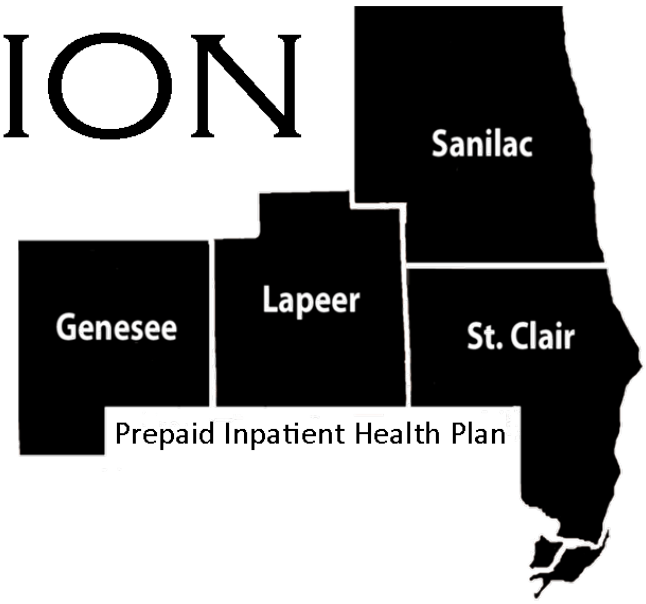
REGION 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 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:** **Q 2 (Jan-Mar):** **The FY2022 Annual Evaluation was submitted timely to MDHHS ahead of the February 28, 2023 deadline.** **Evaluation: This goal was fully met in the first quarter. 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.** **Barrier Analysis: It was identified that the original due date did not allow for sufficient time to provide comprehensive evaluations and updates.** **Next Steps: The deadline extension for annual evaluations will be carried over for FY2023.**
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:** **Q 2 (Jan-Mar):** **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 tasks. The FY2023 Quality Improvement (QI) Program and Workplan were submitted timely to MDHHS ahead of the February 28, 2023 deadline.** **Evaluation: This goal has been met as the PIHP was able to meet the stated December 1, 2022 deadline.** **Barrier Analysis: No barriers identified.** **Next Steps: The HSAG Compliance Review Final Report will be used to inform potential changes to the FY2023 QI Program Description and Workplan. Goals will be monitored and tracked throughout the year to provide accurate progress updates. Goals will**

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			be adjusted as deemed necessary through the results of this constant evaluation.
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. 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.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **<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>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue plan.**
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) 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)	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **<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>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue plan.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Centralized Utilization Management Redesign implementation		
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	Lauren Campbell / Deidre Murch Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **<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-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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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>Evaluation</u>: Progress toward goal.** **<u>Barrier Analysis</u>: Unclear / undefined processes regarding timely WSA updates led to additional work and follow up in order to fully prepare for the surveys.** **<u>Next Steps</u>: Continue work with the Q1 Survey Cycle to achieve a 100% Provider completion rate by April 21, 2023. Upon the survey closing, the PIHP plans to meet with the CMH Leads to debrief and solidify the survey process to ensure readiness for the next quarter.**
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 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>Evaluation</u>: Progress is being made in all areas according to plan.** **<u>Barrier Analysis</u>: It has become increasingly difficult to identify appropriate members for discussion from all six (6) Medicaid Health Plans (MHPs) each month due to low geographic utilization of some plans over others.** **<u>Next Steps</u>: Continue plan. Discussions are ongoing both internally at the PIHP and at a Statewide level surrounding how to overcome the stated barrier most effectively.**
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	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 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**

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

Monitor 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.

</td><td></td><td>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>Evaluation</u>: Progress toward goals.
<u>Barrier Analysis</u>: The data barrier noted above has been encountered and is being addressed.
<u>Next Steps</u>: Continue plan.</td></tr>
<tr><td>Michigan Mission Based Performance Indicator System (MMBPIS)</td><td>
The goals for FY2023 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.
Improve performance with indicators without a set performance standard.
Ensure follow up on recommendations and guidance provided during External Quality Reviews
Provide status updates to relevant committees, such as the Quality Management Committee (QMC), PIHP CEO, PIHP Board.

