff were reviewed. The Q records are slightly above 95% and CMHSP should enhance their reviews of this area to ensure the Q records are submitted timely.** **There were no reported challenges/barriers for encounter reporting. The committee reviewed code chart updates. Encounter Data Integrity Team (EDIT) meeting minutes were shared along with the updated to the telemedicine database, to include the H0038 audio/visual effective 7/31/2023.** **The Electronic Visit Verification (EVV) PowerPoint presentation of authorization and claim processing was provided for CMHSP feedback. CMHSP EVV Lead contact information has been provided to MDHHS, to receive future information and meeting invites directly from MDHHS. The EVV kickoff meeting is scheduled for Thursday, August 24th.** **The Encounter Quality Initiative (EQI) data pulls, and clean-up dates were reviewed for reporting FY2023 Period 2 data. The FY2023 Period 2 timeline was reviewed, Final data pull will be Friday, September 1, 2023. CMHSP final templates are due to the PIHP Monday, September 18, 2023.** **DHHS-2415 Income Only Determination continues to pend guidance from the statewide workgroup.** **Critical incident event totals and the reporting process were reviewed. The committee briefly discussed the process for reporting critical incident events and remediation through the Customer**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Relationship Management (CRM) system. PIHP Quality and Data staff attended a technical assistance (TA) session with MDHHS. The PIHP began developing a process to collect and report remediation information for critical incident events. **<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 CMHSPs and PIHP navigated the new reporting method for critical incident data. Reports during QMC meetings toward the end of the fiscal year indicate the PIHP is in receipt of the critical incident events reported by CMHs. The PIHP will continue quality improvement efforts for critical incident data reporting, as well as for Performance Bonus Incentive Pool indicators, BH-TEDS completeness, and encounter data.** **<u>Barrier Analysis</u>: During monthly QMC meetings, the members are asked to report on any encounter reporting issues or barriers. No barriers were reported related to encounter reporting. A barrier related to critical indicator data and reporting was the change in the method for reporting incidents and implementation of the new process.** **<u>Next Steps</u>: This goal will continue in FY2024 with oversight of Service Code changes, BH TEDS, and Encounter Reporting. The PIHP will also continue oversight of critical incident data and performance bonus incentive pool activities.**
Financial Management	The goals for FY2023 Reporting are as follows to promote sound fiscal management of the region: • Evaluate CMH Direct Run service rates to MDHHS expectations. o Evaluate Independent Rate Model (IRM) report and compare rates to CMH posted rates.	Richard Carpenter Finance Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Discussion regarding this goal occurred but was tabled due to other priorities. The committee will revisit in January.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Evaluate root cause of significant variations by comparing IRM assumptions to CMH actual performance.		**<u>Q 2 (Jan-Mar):</u>** **CMHSPs have completed grids for appendix 4 & 6 to start comparisons against the Independent Rate Model (IRM). Further discussion to occur in April regarding specific observations/findings.** **<u>Q 3 (Apr-June):</u>** **During April, the committee continued to discuss variations between MDHHS/Milliman assumptions and actual costs. CMHSPs will have comparative reports available for the May meeting.** **During May, the Finance Committee reviewed the Independent Rate Model Report and Appendices 4 and 6. The committee found multiple assumptions too low. A formal recommendation will be drafted and shared with MDHHS.** **<u>Q 4 (July-Sept):</u>** **Due to Certified Community Behavioral Health Clinic (CCBHC) Cost Reports due July 1st and members absent for meetings, there was little discussion. Progress evaluation was not available.** **<u>Evaluation</u>: This goal was not entirely completed/met due to the redirected focus on the CMHs to the Certified Community Behavioral Health Clinic (CCBHC) Demonstration.** **<u>Barrier Analysis</u>: Shift in priorities with the CCBHC Demonstration Expansion.** **<u>Next Steps</u>: Move forward with a new goal focused on the CCBHC Demonstration for FY2024.**
Financial Management	The goals for FY2023 Reporting are as follows to promote sound fiscal management of the region: • Evaluate the effectiveness of Standardized Cost Allocation (SCA) implementation.	Richard Carpenter Finance Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Review FY2022 Period 1 Encounter Quality Initiative (EQI) (first report required with SCA) to verify compliance with SCA requirements. o Identify areas of inconsistency within the region that may need modification. o Identify concerns/feedback to MDHHS for areas the model could be improved.		**Discussion regarding this goal occurred but was tabled due to other priorities. The committee will revisit in January.** **<u>Q 2 (Jan-Mar):</u>** **Reviewed the latest Standardized Cost Allocation (SCA) Methodology issued by MDHHS and discussed the various changes made during the year.** **<u>Q 3 (Apr-June):</u>** **During April, the methodology changes for FY2023 were evaluated and discussed in conjunction with Period 1 Encounter Quality Initiative (EQI) due to Region 10 on May 15. Identified areas of concern/inconsistency will be discussed at our June meeting. Feedback to MDHHS is ongoing via the Standardized Cost Allocation (SCA) workgroup, which has begun to focus on the similarities and differences between SCA and CCBHC cost reporting.** **In May, the comparison was completed. Will continue discussion at next Finance Committee meeting.** **In June, the Finance Committee reviewed EQI Period 1 comparisons for all CMHSPs both direct run and contracted. Revisit in August meeting.** **<u>Q 4 (July-Sept):</u>** **Due to Certified Community Behavioral Health Clinic (CCBHC) Cost Reports due July 1st and members absent for meetings, there was little discussion. Progress evaluation was not available.** **<u>Evaluation</u>: This goal was not entirely completed/met due to the redirected focus on the CMHs to the Certified Community Behavioral Health Clinic (CCBHC) Demonstration.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: Shift in priorities with the CCBHC Demonstration Expansion. **<u>Next Steps</u>: Move forward with a new goal focused on the CCBHC Demonstration for FY2024.**
Utilization Management	The goals for FY2023 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. o Monitor and advise on Peter Chang Enterprises (PCE)-based crisis service utilization reports (monthly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Monthly reports were presented, with each CMH representative discussing their findings and trends. No concerning trends were identified.** **<u>Q 2 (Jan-Mar):</u>** **Monthly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified. Youth crisis stabilization services utilization is marginally increased, which is a continued favorable trend away from underutilization.** **<u>Q 3 (Apr-June):</u>** **Monthly crisis reports were reviewed with no concerning trends identified.** **<u>Q 4 (July-Sept):</u>** **Monthly reports were received and reviewed, with CMH representatives identifying no service systems issues.** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year (FY). Ongoing discussion of youth crisis stabilization services was reported as helpful to keep local efforts focused on addressing potential underutilization. This goal is ongoing, as it applies year to year, and so should be continued.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue this goal for FY2024.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Utilization Management	The goals for FY2023 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement. o Monitor and advise on BTPRC data spreadsheet reports: Evaluate reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Quarterly reports were presented, with each CMH representative discussing their findings and trends. No concerning trends were identified.** **<u>Q 2 (Jan-Mar):</u>** **Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified.** **<u>Q 3 (Apr-June):</u>** **Quarterly reports were reviewed with no concerning trends identified.** **<u>Q 4 (July-Sept):</u>** **Quarterly reports were received and reviewed, with CMH representatives identifying no service systems issues.** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year (FY). Committee discussions provided helpful information and support to the selection of Behavioral Health Treatment (BHT) / Applied Behavior Analysis (ABA) services for the Clinical Practice Guidelines FY2023 Annual Evaluation Report. This goal is ongoing, as it applies year to year, and so should be continued.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue this goal for FY2024.**
Utilization Management	The goals for FY2023 Reporting are as follows: • Ensure regional Utilization Review (UR). o PIHP UM Department to conduct UR: ▪ UR on SUD network provider programs (annually)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The SUD Utilization Review (UR) FY2022 Annual Report was reviewed and approved. The 4Q/End of FY2022 CMH Annual Reports (OASIS, GHS) were**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ 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).		**reviewed and approved. First quarter CMH OASIS UR activities were cancelled due to Utilization Management (UM) staffing shortages, although the case-finding outlier reports were reviewed. The delegated (GHS) UR report/activities were reviewed and, with the exception of trending underutilization in youth mobile crisis response services, no service utilization concerns were identified. Committee discussion focused on a range of appropriate responses to consider addressing underutilization trends in youth mobile crisis response services.** **<u>Q 2 (Jan-Mar):</u>** **January:** **No activities at the January meeting. Activities as noted on the annual plan will be initiated late 2Q.** **<u>Q 3 (Apr-June):</u>** **Quarterly CMHSP Utilization Review (UR) reports were completed and reviewed, with service utilization and systems recommendations discussed. Annual SUD UR activities are underway as per the annual review schedule.** **<u>Q 4 (July-Sept):</u>** **SUD utilization review (UR) is underway as scheduled, with the annual report to be completed and reviewed by the end of September. UR activities include the addition of concurrent UR, as directed last year by the Quality Improvement Committee (QIC). Quarterly CMH UR (OASIS, CHIP) is scheduled for September reporting. Quarterly reports to-date have identified broad compliance to medical necessity criteria, with the few service utilization outliers having been addressed.** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year. This goal is ongoing, as it applies year to year, and so should be continued.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: No barriers were encountered, except for downsized OASIS UR activities during 1Q and 4Q due to staffing transitions in data management and in UM/UR staffing shortages. **<u>Next Steps</u>: Continue this goal for FY2024.**
Utilization Management	The goals for FY2023 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 Complete implementation of the MDHHS 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 MDHHS Parity Compliance Workgroup	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Monthly Workgroup and Sub-Workgroup meetings continue, with finalization work in process in the PCE Development Mode. OASIS design issues have been encountered and work continues with the PCE Project Manager to resolve these issues, in order prepare for Utilization Management (UM) Redesign launch during early FY2023.** **<u>Q 2 (Jan-Mar):</u>** **OASIS Users Work Group members have begun working in the OASIS and MIX Demo Mode. The Parity Work Group met in February and addressed the following issues:** **MDHHS review tool update – Launch pending** **Level of Care Utilization System (LOCUS) follow up discussion per review of the Milliman Care Guidelines (MCG) 27th edition Guidelines.** **Inter-Rater Reliability (IRR) subgroup – This subgroup will be formed to work on Michigan-based IRR vignettes. Detroit Wayne Integrated Health Network (DWIHN) will share examples at the next meeting.** **Mid-State Health Network (MSHN) appeal – Contesting score-based level of care (LOC) determinations.** **Utilization Management (UM) PIHP group – This subgroup will be formed as a share and learn entity and to help inform Phase II implementation.** **Region 10 IRR activities began in March.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Q 3 (Apr-June):</u> **Monthly meetings continue with the OASIS Users Workgroup and Sub Workgroup. The service authorization grids have been updated in preparation for the Utilization Management (UM) Redesign launch. The MIX/OASIS demo mode activities remain in-process. The Milliman Care Guidelines (MCG) Inter-Rater Reliability (IRR) activities were reviewed. The quarterly Parity Workgroup Meeting Notes were reviewed, noting the phase out of this workgroup, to be replaced by the new UM Directors' workgroup.** **<u>Q 4 (July-Sept)</u>** **Final work is underway for the OASIS redesign. Service authorization grids have been updated and the annual/initial service authorization menus are finalized. Work continues on the implementation of the Centralized Utilization Management (UM) System (UM Redesign Project), as addressed through the OASIS Users Workgroup and Sub-Workgroup. Phase I of the MDHHS Parity Compliance Plan has been completed, and accordingly the Parity Compliance Workgroup has been dissolved and its Phase 2 activities have been assigned to the new UM Directors Group.** **<u>Evaluation</u>: These activities should be forwarded into FY2024.** **<u>Barrier Analysis</u>: Delays were encountered in the redesign activities assigned to the OASIS users.** **<u>Next Steps</u>: Continue into FY2024.**
Utilization Management	The goals for FY2023 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:** **<u>Q 1 (Oct-Dec)</u>:** **The End of Fiscal Year Report was presented and approved, with UM Committee representatives sharing local input and support for Access**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			operations. No concerning trends were identified, and end of year findings will inform FY2023 centralization of the Access Management System. **<u>Q 2 (Jan-Mar):</u>** **Mid-Year report scheduled for completion by late May.** **<u>Q 3 (Apr-June):</u>** **The semi-annual Access Management System (AMS) Report was reviewed, and discussion ensued regarding progress to-date on centralized Access.** **<u>Q 4 (July-Sept):</u>** **The Access Management System (AMS) Semi-Annual Mid-Year Evaluation Report has been completed, and the End of Year (EOY) Report is scheduled for completion by the end of October. Mid-Year report findings and recommendations were received by the Quality Improvement Committee (QIC).** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year, as noted in the semi-annual reports. This goal is ongoing, as it applies year to year, and so should be continued.** **<u>Barrier Analysis</u>: No barriers were encountered, but transition challenges to centralized operations were encountered and addressed during the fiscal year, in part complicated by additional transition challenges with contract providers for after-hours crisis/referral services and the replacement of the phone service provider.** **<u>Next Steps</u>: Continue this goal for FY2024.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Utilization Management	The goals for FY2023 Reporting are as follows: o Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Quarterly reports were presented, with each CMH representative discussing their findings and trends. No concerning trends were identified.** **<u>Q 2 (Jan-Mar):</u>** **Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified.** **<u>Q 3 (Apr-June):</u>** **Quarterly reports were reviewed, with all CMHSPs actively pursuing customer involvement and community wellness activities. No concerns were identified.** **<u>Q 4 (July-Sept):</u>** **Quarterly reports indicate a wide range of community engagement and education activities. CMHs cite increasing numbers of persons and community agencies engaged.** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year. This goal is ongoing, as it applies year to year, and so should be continued.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue this goal for FY2024.**
Utilization Management	The goals for FY2023 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:** **<u>Q 1 (Oct-Dec)</u>:** **Quarterly reports were presented, with each CMH representative discussing their findings and trends. No concerning trends were identified.** **<u>Q 2 (Jan-Mar):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified. **<u>Q 3 (Apr-June):</u>** **The quarterly Adverse Benefit Determination (ABD) reports were reviewed and the PIHP administrative technical support staff for ABD reporting led discussion on aligned reporting and format updates and expectations.** **<u>Q 4 (July-Sept):</u>** **Quarterly reports indicate a similar range of Adverse Benefit Determination (ABD) events and activities across CMHSPs, with no significant issues identified. That said, committee efforts continue to ensure aligned report formats and report analysis. CMHSPs have been encouraged to report on their ABD data tracking and trending practices, which have also been discussed in connection with the phase-in ABD system that will be part of the Centralized UM Redesign implementation for FY2024.** **<u>Evaluation</u>: This goal has been met per its completed activities during this fiscal year. This goal is ongoing, as it applies year by year. Also, it should be continued in terms of its eventual transition into the ABD system phase-in with Centralized UM Redesign.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue this goal for FY2024.**
Corporate Compliance	The goals for FY2023 Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements o Identify and document responsible entities o Identify and document supporting evidence / practice	Katie Forbes Corporate Compliance Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The FY2023 PIHP Corporate Compliance Program Plan was posted on the PIHP website which was also**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Policy review o Review PIHP Corporate Compliance Plan updates		**discussed with the Corporate Compliance Committee.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP Corporate Compliance Committee discussed goal objectives and will be prepared to discuss program integrity requirements during FY2023 Q3.** **<u>Q 3 (Apr-June):</u>** **The PIHP Corporate Compliance Committee reviewed and approved the FY2024 Corporate Compliance Program Plan.** **Additionally, the committee reviewed and discussed recent contractual language changes in the area of program integrity.** **<u>Q 4 (July-Sept):</u>** **The FY2024 PIHP Corporate Compliance Program Plan was presented to the PIHP Board and approved.** **<u>Evaluation</u>: The Corporate Compliance Committee reviewed and discussed Program Integrity Requirements, discussed responsible entities, and approved the FY2024 PIHP Corporate Compliance Program Plan. This goal is considered met. The development of the FY2024 Corporate Compliance Program Plan will improve the quality of health care and services for members by acting as an internal control to deter fraudulent activities. Similarly to previous fiscal years, this goal has been met through the efforts to focus on Program Integrity Reporting requirements and develop an annual PIHP Corporate Compliance Program Plan.** **<u>Barrier Analysis</u>: No barriers.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps</u>: This goal is considered met. However, this goal will continue into FY2024 to continue ongoing review and education in the area of Program Integrity.
Corporate Compliance	The goals for FY2023 Reporting are as follows: • Support reporting requirements (quarterly and ongoing) as defined by MDHHS, Office of Inspector General (OIG), PIHP, etc. o Review of reporting process o Implementation of revised Program Integrity Report Template	Katie Forbes Corporate Compliance Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The PIHP submitted the FY2022 Q4 Program Integrity Report, Annual Contracted Entities Report, and the Program Integrity Attestation to the Office of Inspector General (OIG).** **The PIHP also received and distributed a revised OIG Program Integrity Report Template to the PIHP Network for FY2023 Q1 reporting onward. The new template has minor changes including the removal of overpayments as an activity type.** **PIHP Corporate Compliance staff met with PIHP internal staff to communicate feedback received on the FY2022 Q4 Program Integrity Report submission to the OIG as an effort to prepare for the OIG moving to a corrective action plan (CAP) model for FY2023 Q3 reporting onward. Discussed quarterly meetings with internal staff for enhancements in the area of program integrity reporting.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP submitted the FY2023 Q1 Program Integrity Report to the Office of Inspector General (OIG). The PIHP also submitted the Managed Care Program Annual Report (MCPAR) as a new reporting requirement. This report included reporting in the area of Program Integrity.** **Additionally, the Corporate Compliance Committee discussed OIG report grading changes including a Corrective Action Plan (CAP) following the first submission.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Q 3 (Apr-June):</u> **The PIHP submitted the FY2023 Q2 Program Integrity Report to the Office of Inspector General (OIG).** **Additionally, the PIHP attended a training facilitated by the OIG on the topic of program integrity reporting. The revised guidance was distributed to the PIHP Provider Network and was discussed in the May Corporate Compliance Committee meeting.** **The PIHP also attended the Biannual OIG meeting which included information on reporting requirements.** **Furthermore, the PIHP Compliance Team reviewed recent contract amendments related to fraud referral reporting and are in the process of updating internal policies and procedures.** **<u>Q 4 (July-Sept):</u>** **The PIHP submitted the FY2023 Q3 Program Integrity Report to the Office of Inspector General (OIG). Additionally, the Corporate Compliance Committee discussed OIG review and allowance of one (1) Program Integrity Report submission prior to issuing a Corrective Action Plan to the PIHP. Emphasized importance of accuracy of Program Integrity Reporting.** **<u>Evaluation</u>: The Corporate Compliance Committee reviewed the reporting process for Office of Inspector General (OIG) reporting including the Program Integrity Report. The PIHP worked with the committee and implemented the revised Program Integrity Report for FY2023 reporting. This goal did improve the quality of health care and services for members and reporting requirements**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			including OIG reporting oversee Program Integrity to deter any inappropriate or fraudulent acts. **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: This goal is considered met. However, this goal will be carried into FY2024 as reporting requirements are fluid with change and continuous efforts in the area of reporting is necessary.**
Corporate Compliance	The goals for FY2023 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	Katie Forbes Corporate Compliance Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **PIHP Compliance Subject Matter (SME) completed the MDHHS Consent to Share Behavioral Health Information record reviews as part of FY2022 Annual Contract Monitoring.** **The PIHP identified SMEs in the area of Corporate Compliance for the FY2023 Contract Monitoring cycle.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP Compliance Subject Matter Expert completed the record reviews for the MDHHS (5515) Consent to Share Behavioral Health Information Form as part of FY2022 Annual Contract Monitoring. Results were provided to the Network by PIHP Provider Network Management staff.** **The Corporate Compliance Committee discussed the upcoming FY2023 Annual Contract Monitoring Review including the MDHHS (5515) Consent to Share Behavioral Health Information Form record reviews. Additionally, discussions were initiated in the February committee meeting to be prepared to discuss current CMH Subnetwork contract Monitoring processes and content.** **<u>Q 3 (Apr-June):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP Compliance Subject Matter Expert attended on-site visits for the four (4) CMH Providers. Additionally, record reviews were completed on the MDHHS (5515) Consent to Share Behavioral Health Information Form for both the CMH and SUD Treatment Networks as part of FY2023 Annual Contract Monitoring. **The PIHP Corporate Compliance Committee discussed the current FY2023 Annual Contract Monitoring cycle including record reviews in the area of corporate compliance. The committee also discussed different practices for monitoring subcontract providers. An agenda item has been added to continue these discussions during the August committee meeting.** **Q 4 (July-Sept):** **The PIHP Compliance Subject Matter Expert completed the FY2023 Annual Contract Monitoring Review Tools and developed plan of corrections in any area(s) that were identified as not met.** **Evaluation: The FY2023 Annual Contract Monitoring Cycle was successfully completed. By completing contract monitoring, the PIHP and Network reviewed and enhanced internal policies and procedures that directly impact an enrollee in the area of Corporate Compliance. This ultimately improves the quality of health care including deterring fraudulent acts and supporting the highest quality of service for the individuals served. This goal is considered met.** **Barrier Analysis: No barriers.** **Next Steps: This goal is considered met. However, this goal will continue into FY2024 as review of Corporate Compliance contract monitoring standards and performance are recommended.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Provider Network	The goals for FY2023 Reporting are as follows: • Address service capacity concerns and ensure resolution of identified gaps in the network based on Gap Analysis Reports. o Review CMH Gap Analysis Reports. o Review SUD Network gaps and capacity concerns. o Review CMH capacity concerns identified	Stephanie Willis-Ritland Provider Network Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **All materials required regarding the Sanilac SUD Outpatient Contract have been obtained and services began November 1st. Services successfully continue. Provider Network Management continues work identifying the challenges of Opioid Treatment Program (OTP) services in the Port Huron area and SUD Adolescent Residential Services throughout the entire network.** **<u>Q 2 (Jan-Mar):</u>** **Outreach has been made to Community Programs (CPI) / Meridian regarding previous PIHP Request for Proposal (RFP) award for Opioid Treatment Program (OTP) site in Port Huron location. Outreach has been made to Arbor Recovery for additional OTP site opportunities. Sanilac County Recovery Housing contract in place and services expected to start in June of this year. Given MDHHS recent guidance on Supports Intensity Scale (SIS) assessments, a gap was identified in Genesee County for SIS Assessors. GHS continues to experience time delays in Autism Services as described in monthly GHS Service Capacity Reporting. Outreach continues in SUD Network on efforts for service expansion (PIHP requested ARPA SUD Grant funds in areas regarding Recovery Housing, Recovery Supports (Peer Recovery Coaches), and Prevention. Work continues to expand the LIST Psychological Services Agreement (e.g., location expansion) as well as transition to full SUD Treatment Service Provider. Contract issued with local Provider (BWROC) to address transportation barriers for SUD services. PIHP issuance of corrective action plan and request for remediation to GHS regarding SIS Assessor service gap.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **The Network Adequacy Report was submitted timely on May 30th. Input was received from providers, the Access Department, the SUD Department, the Quality Department and the Data Department.** **Q 4 (July-Sept):** **The Provider Network Management Department continues to monitor the Provider Network to ensure adequate capacity. The gap analysis report as a separate report is no longer required and instead the information is tracked through the Network Adequacy reporting.** **Evaluation: There are ongoing discussions on a weekly basis between Provider Network Management, the PIHP Finance Department and the SUD Department to monitor Network Adequacy. MDHHS has scheduled a meeting to further discuss the Network Adequacy process with Region 10, in preparation for the MDHHS standard template that will be used for the Annual Network Adequacy Report for FY2023. Region 10 continues to identify areas that need additional support and improves the Provider Network on an ongoing basis in order to improve the quality of health care and services for members. This goal is met, and the gap analysis report is no longer required as a standalone report and Region 10 will continue monitor the network adequacy through the annual Network Adequacy Report. This goal will not carry forward into FY2024.** **Barrier Analysis: None identified.** **Next Steps: The gap analysis report is no longer required as a standalone report. The adequacy of the Region 10 Provider Network will be monitored internally on an ongoing basis and will be reported**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			annually using the MDHHS Network Adequacy Report template anticipated for use for FY2024.
Provider Network	The goals for FY2023 Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards. o Review MDHHS standards and current Network Adequacy. o Address Network Adequacy concerns.	Stephanie Willis-Ritland Provider Network Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The Provider Network Management (PNM) Team met again in December regarding Network Adequacy.** **The drafted overview and general timeline documents of Network Adequacy requirements has been created and is currently being reviewed by all PNM Team members for to continue outlining areas where compliance will need to be maintained.** **The PNM Team has reviewed The PIHP's FY2022 Network Adequacy Plan for potential FY2023 updates including but not limited to SUD ASAM Level of Care additions and preparation activities continued regarding FY2023 Network Certification Reporting requirements.** **An additional meeting is currently being scheduled for the PNM team in January 2023 to review all materials and all contract language has been reviewed for Network Adequacy requirements and due dates. CMHSPs were notified at the December PNC meeting of the upcoming FY2023 Network Certification report due in February.** **<u>Q 2 (Jan-Mar):</u>** **FY2023 Network Adequacy Plan review ongoing. Continuing to review MDHHS Network Adequacy requirements (e.g., ASAM LOC designations) as well as FY2024 SUD Strategic Planning MDHHS requirements. SUD service gaps identified to include access to MAT services, Recovery Housing services (Lapeer County). The FY2023 PIHP Network Adequacy Certification Report is drafted.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **The Network Adequacy Report was submitted timely on May 30th. Input was received from providers, the Access Department, the SUD Department, the Quality Department and the Data Department.** **Q 4 (July-Sept):** **The Provider Network Management Department continues to monitor the Provider Network to ensure adequate capacity.** **Evaluation: There are ongoing discussions on a weekly basis between Provider Network Management, the PIHP Finance Department and the SUD Department to monitor Network Adequacy. MDHHS has scheduled a meeting to further discuss the Network Adequacy process with Region 10, in preparation for the MDHHS standard template that will be used for the Annual Network Adequacy Report for FY2023 reporting. Region 10 continues to identify areas that need additional support and improves the Provider Network on an ongoing basis in order to improve the quality of health care and services for members. This goal is met, but will continue into FY2024 as part of the ongoing maintenance of the Region 10 Provider Network.** **Barrier Analysis: Challenges have been identified by providers in the area of adequate staffing.** **Next Steps: Region 10 continues to work with providers to identify areas where additional support can be provided. Region 10 will continue to monitor the provider network and will seek to solicit additional providers to fill in any service area deficiencies as identified.**

