REGION 10

QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2024

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Annual Evaluation	The goals for FY2024 Reporting Year are as follows: • Submit FY2023 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 10/1/2023. o Present the Annual Evaluation to the Quality Improvement Committee. The Quality Improvement Committee will be responsible for providing feedback on the qualitative analysis, proposed interventions, and implementation plan. o After presentation to the Quality Improvement Committee, the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Deidre Murch Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q 1 (Oct-Dec):** **The FY2023 Quality Improvement (QI) Program and Workplan Annual Report was submitted to MDHHS on October 24, 2023.** **Evaluation: This goal has been met as the FY2023 QI Program Evaluation was submitted timely to the Quality Improvement Committee and the PIHP Board.** **Barrier Analysis: No barriers.** **Next Steps: Continue timeline for FY2024.**
QI Program Structure - Program Description	The goals for FY2024 Reporting Year are as follows: • Submit FY2024 QI Program Description and QI Workplan to Quality Improvement Committee and the Region 10 PIHP Board by 11/1/2023. o Review the previous year's QI Program and make revisions to meet current standards and requirements. o Include changes approved through committee action and analysis. o Include signature pages, Work Plan, Evaluation, Policies and Procedures, and attachments. • Develop the FY2024 QI Program Work Plan standard by 11/1/2023. o Present the work plan to committee by 11/1/2023. 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 Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Quality Improvement Committee (QIC) and the Region 10 PIHP Board approved the QI Program and Workplan at their respective October meetings. The FY2024 QI Program and Workplan was then submitted to MDHHS on October 24, 2023. Responsible staff designations in the area of Corporate Compliance were updated to reflect organizational structure changes at the PIHP.** **Evaluation: This goal is considered met as the FY2024 QI Program Description and Workplan were presented to and approved by the QIC and PIHP Board timely.** **Barrier Analysis: No barriers.** **Next Steps: Continue to monitor Workplan throughout the** **year for necessary changes.**
Aligned System of Care	The goals for FY2024 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service.	Tom Seilheimer	**Quarterly Update:** **Q 1 (Oct-Dec):** **The Annual and Biennial Clinical Practice Guidelines (CPG) Evaluation Reports are completed. The reports'**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor utilization of the PIHP Clinical Practice Guidelines. ○ Complete annual and biennial evaluation reports as per policy. ○ Review Evidence-Based Practices and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., Integrated Dual Disorders Treatment (IDDT), Level of Care Utilization System (LOCUS), Opioid Health Home (OHH). ○ Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan.	Improving Practices Leadership Team (IPLT)	**findings and recommendations will be integrated into the Utilization Management (UM) Program Plan Annual Evaluation Report, which will be sent to QIC for review/approval. The FY2023 LOCUS Implementation Plan report is completed per goals attained. The FY2024 LOCUS Implementation Plan report is completed, with special attention to CMHSPs minimizing over-ride rates, ensuring timely completion, and encouraging CMHSPs to have updated MIFAST fidelity reviews.** **Evaluation:** **Progress toward goal.** **Barrier Analysis:** **None identified.** **Next Steps:** **Continue per plan.**
Employment Services	The goals for FY2024 Reporting Year are as follows: • Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC). Monitor quarterly ESC meetings designed to facilitate share and learn discussions on: ○ CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) ○ Standardized employment services data and report formats ○ In-service / informational materials ○ Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS])	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Lapeer CMHSP has completed the first-year implementation of its Individual Placement and Support (IPS) employment services program. St. Clair CMHSP presented its FY2023 IPS Performance Indicator (PI) report. Sanilac CMHSP and GHS are assessing their prospects for IPS implementation. Share and learn discussions took place regarding topics presented at the State Quarterly Competitive Employment Meeting, and the EOFY Michigan Mission-Based Performance Indicator System (MMBPIS) employment PI findings were also reviewed and discussed.** **Evaluation:** **Progress toward goal.** **Barrier Analysis:** **No barriers encountered.** **Next Steps:** **Continue per annual plan.**

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

Home & Community Based Services	The goals for FY2024 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 HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process
	  o Monitor the provisional approval process
		Deidre Murch / Tom Seilheimer
		
		Improving Practices Leadership Team (IPLT)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			The PIHP received three (3) provisional requests, one from St. Clair CMHSP, one from Lapeer CMHSP, and one from Genesee Health System. All three met the requirements and were approved. Additionally, St. Clair CMHSP had a consultation with MDHHS for a secured setting placement. This was also approved.
			
			Validation and remediation work for the FY2020 survey cycle concluded, with the PIHP submitting timely to MDHHS respective to the November 1 deadline.
			
			The PIHP HCBS Lead attended the CMHA Waiver Conference in November 2023. Information was presented about ensuring that documentation is in compliance with the HCBS Final Rule.
			
			Evaluation: **Progress toward goal.**
			Barrier Analysis: **None identified.**
			Next Steps: **Continue per plan. CMS is hosting a Person-Centered Planning webinar next week that the PIHP will attend.**

Integrated Health Care	The goals for FY2024 Reporting are as follows:
	• Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan.
	  o Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CareConnect360 (CC360) system.
	  o Participate in PIHP/MHP Workgroup initiatives.
	  o Develop a plan to identify members of the youth population appropriate for care coordination.
		Deidre Murch / Tom Seilheimer
		
		Improving Practices Leadership Team (IPLT)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			A workgroup began in October focusing on identification and utilization of risk stratification criteria specific to the youth in foster care population. Efforts for the October session focused around identifying potential sub populations/diagnoses to include in future risk stratification. In November, it was decided that a technical assistance regarding use of CareConnect360 would be useful, and outreach was made to the State to that end.
			
			In the quarter, 42 cases were discussed. Nine (9) care plans were opened during the quarter and eight (8) were closed. Reasons for closing care plans included: all goals met, consumer moved out of catchment area, some goals met, and consumer was unable to reach or locate for several months.