<table>
<tr><th></th><th>FY22 Q4</th><th>FY23 Q1</th><th>FY23 Q2</th><th>FY23 Q3</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>99.57%</td><td>100%</td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td>99.89%</td><td>99.77%</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>54.25%</td><td>54.99%</td><td></td><td></td></tr>
<tr><td>2a.1 MI-Children</td><td>57.62%</td><td>58.48%</td><td></td><td></td></tr>
<tr><td>2a.2 MI-Adults</td><td>54.39%</td><td>53.64%</td><td></td><td></td></tr>
<tr><td>2a.3 DD-Children</td><td>48.72%</td><td>50.00%</td><td></td><td></td></tr>
<tr><td>2a.4 DD-Adults</td><td>48.86%</td><td>61.64%</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</td></tr>
</table>
</td><td>Lauren Campbell

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

<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>Evaluation</u>: Regional performance increased for PI 2a and PI 2b. Regional performance decreased for PI 3. Multiple CMHs and the PIHP missed the set performance standards for PIs 4a, 4b, and 10.
<u>Barrier Analysis</u>: PIHP PI Team will review quarterly report materials, including plans of improvement and plans of correction to identify specific barriers.</td></tr>
</table>

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

14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. No standard					
2b SUD	64.75%	73.11%			
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%			
3.1 MI-Children	87.47%	78.59%			
3.2 MI-Adults	83.51%	80.16%			
3.3 DD-Children	91.96%	85.82%			
3.4 DD-Adults	94.03%	81.97%			
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%			
4a.2 Adults	95.71%	94.64%			
4b SUD	90.67%	94.95%			
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%			
10.2 Adults	8.87%	10.62%			

Next Steps: Review plans of improvement and plans of correction. Coordinate with the PIHP SUD Team to address PI 4b performance.

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 / Lauren Campbell Quality Management Committee (QMC)	**Quarterly Update:** **Q 2 (Jan-Mar):** **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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation</u>: Progress continues toward this goal, with a noted 150% increase in responses of persons served in the RSA over FY2022. **<u>Barrier Analysis</u>: None identified.** **<u>Next Steps</u>: Work has begun to aggregate and analyze data collected from the FY2023 RSA. The PIHP will continue internal and external discussions regarding how to increase completion numbers for the upcoming FY2023 Customer Satisfaction Survey.**
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 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>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered with PIP 1. A data delay barrier continues to be encountered with PIP 2. Provisional analysis reports are being generated in the interim, as a full data set is expected to be available by early June.** **<u>Next Steps</u>: Continue plans.**
External Monitoring Reviews	The goals for FY2023 Reporting are as follows:	Shannon Jackson	**Quarterly Update:** **<u>Q 2 (Jan-Mar):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW]: o Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements. 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 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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue Plan**
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. 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.	Lauren Campbell & Laurie Story-Walker Quality Management Committee (QMC)	**Quarterly Update:** **Q 2 (Jan-Mar):** **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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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 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.** **Evaluation: Progress** **Barrier Analysis: Complete and timely reporting of critical incident data.** **Next Steps: Continue efforts**
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. o Evaluate root cause of significant variations by comparing IRM assumptions to CMH actual performance.	Richard Carpenter Finance Committee	**Quarterly Update:** **Q 2 (Jan-Mar):** **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.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Finalize analysis and prepare feedback to MDHHS where IRM assumptions seem unreasonable.**
Financial Management	The goals for FY2023 Reporting are as follows to promote sound fiscal management of the region:	Richard Carpenter Finance Committee	**Quarterly Update:** **Q 2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• Evaluate the effectiveness of Standardized Cost Allocation (SCA) implementation. 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.		**Reviewed the latest Standardized Cost Allocation (SCA) Methodology issued by MDHHS and discussed the various changes made during the year.** **Evaluation: Progress** **Barrier Analysis: Continuing changes made by MDHHS make this analysis difficult as the target is moving.** **Next Steps: Discussion of variations (if any) in implementation procedures.**
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:** **Q 2 (Jan-Mar):** **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.** **Evaluation: Progress toward goals.** **Barrier Analysis: No barriers encountered.** **Next Steps: Continue plan.**
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:** **Q 2 (Jan-Mar):** **Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified.** **Evaluation: Progress toward goals.** **Barrier Analysis: No barriers encountered.** **Next Steps: Continue plan.**
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:** **Q 2 (Jan-Mar):** **CMH utilization review (UR) quarterly reports were reviewed and approved. Most service outlier issues reviewed documented medical necessity rationale or were transitioning to more appropriate levels of care.**

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).		**SUD UR is in the planning stages for late April implementation, as per plan.** **<u>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue plan.**
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 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.** **<u>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue plan.**
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 2 (Jan-Mar):</u>** **Mid-Year report scheduled for completion by late May.** **<u>Evaluation</u>: Progress toward goals.** **<u>Barrier Analysis</u>: No barriers encountered.** **<u>Next Steps</u>: Continue plan.**