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

Provider Network	The goals for FY2023 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
		Stephanie Willis-Ritland
		
		Provider Network Committee
			Quarterly Update:
			
			<u>Q 1 (Oct-Dec)</u>:
			Planning for the FY2023 Contract Monitoring Kickoff has taken place and is currently being worked on. Progress continues on FY2023 Contract Monitoring Recommendations, and all folders, files and documents have been set up and prepared for the upcoming Monitoring Cycle.
			
			The FY2023 Subject Matter Expert Lists have been sent to department leads for recommendations and the FY2023 Contract Monitoring Annual Tool Templates have been drafted and prepared to be distributed to the SMEs for the Tool Template Review.
			
			FY2023 Contract Monitoring Task Lists have been updated for CMH & SUD and the PNM Team Calendar has been prepared for the upcoming Contract Monitoring Cycle.
			
			<u>Q 2 (Jan-Mar):</u>
			FY2023 PIHP Contract Monitoring Subject Matter Experts identified, and Monitoring Tools drafted. FY2023 Contract Monitoring Evaluation planning continues. Feedback from PIHP Subject Matter Experts ongoing.
			
			<u>Q 3 (Apr-June):</u>
			The Provider Network Management (PNM) Department has completed the on-site visit portion of the FY2023 Contract Monitoring. We are working on finalizing the tools from the visits and will develop and share the plans of correction. The aggregate report will be completed when the data has been finalized.
			
			<u>Q 4 (July-Sept):</u>

<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>The Provider Network Department has finalized all of the contract monitoring tools for FY2023. The Plans of Correction (POCs) have been drafted and all of the information has been aggregated into the Provider Annual Reports and the PIHP Final Report.

<u>Evaluation:</u> The Provider Network Department will continue to work together with the Subject Matter Experts to ensure that deficiencies are thoroughly addressed through the POC process in order to continue to improve the quality of health care and services for members.

<u>Barrier Analysis</u>: None identified.

<u>Next Steps</u>: This goal is considered met for FY2023, and this goal will continue into FY2024. The Provider Network Department has solicited input from the Subject Matter Experts and our providers to identify opportunities for improvement in the contract monitoring process and will work to enhance the process on an ongoing basis.</td></tr>
<tr><td>Customer Service Inquiries</td><td>The goals for FY2023 Reporting are as follows:
To review and analyze baseline customer service inquiry data for the region for FY2023.
To track and trend internally the customer service inquiries on a quarterly basis.
Identify consistent patterns related to member customer service inquiries.
Develop interventions to address critical issues within the organization.
<table><tr><th colspan="8">Reporting Period: FY 2023</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>11</td><td>12</td><td>15</td><td>11</td><td>6</td><td>N/R</td><td>55</td></tr><tr><td>Lapeer</td><td>0</td><td>0</td><td>2</td><td>0</td><td>1</td><td>N/R</td><td>3</td></tr></table></td><td>Katie Forbes

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

<u>Q 1 (Oct-Dec)</u>:
There was a total of nineteen (19) customer service inquiries in Q1 which was a decrease from FY2022 Q1 which had thirty-two (32).

Top Inquiry Dispositions:
Seven (7) of the inquiries were closed due to being unable to reach the consumer for follow up.
Five (5) of the inquiries resulted in a referral to a provider within the PIHP Network.
Three (3) of the inquiries resulted in a referral to PIHP Access for a new screening.</td></tr>
</table>

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

PIHP	0	0	2	0	0	N/R	2
Sanilac	1	2	0	0	1	N/R	4
St. Clair	3	1	4	5	2	N/R	15
SUD	4	7	4	0	3	N/R	18
TOTAL	19	22	27	16	13	N/R	97

Inquiry Resolution Categories:	**Total**
Appeal	18
Grievance	9
Referral to Access	13
Rights Complaint	0
Referral to Provider	36
Other	13
Pending	2
Unable to reach	7

Q 2 (Jan-Mar):
The PIHP had 22 customer service inquiries in Q2, which is a slight increase from Q1 which had 19.

Through FY2023 Q2 Top Inquiry Resolution Categories:

- **Seven (7) of the inquiries resulted in appeals.**
- **Six (6) of the inquiries were referred to the provider within the PIHP Network.**
- **Three (3) of the inquiries were closed due to being unable to reach the consumer for follow-up.**
- **Three (3) of the inquiries were listed in the other category.**

Q 3 (Apr-June):
There was a total of 27 customer service inquiries in Q3 which is a decrease from FY2022 Q3 which had 31.

Top resolution categories:
11 (40%) resulted in a referral to a Provider.
5 (18%) resulted in an appeal being opened.
4 (14%) resulted in a grievance being opened.

Q 4 (July-Sept):
There was a total of 29 customer service inquiries thus far for FY2023 Q4. This is an increase from FY2022 Q4 which had 20.

Note: FY2023 customer service inquiry data includes July and August of 2023.

Top Resolution categories:
12 (41%) resulted in a referral to a Provider.
8 (28%) resulted in a referral to Access.
4 (14%) resulted in an appeal.

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation</u>: The PIHP tracked customer service inquiry data and reviewed for any trends throughout the fiscal year. Through customer service inquiries, the PIHP has improved the quality of care and services for members by supporting the needs of the individuals we serve, including offering available options (e.g., opening an appeal). The PIHP did identify that customer service inquiries did not have any resolutions that resulted in a recipient rights complaint. Additionally, the top resolution category was referral to a Provider which indicates that the enrollee was quickly linked back the their Provider for services/supports. **<u>Barrier Analysis</u>: No barriers.** **<u>Next Steps</u>: This goal is considered met. However, it is recommended to renew this goal for FY2024 in order to continue to track customer service inquiry data and identify trends. Additionally, interventions will be implemented if critical issues are identified.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Appeals</td>
<td>The goals for FY2023 Reporting are as follows:

To review and analyze baseline appeals data for the region for FY2023.

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

<table>
<tr><th colspan="8">Reporting Period: FY 2023</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>1</td><td>6</td><td>4</td><td>2</td><td>3</td><td></td><td>17</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td>SUD</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td>TOTAL</td><td>1</td><td>8</td><td>4</td><td>2</td><td>3</td><td></td><td>19</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Grievance not resolved within 90 days</td><td>0</td></tr>
<tr><td colspan="7">Grievance not resolved within allowed days</td><td>0</td></tr>
<tr><td colspan="7">Request not acted on within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Denial</td><td>7</td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Reduction</td><td>3</td></tr>
<tr><td colspan="7">Service Suspension</td><td>1</td></tr>
<tr><td colspan="7">Service Termination</td><td>8</td></tr>
</table>
</td>
<td>Katie Forbes

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

<u>Q 1 (Oct-Dec)</u>:
There was one (1) appeal in Q1 which was a decrease from FY2022 Q1 which had six (6). The one (1) appeal was related to a service denial.

<u>Q 2 (Jan-Mar):</u>
The PIHP had eight (8) appeals in Q2, which is an increase from Q1 which had one (1) appeal.