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> Progress toward goal. **<u>Barrier Analysis:</u> The PIHP has been unable to have joint care meetings with HAP CareSource due to a lack of a signed agreement.** **<u>Next Steps:</u> Continue per plan.**

Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2024 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.
	    o Monitor CMH and SUD sentinel event review processes and ensure follow-up as deemed necessary.
	    o Monitor CMH and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary.
	    o Monitor CMH and SUD risk events review processes and ensure follow up as deemed necessary.
		Tom Seilheimer
		
		Sentinel Event Review Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Two sentinel events are in the Sentinel Event Review Committee (SERC) review process, thus far noting CMHSP adherence to review and report standards. Network provider Risk Events/Risk Management (RM) reports were reviewed, and SERC regional analysis identified various levels of compliance to RM report standards, as well as noted marginal regional trends pertaining to emergency use of physical intervention (PI) and police responses. Committee feedback is being sent back to network providers to help ensure adherence to reporting standards, as this new RM reporting system moves forward. EOFY CMHSP Mortality Reports were reviewed, noting no significant service provision issues, although recommendations were made to help ensure reports cover all areas noted in the updated PIHP policy. Feedback to SUD providers to onboard their unexpected deaths reporting system also was discussed.
			
			<u>Evaluation:</u> Progress toward goal.
			<u>Barrier Analysis:</u> None identified.
			<u>Next Steps:</u> Continue per plan.

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2024 Reporting are as follows:

The goal is to attain and maintain performance standards as set by the MDHHS contract.

Report indicator results to MDHHS quarterly per contract.
Review quarterly MMBPIS data.
Achieve and exceed performance indicator standards and benchmarks.
Ensure follow up on recommendations and guidance provided during External Quality Reviews
Provide status updates to relevant committees, such as the PIHP QIC, PIHP CEO, PIHP Board.

<table>
<tr><th></th><th>FY23 Q3</th><th>FY23 Q4</th><th>FY24 Q1</th><th>FY24 Q2</th></tr>
<tr><td colspan="5">Ind. 1 – Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td>99.67%</td><td>100%</td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td>99.78%</td><td>99.89%</td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. No standard</td></tr>
<tr><td>2a PIHP Total</td><td>54.23%</td><td>56.34%</td><td></td><td></td></tr>
<tr><td>2a.1 MI-Children</td><td>50.69%</td><td>57.58%</td><td></td><td></td></tr>
<tr><td>2a.2 MI-Adults</td><td>55.19%</td><td>54.86%</td><td></td><td></td></tr>
<tr><td>2a.3 DD-Children</td><td>55.32%</td><td>57.56%</td><td></td><td></td></tr>
<tr><td>2a.4 DD-Adults</td><td>64.00%</td><td>68.00%</td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 2b – Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. No standard</td></tr>
<tr><td>2b SUD</td><td>74.00%</td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. No standard</td></tr>
<tr><td>3 PIHP Total</td><td>81.62%</td><td>82.32%</td><td></td><td></td></tr>
<tr><td>3.1 MI-Children</td><td>80.38%</td><td>84.51%</td><td></td><td></td></tr>
<tr><td>3.2 MI-Adults</td><td>79.37%</td><td>79.33%</td><td></td><td></td></tr>
<tr><td>3.3 DD-Children</td><td>92.86%</td><td>90.05%</td><td></td><td></td></tr>
<tr><td>3.4 DD-Adults</td><td>81.54%</td><td>83.33%</td><td></td><td></td></tr>
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</td>
<td>Lauren Campbell

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

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

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

<u>Evaluation:</u> Progress
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> Continue</td>
</tr>
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<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>
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<tr><td colspan="5">Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%</td></tr>
<tr><td>4a.1 Children</td><td>94.57%</td><td>94.37%</td><td></td><td></td></tr>
<tr><td>4a.2 Adults</td><td>97.21%</td><td>97.94%</td><td></td><td></td></tr>
<tr><td>4b SUD</td><td>95.60%</td><td>94.74%</td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td></tr>
<tr><td>10.1 Children</td><td>7.25%</td><td>14.78%</td><td></td><td></td></tr>
<tr><td>10.2 Adults</td><td>12.01%</td><td>12.79%</td><td></td><td></td></tr>
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</td><td></td><td></td></tr>
<tr><td>Members' Experience</td><td>The goals for FY2024 Reporting are as follows:

Conduct assessments of members' experience with services.

Conduct annual regional customer satisfaction survey.
Conduct the Recovery Self-Assessment (RSA) survey.
Conduct qualitative assessments (e.g., focus groups).
Conduct other assessments of members' experience as needed.
Develop action steps to implement interventions to address areas for improvement based on member satisfaction survey.
Form a workgroup consisting of members of the SUD Provider Network to gather feedback and share ideas to plan upcoming surveys.
Develop and implement action steps to address response rates / totals.

</td><td>Deidre Murch

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

Q 1 (Oct-Dec):
The FY2023 Customer Satisfaction Survey Report was presented to the Quality Management Committee (QMC) on November 29, Quality Improvement Committee (QIC) on December 4, and the Region 10 Board on December 15.

Some highlights from this Report include:

Survey response totals rose 282% for the Adult population from FY2022's survey. A total of 1,647 surveys were completed by adults in services.
Three of the four CMHs saw an increase in response totals, with Sanilac CMH's total dropping slightly.
The percentage of respondents indicating having experienced a barrier to services rose from 18% to 24% during the past year.
The most commonly stated barrier is transportation (24%) with the next most common being inconvenient appointment times (14%).
Recommend to streamline methodology in subsequent survey cycles throughout the network.