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 community access / care management activities. o Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 2 (Jan-Mar):** **Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified.** **Evaluation: Progress toward goals.** **Barrier Analysis: No barriers encountered.** **Next Steps: Continue plan.**
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:** **Q 2 (Jan-Mar):** **Quarterly monitoring reports were presented by their CMHSP representatives, and no service systems or utilization issues were identified.** **Evaluation: Progress toward goals.** **Barrier Analysis: No barriers encountered.** **Next Steps: Continue plan.**
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 o Policy review o Review PIHP Corporate Compliance Plan updates	Katie Forbes Corporate Compliance Committee	**Quarterly Update:** **Q 2 (Jan-Mar):** **The PIHP Corporate Compliance Committee discussed goal objectives and will be prepared to discuss program integrity requirements during FY2023 Q3.** **Evaluation: Progress made towards goal.** **Barrier Analysis: None** **Next Steps: Review Program Integrity requirements will be discussed in the May Corporate Compliance Committee meeting. Review FY2024 Corporate Compliance Program Plan in the August committee meeting.**
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:** **Q 2 (Jan-Mar):** **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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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.** **<u>Evaluation</u>: Progress towards goal.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: PIHP internal development of instructions to support future MCPAR reporting. Submission of the Q3 Program Integrity Report.**
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 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>Evaluation</u>: Progress made towards goal.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: PIHP Compliance staff continue to support initial efforts towards FY2023 Annual Contract Monitoring. Committee discussion on Subnetwork contract monitoring in the May committee meeting.**
Provider Network	The goals for FY2023 Reporting are as follows:	Stephanie Willis-Ritland	**Quarterly Update:** **<u>Q 2 (Jan-Mar):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• 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	Provider Network Committee	**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.** **Evaluation: Progress made towards goal.** **Barrier Analysis: None** **Next Steps: Continue efforts**
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:** **Q 2 (Jan-Mar):** **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.** **Evaluation: Progress made towards goal.** **Barrier Analysis: None** **Next Steps: Continue efforts**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td>Provider Network</td><td>The goals for FY2023 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:

<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>Evaluation</u>: Progress made towards goal.
<u>Barrier Analysis</u>: None
<u>Next Steps</u>: Continue efforts</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></th><th>Q1</th><th colspan="3">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>GHS</td><td>11</td><td>4</td><td>3</td><td>5</td><td></td><td></td><td>23</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>1</td><td>1</td><td>1</td><td>0</td><td></td><td></td><td>3</td></tr>
<tr><td>St. Clair</td><td>3</td><td>1</td><td>0</td><td>0</td><td></td><td></td><td>4</td></tr>
<tr><td>SUD</td><td>4</td><td>0</td><td>5</td><td>2</td><td></td><td></td><td>11</td></tr>
<tr><td>TOTAL</td><td>19</td><td>6</td><td>9</td><td>7</td><td></td><td></td><td>41</td></tr>
<tr><th colspan="7">Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>9</td></tr>
<tr><td colspan="7">Grievance</td><td>4</td></tr>
<tr><td colspan="7">Referral to Access</td><td>4</td></tr>
<tr><td colspan="7">Rights Complaint</td><td>0</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>11</td></tr>
<tr><td colspan="7">Other</td><td>9</td></tr>
</table></td><td>Katie Forbes

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

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

<u>Through FY2023 Q2 Top Inquiry Resolution Categories:</u>
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.
<u>Evaluation</u>: Progress made towards goal.
<u>Barrier Analysis</u>: None
<u>Next Steps</u>: Continue to monitor trends and data for customer service inquiries.</td></tr>
</table>

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td>Pending</td><td>1</td></tr>
<tr><td>Unable to Reach</td><td>4</td></tr>
</table>
</td><td></td><td></td></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.
o To track and trend internally the appeals on a quarterly basis.
o Identify consistent patterns related to member appeals.
o Develop interventions to address critical issues within the organization.

<table>
<tr><th colspan="8">Reporting Period: FY 2023</th></tr>
<tr><th></th><th>Q1</th><th colspan="3">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>GHS</td><td>1</td><td>3</td><td>1</td><td>2</td><td></td><td></td><td>7</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td></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></td><td></td><td>1</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>0</td><td>1</td><td></td><td></td><td>1</td></tr>
<tr><td>TOTAL</td><td>1</td><td>4</td><td>1</td><td>3</td><td></td><td></td><td>9</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>5</td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Reduction</td><td>0</td></tr>
<tr><td colspan="7">Service Suspension</td><td>0</td></tr>
<tr><td colspan="7">Service Termination</td><td>4</td></tr>
</table>
</td><td>Katie Forbes