<u>Trends</u>
Of the eight (8) appeals, four (4) were for service denial and four (4) were for service termination.

<u>Q 3 (Apr-June):</u>
There was a total of 4 appeals in Q3 which is a decrease from FY2022 Q3 which had 7.

Top reasons for the appeal:
1 (25%) were for a service termination.
1 (25%) was for a service suspension.
1 (25%) was for a service reduction.
1 (25%) was for a service denial.

Appeal Outcomes:
1 (25%) were denied which means the PIHP agrees with the Adverse Benefit Determination (ABD) Notice.
1 (25%) was approved which means the PIHP disagreed with the ABD and reinstated services.
1 (25%) was withdrawn by the enrollee.
1 (25%) is still in process and not fully resolved yet.

<u>Q 4 (July-Sept):</u>
There was a total of four (5) appeals thus far for FY2023 Q4. This is a decrease from FY2022 Q4 which had eight (8).</td>
</tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Note: FY2023 appeal data includes July and August of 2023. **Top reason for the appeal:** **2 (40%) were for service reduction.** **2(40%) were for service termination.** **1 (20%) were for service denial.** **Appeal outcomes** **2 (40%) were denied which means the PIHP agrees with the Adverse Benefit Determination (ABD) Notice.** **2 (40%) are still in process and not fully resolved yet.** **1 (20%) was withdrawn.** **<u>Evaluation</u>: The PIHP tracked appeal data and reviewed any trends throughout the fiscal year. Through the resolution of appeals, the PIHP has improved the quality of care and services for members by supporting the needs of the individuals we serve including reinstating services that are deemed to be medically necessary.** **<u>Barrier Analysis</u>: No barriers.** **<u>Next Steps</u>: This goal is considered met. However, it is recommended to renew this goal for FY2024 in order to continue to track appeals data and identify trends. Additionally, interventions will be implemented if critical issues are identified.**
Grievances	The goals for FY2023 Reporting are as follows: • To review and analyze baseline grievance data for the region for FY2023. o To track and trend internally the grievances on a quarterly basis. o Identify consistent patterns related to grievances.	Katie Forbes PIHP Customer Service Department	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Thus far, there has been one (1) grievance in Q1. The PIHP will not receive grievance data from the CMH Network until January 15th. This quarterly update with be provided in the February Quality Improvement Committee with all of the data received.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Develop interventions to address critical issues within the organization.		**Q 2 (Jan-Mar):** **Thus far, there have been three (3) 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.** **Q 3 (Apr-June):** **Thus far the PIHP has received 3 grievances. The PIHP will receive CMH grievance data in July and will complete a quarterly report tracking and analyzing trends in the August QIC meeting.** **Q 4 (July-Sept):** **The PIHP received FY2023 Q3 grievance data from CMH Network Providers. In Q3, there was a total of thirty-six (36) grievances which is an increase from FY2022 Q3 which had twenty-three (23).** **Thus far in FY2023 August the PIHP has received zero (0) grievances. The CMH Providers will report their Q4 grievance data in October.** **Note: FY2023 appeal data includes July and August of 2023 and excludes CMH grievance data.** **Evaluation: The PIHP tracked grievance data and reviewed any trends throughout the fiscal year. Through the resolution of grievances, the PIHP has improved the quality of care and services for members by supporting the needs of the individuals we serve including addressing identified concerns with Network Providers and the delivery of services. Additionally, the PIHP met with each CMH Provider to discuss internal procedures for the receipt and completion of grievances to ensure that contractual requirements are followed.** **Barrier Analysis: There are no identified barriers.**

Reporting Period: FY 2023

	Q1	Q2	Q3	Q4			Total
				Jul	Aug	Sep	
GHS	31	53	33	N/R	N/R	N/R	117
Lapeer	0	0	0	N/R	N/R	N/R	0
PIHP	0	1	0	0	N/R	N/R	1
Sanilac	0	0	0	N/R	N/R	N/R	0
St. Clair	0	0	0	N/R	N/R	N/R	0
SUD	1	1	3	0	1	N/R	6
TOTAL	32	55	36	N/R	N/R	N/R	124

Reason for Grievance:	Total
Financial Matters	1
Quality of Care	90
Service Concerns / Availability	17
Service Environment	4
Suggestions / Recommendations	5
Other	7

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps</u>: This goal is considered met. However, it is recommended to renew this goal for FY2024 in order to continue to track grievance data and identify trends. Additionally, interventions will be implemented if critical issues are identified. The PIHP will also continue ongoing discuss with the CMH Network to ensure that contractual requirements for the receipt and completion of grievances is being followed.
Credentialing / Privileging	The goals for FY2023 Reporting are as follows: • Complete Privileging and Credentialing reviews and / or approval process of Organizational Applications for CMH and SUD Providers. o Review all Organizational Applications: ▪ Current Providers ▪ New Providers ▪ Existing Provider Renewals / Updates ▪ Provider Terminations / Suspensions / Probationary Status ▪ Provider Adverse Credentialing Determinations	Stephanie Willis-Ritland Privileging and Credentialing Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The Privileging and Credentialing Committee reviewed additional locations for Great Lakes Recovery Mission, List Psychological Services, and New Paths. This was discussion only.** **<u>Q 2 (Jan-Mar):</u>** **There were no Organizational Applications to review in January and February. There were five (5) applications for re-credentialing in March, all of which were approved.** **<u>Q3 (Apr-June):</u>** **The Privileging and Credentialing (P&C) Committee reviewed Arbor Recovery as a new provider during the April Committee meeting. There were several questions regarding the application and it was tabled until next month's meeting. The P&C Committee also reviewed and approved an application from Salvation Army Harbor Light Macomb.** **The P&C Committee re-reviewed Arbor Recovery and approved their application during the May P&C Committee Meeting.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The P&C Committee has sent out reminder memorandum to several organizations that have credentials expiring in August and September. **<u>Q 4 (July-Sept):</u>** **The Privileging and Credentialing Committee meets to review Organizational Applications on an ongoing basis as needed.** **<u>Evaluation:</u> The Organizational Application was reviewed by the Committee and a training PowerPoint was created and posted on the Region 10 website to support our providers. When the application review/update was completed, the Committee began to review the Privileging and Credentialing Policy and as soon as the review and update is completed the updated policy will be posted on the Region 10 website. The Privileging and Credentialing process improves the quality of health care and services for our members by ensuring highly qualified providers are approved to provide services for our members. This goal is considered met for FY2023.** **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: The privileging and credentialing process is ongoing and this goal will continue into FY2024.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Credentialing / Privileging	The goals for FY2023 Reporting are as follows: • Complete Privileging and Credentialing reviews and / or approval process of all applicable Region 10 staff. o Review all Individual Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, Access Clinicians [leased staff and direct hires]): ▪ Current Practitioners ▪ New Practitioners ▪ Existing Practitioner Renewals / Updates ▪ Practitioner Terminations / Suspensions / Probationary Status ▪ Practitioner Adverse Credentialing Determinations	Stephanie Willis-Ritland Privileging and Credentialing Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The Privileging and Credentialing Committee approved full privileges for two (2) Access Clinicians.** **<u>Q 2 (Jan-Mar):</u>** **In January the PIHP Privileging and Credentialing (P&C) Committee reviewed and approved two (2) PIHP Access Clinicians for full privileges. In February the P&C Committee approved full privileges for one (1) Peer Recovery Coach. There were no applications for PIHP staff in March.** **<u>Q 3 (Apr-June):</u>** **There were no individual practitioner applications for Access Staff during the month of April.** **There were no individual practitioner applications for Access staff during the month of May.** **The Privileging and Credentialing (P&C) Committee has sent out reminder memorandum to several Access staff who have credentials expiring in August and September.** **<u>Q 4 (July-Sept):</u>** **The Privileging and Credentialing Committee meets to review Region 10 staff applications on an ongoing basis as needed.** **<u>Evaluation:</u> The Practitioner Application was reviewed and updated by the Committee and a training PowerPoint was created and posted on the Region 10 website to support our practitioners. When the application review/update was completed, the Committee began to review the Privileging and Credentialing Policy and as soon as the review and update is completed the updated policy will be**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			posted on the Region 10 website. The Privileging and Credentialing process improves the quality of health care and services for our members by ensuring highly qualified practitioners are approved to provide services for our members. This goal is considered met for FY2023. **<u>Barrier Analysis</u>: No barriers identified.** **<u>Next Steps</u>: The privileging and credentialing process is ongoing and this goal will continue into FY2024.**
Credentialing / Privileging	The goals for FY2023 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. o Review policy content. ▪ Review for alignment between policy and applications ▪ Revise and clarify language where needed	Stephanie Willis-Ritland Privileging and Credentialing Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The Privileging and Credentialing (P&C) Committee discussed questions that were received from a Network Provider related to policies and procedures for the P&C process. The Committee developed recommendations for a response to the Provider. A meeting was facilitated with the provider to discuss questions and responses.** **PIHP Provider Network staff met to discuss future enhancements to the P&C process including the receipt, tracking, and approval process for P&C applications. The P&C Committee discussed upcoming efforts in the P&C process. Additionally, review of Health Services Advisory Group (HSAG) corrective action plans were reviewed and will be implemented in the area of privileging and credentialing.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP attended several MDHHS Demonstrations on a Universal Credentialing Process that will be implemented in FY2023. The PIHP has formed a Privileging and Credentialing (P&C) Workgroup and has developed a project planning document. The workgroup meets weekly**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			and has completed the review of the P&C individual provider application and has requested input from the providers on the recommended changed. The group is currently working on the review/update of the P&C organizational application and the guidance documents. **<u>Q 3 (Apr-June):</u>** **The Privileging and Credentialing (P&C) workgroup completed its review of the organizational and provider P&C applications. The revised provider application was sent to providers for review and input. No substantive feedback was provided by the providers, however, it was noted that training is needed as there was some confusion identified based on the feedback. There were no recommended revisions based on the review of the organizational application. The policy review is ongoing and instruction and guidance documents were reviewed and updated as needed.** **The P&C Committee reviewed and approved the training PowerPoint that was created to support the updated application. The training was emailed to providers and posted on the Region 10 webpage.** **<u>Q 4 (July-Sept):</u>** **The Privileging and Credentialing Committee meets to review Organizational Applications on an ongoing basis as needed.** **<u>Evaluation:</u> The Privileging and Credentialing Applications were reviewed and updated by the Committee and a training PowerPoint was created and posted on the Region 10 website to support our providers. Region 10 has a comprehensive Privileging and Credentialing Policy that is currently being reviewed and updated. The Privileging and Credentialing Committee began to review the Privileging and Credentialing Policy**

<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>when the applications were updated. As soon as the review and update is completed the updated policy will be posted on the Region 10 website. The Privileging and Credentialing process improves the quality of health care and services for our members by ensuring highly qualified providers are approved to provide services for our members. This goal is considered met for FY2023.