The PIHP staff met to discuss potential incentives for persons served to participate in upcoming surveys.</td></tr>
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Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Evaluation: Progress has been made. Discussions continue to identify and incorporate actionable ways to address results of the survey. **Barrier Analysis: No barriers identified.** **Next Steps: Hold the first session of the SUD Workgroup to discuss survey timelines and methodology. Begin preparing for the Recovery Self-Assessment survey.**
State Mandated Performance Improvement Projects (PIPs)	The goals for FY2024 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 This PIP topic is on racial/ethnic disparities in access-to-service-engagement with Substance Use Disorder (SUD) services. Improvement activities are aimed at reducing the rate of disrupted access-to-service-engagement for persons (Medicaid members and non-Medicaid persons) served within Region 10. Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards. • Review Health Services Advisory Group (HSAG) report on PIP interventions and baseline. • Provide / review PIP status updates to Quality Management Committee. 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:** **Q 1 (Oct-Dec):** **Performance Improvement Project (PIP) 1 - First quarter implementation monitoring reports are in the process of aggregate analysis and providing program level feedback.** **PIP 2 - CMHSPs have completed their updated CY2023 improvement action plans, based on quality improvement / quality management consultative feedback provided by the Region 10 PIP team.** **Evaluation: Progress toward goal.** **Barrier Analysis: None identified.** **Next Steps: Continue per plan.**
External Monitoring Reviews	The goals for FY2024 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW]:	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The number of Habilitation Supports Waiver (HSW) enrollees at the close of Q1 was 547 of the PIHP's total 656 slots. There are currently four (4) pending**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions. ○ Ensure both Professional and Aide staff meet required qualifications. ○ Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. ○ Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. ○ Discuss and follow up on HSW slot utilization and slot maintenance.		**applications. Slot utilization continues to be a struggle for the Habilitation Supports Waiver. Disenrollment numbers have increased, which is consistent across the State, due to the Appendix K flexibilities ending November 11, 2023.** **The PIHP HSW Lead has been holding monthly working sessions with the CMH leads to discuss slot utilization and strategize ways, as a region, to increase enrollment numbers. These meetings have been helpful in identifying barriers to the program and discussing program expectations and needs. Additionally, the PIHP lead is scheduling a meeting with Finance to discuss the financial impacts of the decreased enrollment in the HSW program and explore reports to pull potential enrollees.** **In Q1, Region 10 updated Policy language which is now updated on the PIHP website. The policy reinforces timely documentation submission for the HSW program and slot utilization. The PIHP HSW Coordinator attended the 2023 Annual Home and Community Based Waiver Conference which took place in November.** **Another program improvement strategy the PIHP has adopted is at the monthly Quality Management Committee (QMC) meetings, the PIHP has asked the CMH representatives to speak to any outstanding items for the 1915(c) waivers and address any barriers. This oversight has been effective in getting outstanding items cleared up and will continue to be used. With continued oversight, communication, and target deadlines, Genesee Health System has been able to clean up all of the outstanding items for their Children's Waiver Program in Quarter 1.** **Evaluation: Progress** **Barrier Analysis: Continues to be Slot Utilization for the Habilitation Supports Waiver** **Next Steps: Continue**
Monitoring of Quality Areas	The goals for FY2024 Reporting are as follows: • To explore and promote quality and data practices within the region.	Lauren Campbell & Laurie Story-Walker	**Quarterly Update:** **Q 1 (Oct-Dec):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor critical incident data and reporting. ○ Monitor risk event data and reporting. ○ Monitor emerging quality and data initiative / issues and requirements. ○ Monitor and address Performance Bonus Incentive Pool activities and indicators. ○ Monitor and address changes to service codes. ○ Review / analysis of various regional data reports. ○ Review / analysis of Behavioral Health Treatment Episode Data Set (BH TEDS) reports.	Quality Management Committee (QMC)	**BH TEDS MDHHS added H0038 as an excluded CPT code for Substance Use as it was reporting a missing BH TEDS record when the service can be provided prior to the treatment episode. The service can also be provided post discharge, however this was not impacted, because there was a BH TEDS record in the warehouse. MDHHS worked with DTMB to correct some BH TEDS Errors.** **Completion Rates through 9/30/2023:** • **Mental Health – 99.44%** • **Q (Crisis records) – 98.65%** • **SUD – 99.68%** **CCBHC SUD claims have been paused as the PIHP works on updated requirements (email from Richard Carpenter 10/02/2023).** **MichiCANS - Sanilac CMH is a pilot site beginning in January 2024, along with others in the state. The pilot program will provide vital information on how the tool is working and allow for updates/enhancements to the tool and guidance document prior to the statewide go live which is expected for FY2025 (10/01/2024).** **Electronic Visit Verification (EVV) Collaboration and discovery meetings continue to occur with HHAX (vendor and MDHHS) they have also requested additional Provider information from each CMH to assist with the project development. On November 16, 2023, HHAX presented patient authorization, Provider Agency profile and Draft specifications. Proposed go-live date is 3/1/2024.** **DHHS – 2451A Income Only Determination (Ability to Pay) has been programmed into CHIP. Awaiting to hear from OASIS users and will be programmed in MIX for the SUD Providers. The goal for the new process is to have one (1) assessed ability to pay for all entities, mental health, SUD and CCBHC.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Encounter Reporting – Genese Health System is working their PCE Project Manager to ensure the CCBHC T1040 is reporting with the qualifying CCBHC service. Lapeer CMH is reporting CCBHC services and Sanilac CMH is reviewing the data to ensure its accuracy before submitting the encounters. All have their EHR's programmed to attach the TF modifier, which identifies mild-to-moderate population using the LOCUS and CAFAs score. **The memo from Belinda Hawks was shared, adding Skill Building via telehealth to be provided in the home. The CMHSP/PIHP must guarantee the individual is not influenced or prompted for the service. It must be at the request of the individual.** **The October 2023 Encounter Data Integrity Team (EDIT) meeting minutes were shared highlighting agenda topics discussed.** **Critical incident numbers were reviewed with the Quality Management Committee (QMC) members. All CMHs confirmed their numbers were accurate. Follow up continues to ensure critical incident remediations are addressed and submitted in the Customer Relationship Management (CRM) system.** **Additionally, the committee members submitted narratives for the regional Patient-Centered Medical Home narrative as part of the Performance Bonus Incentive Pool (PBIP) requirements. The narrative was submitted to MDHHS on November 13, 2023.** **Evaluation: Progress** **Barrier Analysis: Understanding of the process for critical incident remediation entries within the CRM System.** **Next Steps: Continue activities**
Financial Management	The goals for FY2024 Reporting are as follows: • Establish consistent Region-wide finance reporting for the annual Certified Community Behavioral Health Clinic (CCBHC) Cost report.	Richard Carpenter Finance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The first of the four quarterly trainings was completed on November 17, 2023 at the Lapeer County Country Club.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Region 10 Chief Financial Officer (CFO) will provide quarterly training on specific aspects of the CCBHC cost report designed to inform and direct the CCBHC sites on how to gather and report the required financial information.		**This first training was designed as a financing overview for CCBHC Demonstration. CCBHC Finance Officers, administration staff, and Board members were all invited to participate in the training. Feedback regarding the training was positive.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue**
Utilization Management	The goals for FY2024 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. ○ Monitor and advise on Peter Chang Enterprises (PCE)-based crisis service utilization reports (monthly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Monthly crisis services utilization reports have been reviewed and no concerning trends have been identified.** **Evaluation: Progress toward goal.** **Barrier Analysis: None identified.** **Next Steps: Continue per plan.**
Utilization Management	The goals for FY2024 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement. ○ Monitor and advise on BTPRC data spreadsheet reports: Evaluate reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **No service utilization or treatment issues are identified.** **Evaluation: Progress toward goal.** **Barrier Analysis: None identified.** **Next Steps: Continue per plan.**
Utilization Management	The goals for FY2024 Reporting are as follows: • Ensure regional Utilization Review (UR). ○ PIHP UM Department to conduct UR: ▪ UR on SUD network provider programs (annually) ▪ UR on CMHSP Optimal Alliance Software Information System (OASIS)-user affiliates (quarterly) ○ UMC to monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Annual SUD Utilization Review (UR) was completed as scheduled for the September meeting.** **CMH UR OASIS outlier/case finding reports are still in development with TBDS, and outreach has been maintained to encourage completion of these reports. CHIP CMH UR reports were reviewed in September as scheduled.** **Evaluation: Progress toward goal.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Barrier Analysis:</u> CMH UR OASIS outlier/case finding reports are still in development with TBDS **<u>Next Steps:</u> Continue per plan.**