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

<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>Evaluation</u>: Progress made towards goal.
<u>Barrier Analysis</u>: None
<u>Next Steps</u>: Continue to monitor trends and data for appeals.</td></tr>
<tr><td>Grievances</td><td>The goals for FY2023 Reporting are as follows:
• To review and analyze baseline grievance data for the region for FY2023.</td><td>Katie Forbes

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

<u>Q 2 (Jan-Mar):</u>
Thus far, there have been three (3) grievances in Q2. The PIHP will not receive grievance data from the</td></tr>
</table>

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

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

<table>
<tr><th colspan="8">Reporting Period: FY 2023</th></tr>
<tr><th></th><th>Q1</th><th colspan="3">Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th></th><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th></th><th></th><th></th></tr>
<tr><td>GHS</td><td>31</td><td>1</td><td>N/R</td><td>N/R</td><td></td><td></td><td>32</td></tr>
<tr><td>Lapeer</td><td>0</td><td>N/R</td><td>N/R</td><td>N/R</td><td></td><td></td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>N/R</td><td>N/R</td><td>N/R</td><td></td><td></td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>N/R</td><td>N/R</td><td>N/R</td><td></td><td></td><td>0</td></tr>
<tr><td>SUD</td><td>1</td><td>1</td><td>1</td><td>0</td><td></td><td></td><td>3</td></tr>
<tr><td>TOTAL</td><td>32</td><td>2</td><td>1</td><td>0</td><td></td><td></td><td>35</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Plan or Provider Care Management/Case Management</td><td>1</td></tr>
<tr><td colspan="7">Quality of Care</td><td>22</td></tr>
<tr><td colspan="7">Access and Availability</td><td>6</td></tr>
<tr><td colspan="7">Service Environment</td><td>0</td></tr>
<tr><td colspan="7">Interaction with Provider or Plan</td><td>3</td></tr>
<tr><td colspan="7">Other</td><td>3</td></tr>
</table>
</td><td></td><td>CMH Provider Network until April 15th. This quarterly update will be provided in the May Quality Improvement Committee (QIC) meeting.

<u>Evaluation</u>: Progress
<u>Barrier Analysis</u>: None
<u>Next Steps</u>: Receive Q2 grievance reporting from the CMH Providers and analyze that data. Schedule individual CMH Provider meetings to discuss the grievance process and how it is implemented.</td></tr>
<tr><td>Credentialing / Privileging</td><td>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.

Review all Organizational Applications:

Current Providers
New Providers
Existing Provider Renewals / Updates
Provider Terminations / Suspensions / Probationary Status
Provider Adverse Credentialing Determinations

</td><td>Stephanie Willis-Ritland

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

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

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 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>Evaluation</u>: Progress made towards goal.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Continue efforts**
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 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 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>Evaluation</u>: Progress made towards goal.** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Continue efforts**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Autism Program</td>
<td>
The goals for 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 colspan="2"></th><th>FY22 3Q</th><th>FY22 4Q</th><th>FY23 1Q</th><th colspan="3">FY22 2Q</th></tr>
<tr><th colspan="2"></th><th>Jun</th><th>Sep</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>Genesee</td><td>Overdue List Total</td><td>213</td><td>212</td><td>193</td><td>203</td><td>186</td><td>198</td></tr>
<tr><td></td><td>≥90 (Days)</td><td>173</td><td>148</td><td>166</td><td>167</td><td>137</td><td>137</td></tr>
<tr><td></td><td>60-89</td><td>0</td><td>8</td><td>9</td><td>8</td><td>17</td><td>15</td></tr>
<tr><td></td><td>30-59</td><td>12</td><td>24</td><td>8</td><td>9</td><td>9</td><td>15</td></tr>
<tr><td></td><td>0-29</td><td>28</td><td>32</td><td>10</td><td>19</td><td>23</td><td>31</td></tr>
<tr><td>Lapeer</td><td>Overdue List Total</td><td>4</td><td>3</td><td>5</td><td>3</td><td>3</td><td>4</td></tr>
<tr><td></td><td>≥90</td><td>2</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>60-89</td><td>0</td><td>1</td><td>1</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td></td><td>30-59</td><td>0</td><td>1</td><td>2</td><td>2</td><td>0</td><td>2</td></tr>
<tr><td></td><td>0-29</td><td>2</td><td>1</td><td>2</td><td>0</td><td>2</td><td>2</td></tr>
<tr><td>Sanilac</td><td>Overdue List Total</td><td>6</td><td>3</td><td>3</td><td>3</td><td>2</td><td>3</td></tr>
<tr><td></td><td>≥90</td><td>1</td><td>1</td><td>0</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td></td><td>60-89</td><td>0</td><td>1</td><td>1</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td></td><td>30-59</td><td>3</td><td>0</td><td>2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>0-29</td><td>2</td><td>1</td><td>0</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>St. Clair</td><td>Overdue List Total</td><td>10</td><td>17</td><td>19</td><td>28</td><td>21</td><td>31</td></tr>
<tr><td></td><td>≥90</td><td>6</td><td>2</td><td>7</td><td>8</td><td>9</td><td>12</td></tr>
</table>
</td>
<td>Shannon Jackson