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

<u>Next Steps</u>: The privileging and credentialing process is ongoing and this goal will continue into FY2024.</td></tr>
<tr><td>Autism Program</td><td>The goals for FY2023 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 persons on autism services overdue list total
Monitor completion of behavioral plans of care
Monitor documentation submission to Waiver Support Application (WSA) and Microsoft Teams
<table>
<tr><th></th><th></th><th>FY23 1Q</th><th>FY23 2Q</th><th>FY23 3Q</th><th colspan="3">FY23 4Q</th></tr>
<tr><th></th><th></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>193</td><td>198</td><td>183</td><td>194</td><td></td><td></td></tr>
<tr><td></td><td>≥90 (Days)</td><td>166</td><td>137</td><td>149</td><td>154</td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td>9</td><td>15</td><td>7</td><td>12</td><td></td><td></td></tr>
<tr><td></td><td>30-59</td><td>8</td><td>15</td><td>12</td><td>15</td><td></td><td></td></tr>
<tr><td></td><td>0-29</td><td>10</td><td>31</td><td>15</td><td>13</td><td></td><td></td></tr>
<tr><td>Lapeer</td><td>Overdue List Total</td><td>5</td><td>4</td><td>7</td><td>9</td><td></td><td></td></tr>
<tr><td></td><td>≥90</td><td>0</td><td>0</td><td>1</td><td>1</td><td></td><td></td></tr>
</table></td><td>Shannon Jackson

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

<u>Q 1 (Oct-Dec)</u>:
At the close of first quarter, GHS and St. Clair CMH had individuals waiting over 90 days to begin ABA services. During the first quarter, GHS' overdue totals increased each month. The GHS Autism Lead reported efforts continue to increase capacity within the GHS ABA Provider Network. The PIHP Autism Team will continue to monitor overdue totals and will discuss with the CMH Autism Coordinators during the next regional Autism meeting.

<u>Q 2 (Jan-Mar):</u>
The Waiver Support Application (WSA) will be decommissioned for the Autism Benefit effective April 1st.

At the close of March, GHS, Sanilac CMH, and St. Clair CMH had individuals waiting over 90 days to begin ABA services. The PIHP Autism Team will continue to monitor overdue totals and are coordinating with the CMH Autism Leads on continuing this moving forward. The PIHP met with</td></tr>
</table>

Component	Goal/Activity/Timeframe							Responsible Staff/Department	Status Update & Analysis
		60-89	1	0	1	3			
		30-59	2	2	3	2			
		0-29	2	2	2	3			
	Sanilac	**Overdue List Total**	**3**	**3**	**3**	**3**			
		≥90	0	1	0	0			
		60-89	1	1	0	0			
		30-59	2	0	0	3			
		0-29	0	1	3	0			
	St. Clair	**Overdue List Total**	**19**	**31**	**31**	**35**			
		≥90	7	12	9	11			
		60-89	3	8	3	17			
		30-59	1	6	17	2			
		0-29	8	5	2	5			

Autism CMH Leads on March 27th to further discuss this and continued monitoring options. A tracking draft was shared at this meeting and the PIHP further discussed these options.

The PIHP is finalizing this tracking form which the CMH Autism Leads will complete monthly. Additionally, reports are being explored along with deciphering what data collection is needed from the CMH Autism Leads moving forward, to continue to monitor this goal.

MDHHS met with the PIHP Autism leads on Friday March 24th and further discussed the changes proposed in this program for its future. No guidance was shared on what will continue to be tracked although higher scrutiny will be conducted on Initial Evaluations this year and Telehealth will continue to need approval.

<u>Q 3 (Apr-June):</u>
Encounter Data is still being discussed for this program, and the Funding Source Bucket Report for third quarter is being analyzed and has aided in creating tracking sheets to compare with CMHs' provided data.
CMH Autism Leads have been asked to start completing and submitting an Autism Monthly Reporting Form by the 15th of every Month to the PIHP Autism Lead. July is the first requested reporting month so next month these findings will be shared with this committee.
This reporting form asks to provide the PIHP with the Number of Individuals open to ABA Providers, the number of individuals Eligible but not Authorized for service. And any Telehealth authorization requests and updates on Network capacity or staffing changes.