Utilization Management	The goals for FY2024 Reporting are as follows:
	• Promote aligned care management activities across key areas of network operations.
	  ○ Implement Centralized UM System (UM Redesign Project)
	    ▪ Oversight of the OASIS Users Workgroup and Sub-Workgroup
	  ○ Operate the MDHHS/Region 10 Phase I Parity Compliance Plan
	    ▪ Oversight of the Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability System.
	    ▪ Oversight of Region 10 participation on the UM Directors Group.
		Tom Seilheimer
		
		Utilization Management (UM) Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			OASIS / MIX demoing took place in early December, with plans to complete demoing in January. New Access clinical staff have been onboarded into the Indicia system. The Region 10 Chief Clinical Officer (CCO) participates in the statewide UM Directors Group and reports on the group's activities monthly at UMC.
			
			<u>Evaluation:</u> Progress toward goal.
			<u>Barrier Analysis:</u> None identified.
			<u>Next Steps:</u> Continue per plan.

Utilization Management	The goals for FY2024 Reporting are as follows: • Promote centralized care management operations across the regional Access Management System (AMS). ○ Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The End of (EO) FY2023 Access Management System (AMS) Evaluation Report was completed and reviewed, and its findings and recommendations are being integrated into the Utilization Management (UM) Program Plan Evaluation Report, which will be forwarded to QIC for review/approval.** **<u>Evaluation:</u> Progress toward goal.** **<u>Barrier Analysis:</u> None identified.** **<u>Next Steps:</u> Continue per plan.**
Utilization Management	The goals for FY2024 Reporting are as follows: • Provide oversight on CMHSP affiliate community access / care management activities. ○ Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Quarterly reports were reviewed with all CMHSPs successfully engaged in a broad range of activities.** **<u>Evaluation:</u> Progress toward goal.** **<u>Barrier Analysis:</u> None identified.** **<u>Next Steps:</u> Continue per plan.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Utilization Management	The goals for FY2024 Reporting are as follows: • Provide oversight on regional Adverse Benefit Determination (ABD) operations and reporting processes. o Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The quarterly reports were reviewed, and no concerning trends were noted.** **Evaluation: Progress toward goal.** **Barrier Analysis: None identified.** **Next Steps: Continue per plan.**
Corporate Compliance	The goals for FY2024 Reporting are as follows: o Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements o Identify and document responsible entities o Identify and document supporting evidence / practice o Policy review o Review PIHP Corporate Compliance Plan updates • Support reporting requirements as defined by MDHHS, Office of Inspector General (OIG), Medicaid Fraud Control Unit (MFCU), PIHP, etc. o Review of reporting process. o Review of contractual language changes in reporting. o Ongoing discussion on OIG feedback (e.g., Program Integrity Report feedback).	Kristen Potthoff Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **FY2023 Q4 OIG Program Integrity Report submission completed. PIHP Compliance staff members attended the Quarterly Statewide Compliance Officers Workgroup where contractual language changes and OIG Program Integrity Reporting were discussed. The FY2024 Corporate Compliance Plan was posted on the PIHP website and distributed to both PIHP staff and Network Providers. FY2023 Corporate Compliance Annual Report approved and endorsed by the Regulatory Compliance Committee. Received MDHHS PIHP Contract Amendment 1 which included two (2) new OIG Reports; notification provided to Network Providers.** **Evaluation: Progress.** **Barrier Analysis: Ongoing discussion with OIG on report expectations.** **Next Steps: Continued work with OIG and Network Providers on MDHHS reporting expectations.**
Corporate Compliance	The goals for FY2024 Reporting are as follows: • Compliance with 45 CFR 164.520 Notice of Privacy Practices o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Kristen Potthoff Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP Compliance Team facilitated a consultation meeting with Health Services Advisory Group (HSAG) to ensure that PIHP process for Privacy Notice distribution aligns with federal regulations. Reviewed objectives for this goal including reviewing requirements, identifying and documenting responsible entities, and identifying and documenting supporting evidence / practice.** **Evaluation: Progress.** **Barrier Analysis: None.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Next Steps:</u> Implementation of Privacy Notice distribution plan.

Corporate Compliance	The goals for FY2024 Reporting are as follows:
	• Review regional Corporate Compliance monitoring standards, reports, and outcomes.
	    o Review regional PIHP contract monitoring results
	    o Review current CMH Subcontractor contract monitoring process / content
		Kristen Potthoff
		
		Corporate Compliance Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Discussion of FY2023 Annual Contract Monitoring including ongoing Provider Plans of Correction.
			
			<u>Evaluation:</u> Progress.
			<u>Barrier Analysis:</u> None.
			<u>Next Steps:</u> FY2024 Annual Contract Monitoring Tool development.

Provider Network	The goals for FY2024 Reporting are as follows:
	• Address service capacity concerns and support resolution of identified gaps in the network.
	    o Review and address CMH Network gaps and capacity concerns.
	    o Review and address SUD Network gaps and capacity concerns.
		Stephanie Willis-Ritland
		
		Provider Network Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Implemented enhancements to PIHP / CMH Contract Performance Objectives Attachment regarding Habilitation Support Waiver (HSW) and Autism Services. Successful enrollment of GHS Intensive Crisis Stabilization Services (ICSS) Program (Adult and Children) per recent GHS subcontract provider changes. Evaluation of ARPA Grant Proposals for SUD Recovery Community Organizations and selected providers to receive funding awards. Development and issuance of contracts to selected SUD Recovery Community Organizations related to the American Rescue Plan Act (ARPA) Grant.
			