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

<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 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>Evaluation</u>: Progress
<u>Barrier Analysis</u>: The decommissioning of the WSA to monitor these goals, and lack of guidance at the State level.
<u>Next Steps</u>: Continue
</td>
</tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	<table><tr><td>60-89</td><td>0</td><td>4</td><td>3</td><td>1</td><td>3</td><td>8</td></tr><tr><td>30-59</td><td>2</td><td>7</td><td>1</td><td>7</td><td>2</td><td>6</td></tr><tr><td>0-29</td><td>2</td><td>4</td><td>8</td><td>12</td><td>7</td><td>5</td></tr></table>		
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 2 (Jan-Mar):</u>** **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>Evaluation</u>: Progress** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Continue**
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>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.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			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>Evaluation</u>: Progress** **<u>Barrier Analysis</u>: The decommissioning of the WSA** **<u>Next Steps</u>: Continue**
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 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.** **<u>Evaluation</u>: Progress** **<u>Barrier Analysis</u>: None** **<u>Next Steps</u>: Continue**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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.	Rusmira Bektas Provider Network Management Department Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<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 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>Evaluation</u>: New HHP site and beneficiary enrollment increase.** **<u>Barrier Analysis</u>: Combined SHRC location influenced incorrect program referrals. Some care plans are not uploaded timely.** **<u>Next Steps</u>: Updated process documents for Region 10 and HHP providers. Beginning monthly HHP meetings to support and decrease barriers. Begin site visits for quality management.**
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	Lauren Campbell / Deidre Murch Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **<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**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Complete and maintain non-Medicaid ARPA Grant reporting and activities timely. ○ 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. ○ 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. ○ Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. ○ Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.		**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.** **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.** **Evaluation: Progress continues toward this goal.** **Barrier Analysis: A few issues were noted with PCE-reporting from the CCBHC; however, those have been corrected.** **Next Steps: Continue annual plan.**
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 Monitored by Quality Improvement Committee	**Quarterly Update:** **Q 2 (Jan-Mar):** **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.** **The PIHP continued efforts to outreach and collaborate with CMH Leads to begin enrollment of 1915(i)-eligible individuals in the WSA.**

<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 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>Evaluation</u>: Progress
<u>Barrier Analysis</u>: No barriers
<u>Next Steps</u>: Continue</td></tr>
<tr><td>Supports Intensity Scale</td><td>The goals for FY2023 Reporting are as follows:
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><tr><td>Genesee</td><td>92.2%</td><td>93.9%</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>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></table></td><td>Lauren Campbell

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

<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, 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</td></tr>
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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># 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>
<tr><td># Assessments Completed</td><td>10</td><td>2</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Total</td><td>83.6%</td><td>84.3%</td><td>N/A</td><td>N/A</td></tr>
<tr><td># Assessments Completed</td><td>14</td><td>11</td><td>N/A</td><td>N/A</td></tr>
</table>
</td><td></td><td>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>Evaluation</u>: This goal will be discontinued due to the decision by MDHHS to sunset the SIS.
<u>Barrier Analysis</u>: No barriers.
<u>Next Steps</u>: None.</td></tr>
<tr><td>Verification of Services</td><td>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.
Conduct quarterly claims verification reviews.
Increase the sample size selected for quarterly claims verification reviews to include all providers furnishing services during a quarter.
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.</td><td>Deidre Murch / Lauren Campbell

Quality Management & Data Management Departments</td><td>Quarterly Update:

<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>Evaluation</u>: Progress is noted.
<u>Barrier Analysis</u>: None identified.
<u>Next Steps</u>: Complete FY2022 Q2 review and begin preparations for FY2022 Q3 review.</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
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. o Region 10 and the CMHs employ additional oversight to their performance indicator validation processing to ensure service level detail used for calculating	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation:** Lauren Campbell	**Quarterly Update:** **<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.** **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>Evaluation</u>: Progress** **<u>Barrier Analysis</u>: No barriers** **<u>Next Steps</u>: Request updates on both SFY2021 and SFY2022 Compliance Review corrective action plans and recommendations.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	performance measures capture and match MDHHS specifications.		

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As of 04.06.2023