<u>Q 4 (July-Sept):</u>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Encounter Data and the Funding Source Bucket Reports were utilized to provide Overdue totals for Quarter 3 and July of Quarter 4. The PIHP Autism Lead has worked a considerable amount with GHS staff to update PIHP records. There were discrepancies due to a lack of documentation submission within the Waiver Support Application (WSA) which caused inaccurate numbers. It is expected the overdue totals will reflect more accurate number for GHS moving forward. **The PIHP Autism Lead is finalizing Performance Objective language to incorporate the new Autism Monthly form submission timeline. There is still a hold on Policy language due to anticipated significant changes to the Medicaid Provider Manual. In Quarter 4, the Autism Monthly form has not been consistently submitted timely by any CMH.** **The dates of submission will be monitored for annual Contract Monitoring cycles in future cycles.** **<u>Evaluation</u>: Throughout FY2023, there was not consistent improvement in reducing the number of beneficiaries overdue to begin ABA services. At the beginning of FY2023 there were 235 beneficiaries overdue for services, and at the end of the fiscal year, it is projected to be around 200. The overdue numbers are the number of youth that are found medically eligible and have a need for ABA therapy but are waiting within each region for ABA services due to inadequate provider network capacity.** **The Waiver Support Application (WSA) was decommissioned in April of FY2023 which created a barrier in reporting and obtaining this information. Reports are still being created to aid in streamlining this information. Currently, a Funding Source Bucket report is viewed and communication with the CMH leads is essential in obtaining and confirming this information. A monthly reporting**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			form has been created to request data from CMH Leads to help validate numbers. This goal was not met in FY2023 and will be carried over to FY2024 to continue to monitor this Program. **<u>Barrier Analysis</u>: The WSA decommission has caused a barrier in collecting valuable information on the number of beneficiaries overdue to begin ABA services. Additionally, CMH Leads reported challenges with staffing and ABA provider network capacity.** **<u>Next Steps</u>: The PIHP will continue to monitor overdue totals and network ABA Provider and services capacities. The PIHP is working on developing a Provider Authorization Detail Report that can be used with the Funding Source Bucket Report to help validate individuals currently receiving ABA services and make the reporting process easier. Additionally, CMH's will be asked to continue to communicate and fill out the new Autism Monthly Reporting form to indicate current numbers and efforts being made to improve network capacities.**
Autism Program	The goals for FY2023 Reporting are as follows: • 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 Form (ABCAF) documents to the PIHP related to the Autism Benefit, increased understanding of timeframes for document and data submission, and accurate and timely processing of document submission by the PIHP. o Monitor documentation submission to Waiver Support Application (WSA) and Microsoft Teams	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Communication regarding corrections or clarification needed occurs via Microsoft Teams between the PIHP and CMH Autism Leads/Designees. During the first quarter, no major concerns were identified. The only outstanding case actions are transfers between Region 10 PIHP and other PIHPs. The PIHP Autism Team is also tentatively planning for the statewide decommissioning of WSA. The PIHP Autism Team will follow up with appropriate Leads to discuss continued oversight and data tracking needs.** **<u>Q 2 (Jan-Mar):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Communication regarding corrections or clarification needed occurs via Microsoft Teams between the PIHP and CMH Autism Leads/Designees. During this quarter, no major concerns were identified. The PIHP Autism Team has been planning for the statewide decommissioning of WSA. **The PIHP Autism Team continues to follow up with appropriate Leads to discuss continued oversight and data tracking needs. The PIHP will continue to require the CMH Autism Leads to submit initial Evaluations (ABCAF) forms and Re- Evaluation (ABCAF) forms through Microsoft Teams after the April 1st decommission date. This goal will still be monitored as necessary moving forward.** **<u>Q 3 (Apr-June):</u>** **For the third quarter, CMH Autism Leads/Designees have continued to communicate clearly through Microsoft Teams and through email or phone conversation. CMH Autism leads continue to upload initial Evaluation (ABCAF) forms and Re-Evaluation (ABCAF) forms through Microsoft Teams.** **As stated in the last goal, reporting standards are changing and all CMHSPs will be required to submit to the PIHP timely and complete monthly Autism Reporting Forms. This goal will encompass the timely and accurate submission of this data. Communication has been clear and there have been no concerns identified.** **<u>Q 4 (July-Sept):</u>** **CMH Autism Leads have inconsistently submitted new Autism Benefit Case Action Form (ABCAF) documentation through Microsoft Teams after the decommission of the WSA. Outreach has been made to inquire about these issues.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			CMH Leads are not consistently submitting Autism Reporting Forms to the PIHP by the 15th of the month as well. Follow-up and reminders are being sent out. Additionally, updated language is being added to the Performance Objectives to define the timeline and expectations. **CMH Leads are asked to continue to submit ABCAF documentation through Microsoft Teams for initial evaluations and Recertifications. Additionally, some CMHs have requested to submit disenrollment ABCAFs to help maintain clear numbers between the PIHP and the CMH Autism Staff.** **Evaluation: Overall, this goal was met. Microsoft Teams was utilized by the PIHP and CMH Leads, and communication was clear through the decommissioning of the WSA. There have been individual meetings held with each CMH Autism Lead to help work through struggles. Reporting has changed throughout FY2023, and the PIHP is finalizing policy language to include the new process and documentation submission expectations moving into FY2024.** **Barrier Analysis: The barriers that go with submission of a new document. CMH Leads remembering to submit timely and provide accurate oversight of the program with the changes made in FY2023.** **Next Steps: This objective will continue into FY2024. Reporting methods and documentation submission have changed after the WSA decommission in April of FY2023. Region 10 would like to monitor timely submission of reporting for the Autism Program with the newly established reporting methods.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Autism Program	The goals for FY2023 Reporting are as follows: • Maintain regular communication with CMH Autism Coordinators in order to best support the program with the decommissioning of the WSA and navigating new reporting expectations. • Educate PIHP and CMH staff on program requirements and operations as changes are implemented. • Update the PIHP Autism Benefit Policy 05.03.10 and PIHP/CMH Contract to best reflect program modifications.	Shannon Jackson Monitored by Quality Improvement Committee	**Quarterly Update:** **<u>Q1 (Oct-Dec)</u>:** **The PIHP Autism Team continues to regularly communicate with CMH Autism Coordinators/designees, mostly through email or Microsoft Teams communications. The PIHP did not host/facilitate an Autism Coordinator meeting in the first quarter. The PIHP Autism Team anticipates the PIHP Autism Benefit Policy 05.03.10 will need to be updated when the WSA is decommissioned.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP Autism Team met with the CMH Autism leads/designees March 27th to discuss WSA decommissioning and updates with this program. This meeting provided an opportunity for discussion and feedback on the new tracking form the PIHP is exploring. The PIHP Autism Leads have scheduled meetings monthly in the next few months to continue to collaborate as we enter this new tracking process.** **The PIHP Autism Leads are updating the PIHP Autism Benefit Policy 5.03.10 and reflecting changes in the program to continue to hold the CMHs responsible and continue monitoring this program after the WSA decommission.** **<u>Q 3 (Apr-June):</u>** **During the third quarter, the PIHP Autism Team met with the CMH Autism leads/designees regularly and provided updates on the changes happening with this program. The PIHP staff and CMH Autism Lead staff have had clear communication through the past months and through the Waiver Support Application (WSA) decommission.** **At the June Autism Council Meeting there was discussion on change recommendations to the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Medicaid Provider Manual. This discussion had some feedback, and it was resolved to bring back up for further discussion at the next Council Meeting. These policy changes would affect the process of initial services provided to beneficiaries and change the re-evaluation process currently in place. These changes would require a change to our current policy so the PIHP Autism staff will continue to hold off on updating Policy and Contract Language until more information is provided at the State level. These draft Policy and Contract changes are to incorporate the adjustments to the Autism Program since the decommissioning of the WSA. **<u>Q 4 (July-Sept):</u>** **New standards are being established and policy and contractual language is being addressed to incorporate these changes.** **Medicaid Provider Manual language changes continue to be finalized and discussed at the State level. The PIHP has moved forward with drafting changes to the PIHP/CMH Performance Objectives Contract Attachment until language is finalized.** **<u>Evaluation</u>: During FY2023, the PIHP Autism Team communicated and addressed questions and concerns with the CMH Autism Leads throughout the decommission of the WSA process. Collaborative discussion has been helpful and essential in this process. This goal has been met, and program changes and requirements are shared regularly with CMH Leads and the PIHP is in the process of updating Policy and contract language to reflect the changes to reporting.** **<u>Barrier Analysis</u>: No Barriers** **<u>Next Steps</u>: The PIHP will discontinue this goal. This goal was established for FY2023 to help aid in**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			the process of the WSA decommissioning, this process has successfully been completed and we have moved to a new form of reporting that will be monitored still by the Quality Improvement Committee in the previous goal stated.
Customer Relationship Management (CRM) System	The goals for FY2023 Reporting are as follows: • Monitor the implementation and integration of the Customer Relationship Management (CRM) System and those business processes that are housed within the platform. o Provide technical assistance to users as needed. o Evaluate implementation throughout Region 10. o Maintain oversight of business processes within the CRM, including: ▪ American Society of Addiction Medicine (ASAM) Level of Care ▪ Certified Community Behavioral Health Clinic (CCBHC) Certification ▪ CMHSP Certification ▪ CMHSP Programs & Services Certification ▪ Contract Management ▪ Critical Incident Reporting ▪ Customer Service Inquiry ▪ First Responder Line ▪ Michigan Crisis and Access Line (MiCAL) ▪ Universal Credentialing ▪ Warmline	Tayler Job Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The BHDDA Customer Relationship Management (CRM) system is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BHDDA and its customers.** **Beginning 10/1/2022 all PIHPs and provider agencies were required to begin using the CRM system to complete and submit ASAM Level of Care Designation Applications. On 10/1/2022 MDHHS also moved the reporting of the Substance Use Disorder (SUD) Critical Incidents (CI) and Sentinel Events (SE) into the CRM platform. Our internal CIR/SE team is scheduled to meet next week to make reporting process improvements as needed.** **<u>Q 2 (Jan-Mar):</u>** **Certification of Programs Requiring Special Approval will now be processed through the Customer Relationship Management (CRM) platform. Certification reviews will begin with Home-Based Services. Region 10's lead staff have been identified and attended a training on February 28th, 2023. Job aids for the Home-Based Services Certification process have been uploaded onto the CRM platform. Our internal team is meeting to review the materials provided by MDHHS and develop a training plan for the CMHSPs. Following the training, CMHSPs will have until May 31, 2023, to submit certifications for each program.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 3 (Apr-June): **The CMHSPs had until May 31, 2023, to submit certifications for their Home-Based programs. The PIHP has reviewed and approved all certifications and they are currently pending MDHHS approval in the Customer Relationship Management (CRM) system.** **Additionally, the PIHP has requested a technical assistance call with the department to get a better understanding of the remediation process for critical incidents.** **Q 4 (July-Sept):** **The PIHP had a technical assistance call with the department regarding the critical incident remediation process. Now that we have a better understanding of the department's expectations, PIHP staff created a process document to assist the CMHSPs with the new reporting process. In August, MDHHS completed their review of the CMHSPs' home-based certifications. All CMHSP revisions and follow-up requests are due one month from the date the request was received.** **Evaluation: Beginning in FY2023, all PIHPs and provider agencies were required to begin using the Customer Relationship Management (CRM) system to complete and submit ASAM Level of Care Designation Applications, SUD Critical Incidents, Sentinel Events, and home-based certifications.** **The PIHP was successful in implementing these business processes and meeting implementation deadlines. However, this goal is not met, as there are several other processes expected to be rolled out and housed within the CRM platform. We will continue to implement, monitor, and provide technical assistance as these rollouts take place.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis</u>: The PIHP identified several technical issues within the CRM system throughout the implementation of critical incident reporting and home based-certification submissions. There was also a barrier when completing the critical incident remediation process, as the PIHP was completing the process based on the functionality of the system, which did not align with the department's expectations. The technical assistance call with MDHHS resolved this issue. **<u>Next Steps</u>: The PIHP will continue this goal for FY2024.**