			<u>Evaluation:</u> Progress.
			<u>Barrier Analysis:</u> None.
			<u>Next Steps:</u> Continued work with CMH Network Providers on Habilitation Support Waiver (HSW) and Autism Service availability. Continue monitoring SUD network capacity.

Provider Network	The goals for FY2024 Reporting are as follows:
	• Review Network Adequacy requirements and address compliance with standards.
	    o Review requirements.
	    o Identify and document responsible entities.
	    o Identify and document supporting evidence / practice.
	    o Policy review.
		Stephanie Willis-Ritland
		
		Provider Network Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Discussion with MDHHS on upcoming changes to Network Adequacy Standards. MDHHS will identify maximum time and distance standards by PIHP region with additional information forthcoming. Received MDHHS recommendations on maximum time and distance standards regarding Network Adequacy and

<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>reviewing for additional considerations on county designations within network. Outreach made to Sanilac County CMH regarding capability to meet standards.

<u>Evaluation:</u> Progress.
<u>Barrier Analysis:</u> Pending reporting template and instructions from MDHHS.
<u>Next Steps:</u> Continued work with MDHHS on reporting expectations.</td></tr>
<tr><td>Provider Network</td><td>The goals for FY2024 Reporting are as follows:
Review most recent FY PIHP Contract Monitoring Results.
Review FY Contract Monitoring Aggregate Report.
Discuss trends and improvement opportunities.</td><td>Stephanie Willis-Ritland

Provider Network Committee</td><td>Quarterly Update:

Q 1 (Oct-Dec):
Enhancement of PIHP process to review Provider Annual Contract Monitoring Plans of Correction. Initial Subject Matter Expert (SME) review of Provider Annual Monitoring Plans of Correction complete. Issued notification to Providers on any Plan of Correction non-acceptance with requests for additional follow up. Draft materials developed for planned FY2024 Annual Contract Monitoring Kick Off Meeting.

<u>Evaluation:</u> Progress.
<u>Barrier Analysis:</u> None.
<u>Next Steps:</u> Ongoing development of FY2024 Monitoring Tools / Worksheets and process.</td></tr>
<tr><td>Customer Service Inquiries</td><td>The goals for FY2024 Reporting are as follows:
To review and analyze baseline customer service inquiry data for the region for FY2024.
To track and trend internally the customer service inquiries on a monthly basis.
Identify consistent patterns related to customer service inquiries.
Develop interventions to address critical issues within the Network.
<table>
<tr><th colspan="8">Reporting Period: FY2024</th></tr>
<tr><th rowspan="2"></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>7</td><td>5</td><td>2</td><td></td><td></td><td></td><td>14</td></tr>
<tr><td>Lapeer</td><td>1</td><td>1</td><td>1</td><td></td><td></td><td></td><td>3</td></tr>
</table></td><td>Katie Forbes

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

Q 1 (Oct-Dec):
There was a total of thirty-four (34) customer service inquiries in Q1. This is an increase from FY2023 Q1 which had nineteen (19).

Top Inquiry Dispositions:
Ten (10) of the inquiries resulted in a referral to a provider within the PIHP Network.
Five (5) of the inquiries resulted in an appeal.
Five (5) of the inquiries were closed due to being unable to reach the consumer for follow-up.
<u>Evaluation:</u> Progress towards goal.
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> Continued efforts towards goal.</td></tr>
</table>

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

	Oct	Nov	Dec	Q2	Q3	Q4	Total
PIHP	2	0	6				**8**
Sanilac	1	0	0				**1**
St. Clair	1	1	2				**4**
SUD	0	2	2				**4**
TOTAL	12	9	13				**34**

Inquiry Dispositions:	**Total**
Appeal	**5**
Grievance	**0**
Referral to Access	**6**
Rights Complaint	**0**
Referral to Provider	**10**
Other	**4**
Unable to Reach	**5**
Pending	**4**

Appeals

The goals for FY2024 Reporting are as follows:

- To review and analyze baseline appeals data for the region for FY2024.
    - To track and trend internally the appeals on a monthly basis.
    - Identify consistent patterns related to appeals.
    - Develop interventions to address critical issues within the Network.

Reporting Period: FY2024							
	Q1			**Q2**	**Q3**	**Q4**	**Total**
	Oct	**Nov**	**Dec**				
GHS	**2**	**2**	**1**				**5**
Lapeer	**0**	**0**	**0**				**0**
PIHP	**0**	**0**	**0**				**0**
Sanilac	**0**	**0**	**0**				**0**
St. Clair	**0**	**0**	**1**				**1**
SUD	**0**	**0**	**0**				**0**
TOTAL	**2**	**2**	**2**				**6**

Reason for Appeal:	**Total**
Grievance not resolved within 90 days	**0**

Responsible Staff/Department: Katie Forbes

PIHP Customer Service Department

Quarterly Update:

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

Top Reasons for Appeal:

- **Four (4) appeals were for service termination.**
- **Two (2) appeals were for service denial.**

Evaluation: **Progress towards goal.**
Barrier Analysis: **None**
Next Steps: **Continued efforts towards goal.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td>Grievance not resolved within allowed days</td><td>0</td></tr>
<tr><td>Request not acted on within 14 days</td><td>0</td></tr>
<tr><td>Service Denial</td><td>2</td></tr>
<tr><td>Service not started within 14 days</td><td>0</td></tr>
<tr><td>Service Reduction</td><td>0</td></tr>
<tr><td>Service Suspension</td><td>0</td></tr>
<tr><td>Service Termination</td><td>4</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Grievances</td><td>
The goals for FY2024 Reporting are as follows:
• To review and analyze baseline grievance data for the region for FY2024.
○ To track and trend internally the grievances on a monthly basis.
○ Identify consistent patterns related to grievances.
○ Develop interventions to address critical issues within the Network.
○ Meet with CMHSPs quarterly to discuss procedures for the receipt and completion of grievances.
<table>
<tr><th colspan="8">Reporting Period: FY2024</th></tr>
<tr><th rowspan="2"></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>Lapeer</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>Sanilac</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>St. Clair</td><td>n/r</td><td>n/r</td><td>n/r</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><td>TOTAL</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>n/r</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Financial Matters</td><td>n/r</td></tr>
<tr><td colspan="7">Quality of Care</td><td>n/r</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>n/r</td></tr>
<tr><td colspan="7">Service Environment</td><td>n/r</td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td>n/r</td></tr>
<tr><td colspan="7">Other</td><td>n/r</td></tr>
</table>
</td><td>Katie Forbes