Opioid Health Home (OHH)	The goals for FY2023 Reporting are as follows: • 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 / Rusmira Bektas Provider Network Management Department Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **Region 10 has gained 33 new OHH enrollees due to an outreach effort by Sacred Heart Richmond/Port Huron resulting in over a 30% increase of enrollees in the program. As of November 23, 2022 BIOMED has an approved OHH application from MDHHS for Roseville and Flint locations to treat Region 10 enrollees.** **<u>Q 2 (Jan-Mar):</u>** **During this quarter, the OHH program has increased their Health Home Providers (HHP) with the addition of BIOMED to increase service to the area. Region 10 has ended this quarter with increased enrollment to 116 total beneficiaries with forty-one (41) at BIOMED, thirty (30) at Sacred Heart Flint and forty-five (45) at Sacred Heart Richmond/Port Huron. The PIHP consulted with MDHHS to separate the Sacred Heart Richmond and Port Huron in the WSA system into two (2) locations to streamline enrollment and billing processes. An internal meeting was conducted to review process, procedure, and policy documents and identify areas to improve. A meeting for the Health Home Providers (HHP) has been set up for**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			mid-April to review updated process documents, share resources to care plan expectations, to resolve barriers, collaborate on processes and share upcoming changes to policy. The final update of the Region 10 OHH Policy is set to be released May 1, 2023. Quality management site visits are in development for next quarter. **<u>Q 3 (Apr-June):</u>** **The Opioid Health Home (OHH) Coordinator held one Health Home Partner (HHP) meeting each month to discuss progress, barriers, and to answer questions. The approved two logins for individual Sacred Heart Rehabilitation Center (SHRC) users have eliminated the incorrect program referral barrier. Two contract monitoring site visits were conducted to discuss OHH Coordinators findings about Care Plan compliance barriers.** **MDHHS OHH Coordinator meetings were held in April and May to give guidance on CareConnect360 and the end of the Public Health Emergency (PHE). The one for June was canceled. Region 10 participated in the two MDHHS trainings on the Waiver Support Application (WSA) and Health Care Integration. The OHH Policy 05.03.16 update was submitted to stay in compliance with MDHHS End of PHE. The PIHP's measurement year (MY) metric was met with pay-for-performance (P4P) equaling $6,962.34 paid to SHRC.** **Two inter-regional OHH Coordinator meetings were conducted with Region 1 and Region 6 (separately) to discuss outreach and transportation barriers and solutions in each respective region's counties.** **Region 10 outreach resulted in meetings with Blue Water Recovery and Outreach Center (BWROC) in St. Clair County and with McKenzie Health System**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			(MHS) in Sanilac County. MHS requested an additional meeting to discuss the process of possibly moving forward to becoming an HHP. Outreach to prescribing physicians to become OBOT did not result in direct contact, possible due to lack of knowledge of OHH program and time barriers. **Current enrollees have increased over Q3 from 117 to 136 beneficiaries (BioMed 63, SHRC Flint 32, SHRC Richmond 38, SHRC Port Huron 4) which is a growth of 16%.** **<u>Q 4 (July-Sept):</u>** **The Opioid Health Home (OHH) Coordinator facilitated two meetings with PIHP officers and Mackenzie Health System (MHS) to further discuss the possible contract development to become a Health Home Partner (HHP) over this quarter. Meetings were also held with current providers New Paths and Flint Odyssey House to provide an overview and education on the OHH program. Arbor Recovery and New Paths have submitted and had their MDHHS applications approved to become an HHP, with amendments to their FY2024 contracts in process. Monthly HHP meetings were held for discussions on progress and barriers, with the primary concern for Sacred Heart Rehabilitation Center (SHRC) in Flint during the quarter being staff retention issues which was limiting their admissions. MDHHS meetings shared that all regions experienced a decrease of enrollments during this quarter. Current enrollment for Region 10 is at 161 beneficiaries (BioMed 81, SHRC Flint 33, SHRC Richmond 40, SHRC Port Huron 4).** **<u>Evaluation:</u> All goals were met for FY2023. In FY2023, the PIHP expanded the program with the addition of one HHP, Biomed, with two site locations in Flint and Roseville and the onboarding**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			of a new provider, Arbor Recovery in Flint, for the implementation of OHH services in FY2024. Discussions have been progressing with a potential new provider, Mackenzie Health System in Sanilac County and current providers Flint Odyssey House and New Paths in Flint. New Paths has submitted the required application to MDHHS and is waiting for approval. OHH services in the region has shown an increase from 811 units in FY2022 to 1,264 units claimed in FY2023, supporting the increased utilization of the program. The total approved OHH enrollees for Region 10 PIHP currently for FY2023 stands at 161 beneficiaries, which is an increase of 177% from end of FY2022 total of 58 enrolled beneficiaries. Also, HHP provider support was improved with monthly meetings, updated process documents, and trainings for quality improvements. Working with MDHHS, an additional WSA log-in for provider SHRC was initiated, eliminating location billing errors that were occurring also. MDHHS compares the PIHP's OHH program metric performance against the performance for the entire state and the PIHP region in certain categories. The FY2022 metrics reflect higher engagement numbers for Region 10 than Michigan's. In the Follow-up within 7 days after discharge of ED visit for Substance use category: Michigan's rate was 14.64, Region 10 (total) 14.81 at end of FY2022. In the Follow-up within 30 days after discharge of ED visit for Substance use category: Michigan's rate was 23.78, Region 10's rate was (total) 24.45 and Region 10's (OHH) rate was 100 at end of FY2022. In the Initiation of Alcohol and Other Drug Treatment within 14 days category: Michigan's rate was 38.02 and Region 10's (total) 40.81 for FY2022. FY2023 metrics are still being evaluated. **<u>Barrier Analysis:</u> An identified barrier to the expansion of the program is lack of provider**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			staffing to support the capacity of new enrollees and lack of knowledge about the OHH program in the communities at treatment provider level. **<u>Next Steps:</u> Continue with this goal for FY2024 with an emphasis on expansion of enrollment and onboarding of Health Home Partners for the underserved areas within region, with the focus on community outreach to build a larger provider capacity to support an increase of enrollees.**
Certified Community Behavioral Health Clinic (CCBHC) Demonstration	The goals for FY2023 Reporting are as follows: • Continue development of the Certified Community Behavioral Health Clinic (CCBHC) demonstration within Region 10. o Follow up on and monitor MDHHS Site Visit deficiencies. o Complete and maintain non-Medicaid ARPA Grant reporting and activities timely. 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.	Lauren Campbell / Dena Smiley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **The PIHP 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. A non-Medicaid Grant report was due in EGrAMS November 30th. The PIHP CCBHC Team is preparing for a presentation to the Region 10 CEO group to share high-level information on the CCBHC Demonstration. Additionally, WSA users from St. Clair CMH and the PIHP met for a CCBHC WSA Subcommittee meeting.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP 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. PIHP staff reviewed the proposed changes to the CCBHC Handbook and submitted feedback to MDHHS, with an updated version of the CCBHC Handbook (v1.5) being finalized and distributed by MDHHS in February.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP led a presentation to the Region 10 CEO group at their January meeting to share high-level information on the CCBHC Demonstration. **MDHHS began a Metrics Workgroup for CCBHCs and PIHPs to discuss quality metrics and reporting, which the PIHP has participated in each month.** **The CCBHC Demonstration Year (DY) 1 Annual Reporting Template and CCBHC Supplemental Data Request Template were submitted to MDHHS ahead of the March 31st deadline.** **Additionally, WSA users from St. Clair CMH and the PIHP met twice throughout the quarter for a CCBHC WSA Subcommittee meeting.** **<u>Q 3 (Apr-June):</u>** **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.** **The State has requested funds to expand the CCBHC Demonstration. A letter was sent soliciting requests for new clinics to join the Demonstration at the start of FY2024. Information and technical assistance sessions have been held for interested sites. Genesee Health System, Lapeer CMH, and Sanilac CMH have expressed interest in joining the CCBHC Demonstration.** **PIHP staff reviewed the proposed changes to the CCBHC Handbook and submitted feedback to MDHHS. An updated version of the CCBHC Handbook (v1.6) was provided by MDHHS.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The Consultation Draft of the DY1 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 and thus did not earn back the withhold amount as a CCBHC must meet all six QBP initiatives to receive the withhold. However, funds not earned through the State are redistributed to CCBHCs that submitted reports timely. From this, St. Clair CMH did receive an award. **<u>Q 4 (July-Sept):</u>** **During fourth quarter, PIHP staff continued to review and assign cases in the Waiver Support Application (WSA). Additional staff were trained on the processes related to reviewing and assigning cases in the WSA.** **The PIHP submitted a quarterly non-Medicaid ARPA Grant report in the Electronic Grants Administration & Management System (EGrAMS).** **The Final Demonstration Year (DY) 1 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 and thus did not earn back the original withhold amount. However, St. 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 St. Clair CMH. The PIHP Team met with St. Clair CMH to address findings.** **Genesee Health System, Lapeer CMH, and Sanilac CMH completed the certification application**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			process to pursue becoming CCBHC Demonstration sites beginning FY2024. In August, MDHHS provided notification that Genesee Health System, Lapeer CMH, and Sanilac CMH received full certification to begin the Demonstration beginning in October. PIHP department leads and staff considered the impact of this demonstration to plan for any adjustments to current processes. **Evaluation: This goal is partially met. Throughout FY2023, the PIHP maintained non-Medicaid ARPA Grant reporting, monitored quality measures, oversaw case enrollment within the WSA, and maintained communication with CCBHC staff. The PIHP did not participate in the MDHHS Site Visit and did not follow up with St. Clair CMH on the recommendations provided by MDHHS. St. Clair CMH achieved a total score of 99% for the Site Visit. Additionally, 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 53.3% for St. Clair CMH. Additional follow-up should occur to improve performance.** **Barrier Analysis: No specific barriers are identified. Regarding the SAA measure, there are differences in MDHHS' final count and St. Clair CMH's estimates.** **Next Steps: This goal should be carried forward into FY2024. All four CMHSPs in the region will 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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
1915(i) State Plan Amendment	The goals for FY2023 Reporting are as follows: • Identify and enroll eligible 1915(i) State Plan Home and Community-Based Services Benefit beneficiaries in the Waiver Support Application (WSA). • Monitor beneficiary enrollment in other overlapping programs. • Manage case transfers and disenrollments, as needed. • Maintain oversight to ensure documentation submitted to the WSA is complete and accurate.	Lauren Campbell / Shelley Wilcoxon Monitored by Quality Improvement Committee	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **On October 21, 2022 MDHHS hosted a PIHP/CMHSP Leads meeting. During the meeting, it was noted that an Extension Request was approved which would allow the State an additional year to transition the eligibility determination for 1915(i)SPA from the PIHP to MDHHS, with this occurring on October 1, 2023. It was also noted that Region 10 was one of eight PIHPs that had cases pending in the Waiver Support Application (WSA) at that time. These cases were all submitted by St. Clair CMH. WSA training and updates were also discussed.** **On November 18, 2022, MDHHS hosted a PIHP/CMHSP Leads meeting. It was noted during this meeting that Region 10 now has open cases in the WSA along with several cases that are still pending MDHHS review. PIHP staff has met to discuss process planning to ensure all CMHSPs are prepared to meet the October 1, 2023 start date.** **During the first quarter, PCE introduced a 1915(i)SPA Referral Form which can be implemented into PCE systems / electronic health records. The Referral Form is intended to support information sharing between CMH/Provider clinical staff and staff designated to complete data entry in the Waiver Support Application (WSA).** **<u>Q 2 (Jan-Mar):</u>** **MDHHS hosted a 1915(i) Leads meeting with PIHPs and CMHs on January 20, 2023. Data from January 19, 2023 from the Waiver Support Application (WSA) shows there are 12,555 potential enrollees remaining statewide. Also, per MDHHS, Region 10 PIHP only had 30 individuals enrolled in WSA as of January 19, 2023.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP continued efforts to outreach and collaborate with CMH Leads to begin enrollment of 1915(i)-eligible individuals in the WSA. **The PIHP and CMH 1915(i)SPA Leads attended a Technical Assistance Training session with MDHHS on February 7, 2023. MDHHS reviewed and discussed an overview of the 1915(i)SPA, enrollment data, eligibility and needs-based criteria, evaluations, housing assistance, and the WSA.** **On February 9, 2023, the PIHP facilitated a 1915(i)SPA Leads meeting with the CMH Leads. During this meeting, CMHs reported on efforts to train staff and begin identifying individuals to enroll in the 1915(i)SPA. Regarding the Referral Form developed by PCE to assist with information sharing, GHS is implementing the Referral Form into CHIP. The CMHs using OASIS have discussed using the Referral Form but have not added the document into OASIS yet.** **<u>Q 3 (Apr-June):</u>** **MDHHS hosted 1915(i)SPA Leads meetings with the PIHPs and CMHs. When comparing enrollment totals to the number of estimated enrollees, Region 10 PIHP has completed 36% of enrollments (per MDHHS' calculations). Statewide, enrollment is not on track.** **All CMHs are now entering cases into the Waiver Support Application (WSA) for review and approval by the PIHP. PIHP Quality Team staff continue to review recommended cases within the WSA.** **Additionally, the PIHP 1915(i)SPA Lead changed. The PIHP will continue meeting and sharing information with the CMH 1915(i)SPA Leads.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 4 (July-Sept): **MDHHS hosted 1915(i)SPA Leads meetings with the PIHPs and CMHs. Achieving enrollment benchmarks has continued to be a struggle statewide. On September 1st, MDHHS reported statewide enrollment at 80 percent, with Region 10 at 75 percent of the 2,951-case target (PIHP projected, rather than 3,147 projected by OPTUM) beneficiaries. To meet the October 1st enrollment deadline, MDHHS has requested that all cases be processed and in the State's queue by September 17 for final approval. A new PIHP Administrative Technician was hired and trained to assist with processing cases. The CMHSPs have expressed concern that target enrollment numbers were overstated. St. Clair CMH, a CCBHC Demonstration site, indicated they have nearly exhausted their list of Potential Enrollees, possibly as a result of overlap in services with the 1915(i)SPA. The PIHP is working with the Data Department to pull a more current Potential Enrollee list to consider if numbers were overstated and/or identify more Potential Enrollees. The PIHP will continue meeting and sharing information with the CMH 1915(i)SPA Leads.** **Evaluation: In FY2023, an Extension Request was approved to allow MDHHS an additional year to transition the eligibility determination for the 1915(i)SPA from the PIHP to MDHHS. The target date for enrollment was set for October 1, 2023. Training and updates provided by MDHHS have continued through the year and have been shared with Region 10 CMHSPs. The first cases were opened in November 2022. Initial figures from MDHHS calculated by OPTUM projected enrollment at 3,147 beneficiaries. MDHHS later accepted PIHP projections, which Region 10 calculated to be 2,951. During the first quarter, PCE**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			introduced a Referral Form intended to support information sharing between CMH staff and those completing data entry to submit cases in the Waiver Support Application (WSA). Case enrollment progressed slowly through the first and second quarters, with Region at 36 percent of target enrollment near the end of the third quarter. Lack of trained staff was noted as a barrier at the CMH level, along with implementation of the PCE Referral form. At the PIHP, the 1915(i)SPA Lead changed near the end of the third quarter, and a new Administrative Technician was hired and trained to assist with processing cases in July. Enrollment reported by MDHHS on September 1st noted Region 10 enrollment at 75 percent. Current PIHP analysis indicates all but one CMHSP is at or above 94 percent of the target if all cases in the queue are approved. All goals were met for FY2023. **<u>Barrier Analysis</u>: The time frame to enter cases was shortened by MDHHS from October 1st to September 17th to allow time for case processing. Also, projected enrollment numbers may have been overstated for St. Clair CMH (CCHBC Demonstration site) due to difficulty predicting enrollment in CCBHC services that overlap with those offered under the 1915(I)SPA. As a result, St. Clair CMH is at 82 percent and may not meet the target enrollment number, although all FY2023 goals were met.** **<u>Next Steps</u>: Continue to process case enrollments and monitor CMHSP progress, ensuring timeliness of re-evaluations and supporting documentation. Additionally, work with the Data Department to run an updated report of 1915(i) Potential Enrollees to verify all beneficiaries who qualify are receiving necessary services.**
Supports Intensity Scale	The goals for FY2023 Reporting are as follows:	Lauren Campbell	**Quarterly Update:**