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

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

<u>Evaluation:</u> Progress towards goal.
<u>Barrier Analysis:</u> None
<u>Next Steps:</u> Continued efforts towards goal.
</td></tr>
</table>

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

Credentialing / Privileging	The goals for FY2024 Reporting are as follows:
	• Complete Privileging and Credentialing reviews of Organizational Applications for CMH and SUD Providers.
	  ○ Review and approve or deny all Organizational Applications:
	    ▪ Current Providers
	    ▪ New Providers
	    ▪ Existing Provider Renewals / Updates
	    ▪ Provider Terminations / Suspensions / Probationary Status
	    ▪ Provider Adverse Credentialing Determinations
		Stephanie Willis-Ritland
		
		Privileging and Credentialing Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Approval of five (5) existing Provider Organizational Applications.
			
			Evaluation: **Progress.**
			Barrier Analysis: **None.**
			Next Steps: **Continue with goal.**

Credentialing / Privileging	The goals for FY2024 Reporting are as follows:
	• Complete Privileging and Credentialing reviews of all applicable Region 10 staff.
	  ○ Review and approve or deny all PIHP Individual Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, direct hire Access Clinicians):
	    ▪ Current Practitioners
	    ▪ New Practitioners
	    ▪ Existing Practitioner Renewals / Updates
	    ▪ Practitioner Terminations / Suspensions / Probationary Status
	    ▪ Practitioner Adverse Credentialing Determinations
	  ○ Review of all Access Center leased staff credentialing decisions from St. Clair County CMH.
		Stephanie Willis-Ritland
		
		Privileging and Credentialing Committee
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			Approval of three (3) Access Center Practitioner Applications.
			
			Evaluation: **Progress.**
			Barrier Analysis: **None.**
			Next Steps: **Continue with goal.**

Credentialing / Privileging	The goals for FY2024 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. ○ Review and update the current PIHP Privileging and Credentialing policy content.	Stephanie Willis-Ritland Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Discussion regarding updated MDHHS Credentialing Policy. Received information from MDHHS on Universal Credentialing upcoming training and notified Universal Credentialing activities paused. Discussion regarding**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Review for alignment between policy and applications. ▪ Revise and clarify language where needed.		**enhancements necessary to PIHP Annual Contract Monitoring of Provider credentialing records and performance standards.** **Evaluation: Progress.** **Barrier Analysis: Pending MDHHS Universal Credentialing expectations.** **Next Steps: Continue work with MDHHS on Universal Credentialing expectations. Continued discussion on PIHP Policy enhancements.**
Autism Program	The goals for FY2024 Reporting are as follows: • Reduce the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services, as measured by the number of persons on the overdue list and length of stay on the overdue list before beginning services. o Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form. o Compare submitted Autism Benefit Case Action Forms (ABCAFs) in Microsoft Teams with encounter data to identify cases active and cases not receiving services.	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **In Q1, St. Clair CMH and Genesee Health System signed on new Providers to help keep up with service capacity demands. This effort is not reflected in the numbers provided, however. All four CMHSPs have individuals eligible and not yet receiving services. CMHSPs have reported applications are being accepted for BCBAs and QBHPs along with Behavioral Technicians to help improve the demand for services.** **Evaluation: Progress** **Barrier Analysis: Network capacity issues** **Next Steps: Continue**

		FY23 2Q	FY23 3Q	FY23 4Q	FY24 1Q		
		Mar	Jun	Sep	Oct	Nov	Dec
Genesee	**Overdue List Total**	**142**	**180**	**206**	**210**	**240**	**263**
	≥90 (Days)	104	142	181	189	220	234
	60-89	5	9	16	14	10	18
	30-59	15	14	6	5	9	10
	0-29	18	15	3	2	1	1
Lapeer	**Overdue List Total**	**3**	**7**	**11**	**12**	**13**	**14**
	≥90	1	1	5	6	11	11
	60-89	0	0	0	4	0	1
	30-59	1	3	4	1	1	1

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<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td>0-29</td><td>1</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Sanilac Overdue List Total</td><td>1</td><td>0</td><td>0</td><td>5</td><td>6</td><td>7</td></tr>
<tr><td>≥90</td><td>0</td><td>0</td><td>0</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>60-89</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>2</td></tr>
<tr><td>30-59</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>0-29</td><td>1</td><td>0</td><td>0</td><td>1</td><td>2</td><td>0</td></tr>
<tr><td>St. Clair Overdue List Total</td><td>20</td><td>36</td><td>42</td><td>40</td><td>40</td><td>40</td></tr>
<tr><td>≥90</td><td>11</td><td>13</td><td>26</td><td>26</td><td>31</td><td>31</td></tr>
<tr><td>60-89</td><td>2</td><td>3</td><td>4</td><td>8</td><td>4</td><td>2</td></tr>
<tr><td>30-59</td><td>3</td><td>17</td><td>7</td><td>4</td><td>3</td><td>3</td></tr>
<tr><td>0-29</td><td>4</td><td>3</td><td>5</td><td>2</td><td>2</td><td>4</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Autism Program</td><td>The goals for FY2024 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 Forms (ABCAFs) for initial and re-evaluation documents to the PIHP related to the Autism Benefit.
• The CMHSPs will additionally submit an Autism Monthly Reporting Form to the PIHP by the 15th of each month to report data for the previous month. The PIHP will work with CMHSPs on understanding of timeframes for document and data submission, and accurate and timely processing of document submission by the PIHP.</td><td>Shannon Jackson

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

Q 1 (Oct-Dec):
Sanilac CMH has continued to not submit ABCAF documentation to the PIHP since April despite numerous outreach attempts. Sanilac CMH has also not consistently been submitting the Autism Reporting Form. Communication has increased with the CMH Lead to address this issue along with communication with the Quality Management Committee (QMC) CMH representative as an outstanding item to follow up on. This has proven to be a helpful strategy with these continued efforts and communication has improved. Outreach has been made to remind CMH Autism Leads of the program expectations as the Autism Monthly Reporting Form continues to not be submitted timely. More monthly communication is being made to help gain greater program accuracy and knowledge.