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Reduce the region’s number of overdue Supports Intensity Scale (SIS) assessments.

Monitor percentage of eligible individuals overdue for a SIS assessment each month and number of assessments completed monthly.
Monitor regional SIS Assessor capacity.
Monitor SIS Assessors’ certification statuses and annual conflict-free agreements.

<table>
<tr><th></th><th>FY23 Q1</th><th colspan="3">FY23 Q2</th></tr>
<tr><th></th><th>12/1/2022</th><th>1/1/2023</th><th>2/1/2023</th><th>3/1/2023</th></tr>
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<tr><td>Lapeer</td><td>40.9%</td><td>39.7%</td><td>N/A</td><td>N/A</td></tr>
<tr><td># Assessments Completed</td><td>4</td><td>9</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Sanilac</td><td>64.4%</td><td>64.0%</td><td>N/A</td><td>N/A</td></tr>
<tr><td># Assessments Completed</td><td>0</td><td>0</td><td>N/A</td><td>N/A</td></tr>
<tr><td>St. Clair</td><td>87.3%</td><td>87.4%</td><td>N/A</td><td>N/A</td></tr>
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<tr><td># Assessments Completed</td><td>14</td><td>11</td><td>N/A</td><td>N/A</td></tr>
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<td>Monitored by Quality Improvement Committee (QIC)</td>
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<u>Q 1 (Oct-Dec)</u>:
The PIHP has begun tracking the percentage of eligible consumers that are overdue for a SIS assessment. Data obtained from the Explore SIS site (maintained by TBD Solutions) shows Region 10 continues to have the highest percentage of eligible consumers that are overdue for an assessment among the PIHPs. As of November, Genesee Health System (GHS) and St. Clair CMH have the highest percentage of eligible consumers overdue for a SIS assessment in the region.

Sanilac CMH continues contracting with MORC to complete SIS assessments. Lapeer CMH and St. Clair CMH each have on SIS assessor. GHS currently does not have a SIS assessor, and this will continue to be monitored via the outstanding Plan of Correction.

During November, the SIS Steering Committee Meeting was held where it was pointed out that Region 10 does not currently have enough active SIS assessors. The Region 10 Quarterly SIS Training hosted by MORC was held via Zoom in November, with attendance from Lapeer CMH and St. Clair CMH assessors, as well as PIHP SIS Leads.

<u>Q 2 (Jan-Mar):</u>
During January and February, data obtained from the Explore SIS site (maintained by TBD Solutions) showed Region 10 continued to have the highest percentage of eligible consumers that were overdue for an assessment among the PIHPs. Genesee Health System (GHS) and St. Clair CMH continued to have the highest percentage of eligible consumers overdue for a SIS assessment in the region.

On February 23, 2023, the PIHP asked CMHs to submit remediation plans to address SIS completion rates and SIS Assessor capacity. Additionally,
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Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			during February, the PIHP was made aware GHS and St. Clair CMH have plans to send staff to the SIS Assessor Training in March. **On March 1, 2023, the PIHP received a memo from MDHHS indicating MDHHS will not be renewing the contract with AAIDD (the American Association on Intellectual and Developmental Disabilities) for the use of the SIS. Effective March 23, 2023, no SIS assessments should be completed.** **Additionally, the Explore SIS site (maintained by TBD Solutions) is no longer available for public use.** **<u>Q 3 (Apr-June):</u>** **No update. This goal was completed.** **<u>Q 4 (July-Sept):</u>** **No update. This goal is completed.** **<u>Evaluation</u>: During FY2023, this goal was completed but not necessarily met. During FY2023, the PIHP continued tracking overdue Supports Intensity Scale (SIS) assessments and completion rates and requested remediation plans from CMHSPs. However, during the fiscal year, MDHHS did not renew the contract with the American Association on Intellectual and Developmental Disabilities (AAIDD) for the use of the SIS. Data from January 2023 showed there were only 11 assessments completed within the region in the month, with 84.3% overdue.** **<u>Barrier Analysis</u>: Earlier in the fiscal year, it was suspected that SIS Assessor capacity was a major barrier to completing SIS Assessments.** **<u>Next Steps</u>: This goal will not be continued. PIHP staff will support planning efforts for the implementation of other standardized assessments.**

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Verification of Services	The goals for FY2023 Reporting are as follows: • The PIHP will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors. o Conduct quarterly claims verification reviews. o Increase the sample size selected for quarterly claims verification reviews to include all providers furnishing services during a quarter. o Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. o Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. o Send Explanation of Benefits (EOB) letters biannually during the fiscal year. o Send EOB letters to more than 5% of consumers receiving services.	Deidre Murch Quality Management & Data Management Departments	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>: In early October, preliminary letters were sent to providers found to be out of compliance during the Claims Verification FY2022 Quarter 1 review. Final letters were sent to those providers found to be fully in compliance. Responses to preliminary letters were reviewed and final letters will be sent the first week of January. One Plan of Correction was received and approved from Lapeer CMH. Work has begun on FY2022 Quarter 2 Claims Verification, using a new report to increase the sample size selected to review each quarter, along with including all providers that furnished services during the quarter. Requests for documentation will be sent during January. The PIHP team met again in December to finalize the sample pulling process along with preliminary/final letter processes. Process documents are being updated to reflect these changes. The annual report detailing Region 10 Claims Verification methodology and findings was submitted to MDHHS on December 20, 2022.** **The PIHP is currently the process of running EOBs to be sent to members who received services.** **<u>Q 2 (Jan-Mar):</u>** **Final letters were sent to providers found to be out of compliance during the FY2022 Quarter 1 review. Work continued for the FY2022 Quarter 2 review with requests for documentation being sent on February 1, 2023 to all providers of services during that time. A deadline was given of February 22, 2023. All documentation has been received. The PIHP continues reviewing documentation submitted.** **<u>Q 3 (Apr-June):</u>**

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			Initial review of the FY2022 second quarter claims concluded. Preliminary letters were sent to Providers out of compliance and final letters were sent to those Providers in full compliance after review. **<u>Q 4 (July-Sept):</u>** **A final review of documentation for the FY2022 Q2 claims took place. Final letters were sent to Providers found to be out of compliance. The PIHP also requested documentation for the FY2022 Q3 review. The review process has begun.** **<u>Evaluation</u>: This goal is partially met. The PIHP did ensure that the sample size was increased each quarter in order to encompass claims from each Provider. The Annual Report was submitted timely at the end of CY2022 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 FY2023, satisfying the biannual objective. Surpassing the 5% benchmark, they were sent to 7.8% of those in services.** **<u>Barrier Analysis</u>: Staff learning and training was the PIHP's biggest barrier this year. All staff working on the Claims Verification process were new to the project in December of 2022.** **<u>Next Steps</u>: This goal will be carried over into FY2024. Staff are now trained and claims are being reviewed more efficiently. Additionally, the Claims Verification Policy will be reviewed and updated as necessary in FY2024.**

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External Quality Review Corrective Actions	The goals for FY2023 Reporting are as follows: • Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. o Standard Leads will report CAP updates monthly to the External Quality Review Team / Quality Manager. o Recommendations resulting from the Performance Measure Validation (PMV) Review will be addressed by the Quality Manager and PIHP Performance Indicator Team. Following the 2022 External Quality Review of Region 10 PIHP, CAPs and/or follow up on recommendations were needed for the following areas: o Standard VII. Provider Selection o Standard VIII. Confidentiality o Standard IX. Grievance and Appeal Systems o Standard X. Subcontractual Relationships and Delegation o Standard XI. Practice Guidelines o Standard XII. Health Information Systems o Standard XIII. Quality Assessment and Performance Improvement Program Per the 2022 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended: o Region 10 identify and implement a mechanism through which it can monitor encounter data-dependent rate impact if the CMHSPs' encounters are delayed in the future. o Region 10 consider reaching out to MDHHS on behalf of the CMHs to obtain guidance on program changes prior to reporting quarterly indicator rates in order to mitigate any issues that might be a barrier in reporting indicator rates.	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation:** Lauren Campbell	**Quarterly Update:** **<u>Q 1 (Oct-Dec)</u>:** **HSAG provided the SFY2022 Compliance Review Final Report. Standard Leads prepared corrective action plans (CAPs) and responses to recommendations. SFY2022 Compliance Review CAPs were submitted to HSAG on December 5th. The PIHP has not yet received notification from HSAG and MDHHS if the submitted CAPs were accepted.** **The External Quality Review Team prepared template documents to track corrective action plans and responses to recommendations from the SFY2022 Compliance Review and the Performance Measure Validation Review. Standard Leads are continuing work to address citations and recommendations provided during FY2022.** **<u>Q 2 (Jan-Mar):</u>** **In January, HSAG provided notification and documentation that Region 10 PIHP's SFY2022 Compliance Review corrective action plans (CAPs) were accepted by HSAG and MDHHS. Throughout the quarter, Standard Leads continued work to address citations and recommendations from the SFY2022 Compliance Review. Additionally, a copy of the SFY2022 Compliance Review Corrective Action Plan Template document with progress updates was submitted to HSAG on March 31, 2023.** **The PIHP Performance Measure Validation (PMV) Review Team met to further discuss recommendations provided by HSAG following the 2022 PMV Review. Action plans and steps are documented on a Recommendation Tracking Template specific to the 2022 PMV Review.**

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	○ Region 10 and the CMHs employ additional oversight to their performance indicator validation processing to ensure service level detail used for calculating performance measures capture and match MDHHS specifications.		**The SFY2023 Compliance Review, which will be a review of SFY2021 and SFY2022 corrective actions, is scheduled for Monday, August 14th. The PIHP External Quality Review Team began planning for the SFY2023 Compliance Review.** **In late March, MDHHS shared the SFY2022 External Quality Review Technical Report with PIHPs. The PIHP Quality Manager reviewed the report for overall findings, weaknesses, and recommendations.** **<u>Q 3 (Apr-June):</u>** **Standard Leads continued work to address citations and recommendations from the SFY2022 Compliance Review. Standard Leads were also asked to provide updates on citations and recommendations from the SFY2021 Compliance Review. The PIHP Performance Measure Validation (PMV) Team continued efforts to address recommendations from the 2022 PMV Review.** **The SFY2023 Compliance Review, which will be a review of SFY2021 and SFY2022 corrective actions, is scheduled for Monday, August 14th.** **Additionally, during April, HSAG hosted a kickoff webinar with managed care entities to introduce the Encounter Data Validation (EDV) study. PIHP Quality and Data staff submitted the Encounter Data Validation (EDV) Questionnaire responses and supporting documentation on May 15, 2023.** **The PIHP Performance Measure Validation (PMV) Team submitted the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents to HSAG on May 19, 2023. HSAG provided notification the 2023 PMV Review will be scheduled for July 13, 2023.**

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			HSAG and MDHHS reviewed the progress update (submitted in March) for the SFY2022 Compliance Review corrective action plans (CAPs). Feedback was shared with Standard Leads. Where CAPs were marked completed, HSAG will expect to see evidence documentation at future Compliance Reviews. **Standard Leads continue work on SFY2021 and SFY2022 Compliance Review CAPs and recommendations. The PIHP External Quality Review Team is preparing to schedule working sessions for the SFY2023 Compliance Review.** **<u>Q 4 (July-Sept):</u>** **In July, the PIHP participated in the 2023 Performance Measure Validation (PMV) Review. Follow-up items were addressed. The PIHP anticipates receiving the draft and final reports from HSAG in September 2023.** **During fourth quarter, Standard Leads continued work to address citations and recommendations from the SFY2021 and SFY2022 Compliance Reviews. In August, the PIHP External Quality Review (EQR) Team and Standard Leads participated in the SFY2023 Compliance Corrective Action Plan (CAP) Review.** **<u>Evaluation</u>: During the SFY2023 Compliance CAP Review, preliminary feedback from HSAG indicated not all CAPs from SFY2021 and SFY2022 were sufficiently addressed and/or completed.** **<u>Barrier Analysis</u>: Barriers to completing SFY2022 Compliance Review corrective action plans were reported to HSAG in March on a progress update tool. Reported barriers included uncertainty of universal credentialing impact on PIHP processes, time constraints related to completing**

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			enhancements on required templates, and information collection and review related to the implementation of an Application Programming Interface (API). **<u>Next Steps</u>: Continue this goal with modifications to include SFY2023 findings, recommendations, and corrective actions. Additionally, the PIHP External Quality Review (EQR) Team will enhance the process for preparation for Compliance Reviews and will emphasize the importance of ongoing work to address deficiencies.**

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As of 09.07.2023