<u>Evaluation:</u> Progress
<u>Barrier Analysis:</u> Receiving timely documentation submission
<u>Next Steps:</u> Continue</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Customer Relationship Management (CRM) System	The goals for FY2024 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 Schweiger Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Alcohol Information and Counseling Center's (AICC) name and address change request has successfully been completed; the change is reflected throughout the applications in the Customer Relationship Management (CRM) system.** **Additionally, all CMHSP Homebased Certifications have been approved by MDHHS and are effective until September 2026.** **The PIHP had a ticket open with MDHHS regarding our region's critical incident remediations no longer being visible in the system. This was resolved and the PIHP's Critical Incident team is able to view remediations in the CRM system.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue**
Opioid Health Home (OHH)	The goals for FY2024 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 Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **During this quarter, the OHH program has increased the total number of HHPs from two (2) to five (5) and from two (2) locations from five (5) to seven (7) in the region. This has resulted in an increased number of beneficiaries during the quarter from 167 to 269 enrolled, a 61% increase. With one new HHP, Arbor Recovery, not enrolling yet due to staff capacity.** **Plans continue to add OHH services to the claims verification process. OHH Coordinator has begun tracking monthly services submitted for utilization of program. Monthly recoupment reports have shown a decrease in recoupments from 10% in October and November to 3% for December.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Quality Metrics tracked by MDHHS for Pay 4 Performance standards were released in CC360 for June 30th, 2023. The latest FY2023 data reflects Programs total rate has continued to exceed Michigan and Region 10's rate for Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge (FUA-7); Michigan 27.45, Region 10 26.99, and Program total 60.81. Initiation and Engagement of Alcohol and Other Drug Treatment within 14 days (IET-14); Michigan 36.79, Region 10 38.38, Program total 76.8, and Region 10 Program 100. **Evaluation: Progress towards goals** **Barrier Analysis: OHH program involvement when higher needs beneficiaries engaged with Detox or Residential services and the OORP program has resulted in claims challenges for HHPs.** **Next Steps: OHH Coordinator will continue to work with HHPs for better understanding of qualified service claims submissions with ongoing trainings and support. Coordinator will also continue to work on identifying potential OBOTs.**

Certified Community Behavioral Health Clinic (CCBHC) Demonstration	The goals for FY2024 Reporting are as follows:
	• Continue development of the Certified Community Behavioral Health Clinic (CCBHC) demonstration within Region 10.
	    o Follow up on and monitor MDHHS Site Visit deficiencies.
	    o Review CCBHC Reported Measures and State Reported Measures to maintain oversight of CCBHC Demonstration performance measures and to ensure Quality Bonus Payment benchmarks are met.
	    o Oversee enrollment of CCBHC Beneficiaries in the WSA and maintaining accurate enrollee reporting:
	        ▪ Continue updating WSA processes per the most current version of the Demonstration Handbook changes or implementations.
	        ▪ Complete assignment into the program, transfer cases, and disenroll consumers, as needed.
		Dena Smiley
		
		Monitored by Quality Improvement Committee (QIC)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
			The PIHP Certified Community Behavioral Health Clinic (CCBHC) Team continues to review quality measures, manage the Waiver Support Application (WSA), Electronic Grants Administration & Management System (EGrAMS) non-Medicaid ARPA Grant reporting, and other CCBHC functions.
			
			Medicaid Bulletin MMP 23-56 was reviewed.
			
			A process document was developed and distributed to all the CCBHC Demonstration Sites to help assist them with Waiver Support Application (WSA) case actions.
			
			The new demonstration sites continue to use the CCBHC FAQ Tracker and submission channel that is used as a central location for the PIHPs and CCBHCs to submit

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Continuing WSA Subcommittee meetings with CCBHC staff. o Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. o Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses. o Adjust processes as needed to accommodate the increased capacity expected as a result of the expansion of the CCBHC Demonstration.		**and ask questions for the MDHHS Program team to respond to and track.** **The new CCBHC Demonstration CMHs reported that their CHIP and OASIS systems were set up and ready to submit encounters with the T1040 code and TF modifier.** **The Quality Management Team has met to discuss the overlap and review process with 1915 (i)SPA/ CCBHC.** **At the close of first quarter, there were approximately 70 CCBHC cases remaining in the PIHP work queue waiting for assignment. 30 of the outstanding cases are being reviewed by the state for WSA system issues or errors.** **Evaluation: Progress towards goals** **Barrier Analysis: WSA errors** **Next Steps: Continue to educate CCBHC sites on new information**
1915(i) State Plan Amendment	The goals for FY2024 Reporting are as follows: • Continue development of the 1915(i)SPA model within Region 10. o Enroll and manage eligible 1915(i) Home and Community-Based Services State Plan Amendment Benefit beneficiaries in the Waiver Support Application (WSA) and maintain accurate enrollee reporting. o Monitor beneficiary enrollment to meet MDHHS guidelines regarding assessments, evaluator credentials, and overlap with other programs. o Review and share reports to maintain timely submission of updated Re-evaluations. o Educate PIHP and CMHSP staff on 1915(i) requirements as changes are made.	Shelley Wilcoxon Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **The 1915(i)SPA went live on October 1, 2023. As of December 28th, there were 3,174 iSPA cases open in the Waiver Support Application (WSA); five (5) new cases to enroll; 521 past due re-evaluations; and 19 re-evaluations coming due in the next 30 days. The primary focus in the first quarter was identifying new beneficiaries for enrollment and processing timely re-evaluations. The PIHP met monthly with the CMHSPs to monitor processes, discuss enrollment barriers and WSA issues, and share MDHHS updates. Additional MDHHS guidance was needed on expectations for enrollment when services between the iSPA and CCBHC overlap. PIHP Leads attended the Waiver Conference in November, including informative sessions on the 1915(i)SPA and the site review process. Information was shared at debriefing meetings with the PIHP Quality Department, Data Department, and CMH Leads, and will be used to guide planning for 2024 site reviews. In December, the PIHP participated in a technical assistance (TA) call with MDHHS for further**

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			clarification, particularly on processing adoption cases; notice required for Disenrollments; and CCBHC enrollment/disenrollment as it relates to iSPA enrollment. These topics required further investigation by MDHHS with a response anticipated in early 2024. **Evaluation: Since the 1915(i)SPA go live date October 1st, the PIHP has continued to focus on enrollment along with monitoring reports and processing of timely re-evaluations. Monthly meetings with the CMHs have helped to identify enrollment barriers, challenges, and WSA issues. The PIHP has worked with the CMHs on resolutions and/or sought further guidance from MDHHS, in part related to the October 1st CCBHC expansion to all Region 10 CMHs. Additionally, cases are reviewed for appropriate assessments and evaluator credentials, as well as service overlap with other Waivers/programs. Sharing of MDHHS guidance is ongoing at monthly PIHP-CMH Leads meetings, Quality Department meetings, and via email. There is continued collaboration between the PIHP CCBHC and iSPA Leads to share information, clarify processes, and avoid issues due to overlapping services.** **Barrier Analysis: A barrier reported by the new CCBHC Demonstrations site CMHs as of October 1st (GHS, Lapeer CMH, and Sanilac CMH) was the volume of CCBHC cases for enrollment, splitting the focus between that and iSPA enrollment/ timely re-evaluations. Also, additional technical assistance/support is needed from MDHHS due to unforeseen scenarios.** **Next Steps: Share and/or implement guidance, once received from MDHHS, regarding processing adoption cases; notice required for Disenrollments; and CCBHC enrollment/disenrollment as it relates to iSPA enrollment. Continue to monitor new enrollments and timely processing of re-evaluations. Begin planning for August/September 2024 site reviews.**
Verification of Services	The goals for FY2024 Reporting are as follows: • The PIHP will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors.	Deidre Murch Quality Management & Data Management Departments	**Quarterly Update:** **Q 1 (Oct-Dec):** **The PIHP completed review of FY2022 Q3 claims and submitted final letters to providers initially found to be in compliance on November 28 – 30. Final letters were**

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	○ Conduct quarterly claims verification reviews for each provider contracted during the quarter being reviewed. ○ Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. ○ Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. ○ Send Explanation of Benefits (EOB) letters biannually during the fiscal year. ○ Send EOB letters to more than 5% of consumers receiving services.		**prepared for those initially found to be out of compliance and are under review.** **A new guidance document was drafted for use with the next request for documentation to aid providers in selecting the correct documents to send.** **Explanations of Benefits (EOBs) were sent in December. 905 letters were sent to consumers of GHS, 140 to consumers of Lapeer CMH, 88 to Sanilac CMH consumers, 424 to consumers of St. Clair CMH, and 96 letters sent to consumers in the SUD Provider Network. This equates to approximately 8.7% of consumers.** **The Claims Verification Annual Report was drafted.** **<u>Evaluation:</u> Progress has been made on this continuing goal. The new guidance document should help streamline the review process as well as simplify requests for documentation. The EOB objectives continue to be met with activities taking place this quarter.** **<u>Barrier Analysis:</u> No new barriers identified.** **<u>Next Steps:</u> Send FY2022 Q3 Final Letters, MDHHS summary letter, and FY2022 Q4 requests for documentation in January 2024.**
Long-Term Services and Supports	The goals for FY2024 reporting are as follows: • The PIHP will assess the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS), including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. Mechanisms to assess include: ○ Periodic reviews of plans of service ○ Utilization reviews ○ Claims verification reviews ○ Clinical case record reviews ○ Customer satisfaction surveys • The PIHP will assess each beneficiary identified as needing LTSS to identify any ongoing special conditions of the	Tom Seilheimer / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **No utilization reviews of case records were completed during the first quarter of FY2024. Periodic reviews of plans of service continue per person-centered planning principles, but the reviews of these plans are pended to the utilization review case record review process.** **Clinical case record reviews for 1915(c) Waiver enrollees and individuals receiving Applied Behavior Analysis services are scheduled to occur during Annual Contract Monitoring.** **Claims verification reviews continued for the random sample of FY2022 Q3 claims.**

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	beneficiary that require a course of treatment or regular care monitoring. Mechanisms to assess include: o Biopsychosocial assessments o Ancillary assessments • At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.		**Following the administration of the FY2023 Customer Satisfaction Survey, the PIHP aggregated responses to prepare a report with findings.** **Through the person-centered planning process, the PIHP ensures the CMHSPs conduct initial and annual biopsychosocial assessments, and other assessments as needed.** **Evaluation:** **Barrier Analysis:** **Next Steps:**
External Quality Review Corrective Actions	The goals for FY2024 Reporting are as follows: • Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. Following the SFY2023 Compliance CAP Review of Region 10 PIHP, designated Standard Leads will address any outstanding findings and CAPs from SFY2021 and SFY2022 Compliance Reviews. Per the 2023 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended: o Region 10 and the CMHSP expand upon their performance indicator validation checks to ensure any manually entered dates as a result of system overrides are reviewed for accuracy.	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation:** Lauren Campbell	**Quarterly Update:** **Q 1 (Oct-Dec):** **The final 2023 Performance Measure Validation (PMV) Review Report was received from HSAG. The report was presented to the Quality Management Committee, Quality Improvement Committee, and PIHP Board. The identified weakness and recommendation were highlighted with the committee members. The PIHP will plan for additional follow up in the future to ensure CMHs have expanded validation checks for performance indicator events with any manual entries or overrides.** **The PIHP also received the SFY2023 Compliance Review Report with final findings. All but two corrective action plans were found to be complete. However, no technical assistance sessions were needed. The External Quality Review Team asked Standard Leads for responses to the recommendations provided in the SFY2023 Compliance Review Report.** **The External Quality Review Team hosted a kick-off meeting to prepare for the SFY2024 Compliance Review. Standard Leads were asked to begin reviewing Standards and consider needed evidence documents. Additionally, HSAG scheduled the SFY2024 Compliance Review and provided key dates for the review. The SFY2024 Compliance Review is scheduled for September 16, 2024.** **Evaluation:** **Progress on addressing SFY2023 PMV and Compliance Review recommendations. Work is**

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			underway to prepare for the SFY2024 Compliance Review. **Barrier Analysis: No specific barriers identified.** **Next Steps: Continue efforts to address recommendations and to plan for the upcoming review(s).**

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As of 01.04.2024