REGION 10 PREPAID INPATIENT HEALTH PLAN



FY2026 Quality Improvement (QI) Program Annual Evaluation Report
Executive Summary
October 2026

Background and Introduction

Since Region 10 PIHP was established in 2014, our mission has been to promote opportunities for Recovery, Discovery, Health and Independence for Individuals receiving services through ease of access, high quality of care and best value. To ensure Region 10 achieves our mission, Region 10 utilizes the Quality Assessment and Performance Improvement Program (QAPIP) to guide improvement actions and activities. With oversight from the Region 10 PIHP Board and the Quality Improvement Committee (QIC), the Quality Improvement (QI) Program Standing Committees and Region 10 staff cooperate to create a QI Workplan that contains ongoing QI activities, goals, and improvement strategies. The QI Workplan is a dynamic document and is updated as needed by the QIC.

The QAPIP is a coordinated approach to improve the quality and safety of services and outcomes for Region 10 consumers. Region 10 works collaboratively with Community Mental Health Service Providers (CMHSPs), Substance Use Disorder (SUD) Network Treatment Providers, and individuals served to improve services and health outcomes across the region. Region 10 is fully committed to maintaining a system-wide approach to ensure improvement in both clinical and non-clinical operations.

This Annual Evaluation Report is a summary and assessment of the activities and initiatives completed by Region 10 PIHP from October 1, 2025, through September 30, 2026, as part of the PIHP's FY2026 QI Workplan.

Performance and Findings

Out of fifty (50) QI goals featured in this report, forty-five (45) goals are considered to be met, four (4) goals are partially met, and one (1) goal is considered not met.

Evaluations of FY2026 QI goals are provided on the following pages. The FY2026 QI Workplan, which includes additional details and quarterly summary updates, is included as an attachment.

Next Steps

Region 10 PIHP staff and QAPIP Committee members used the FY2026 goal evaluations to determine goals for FY2027. Both the FY2026 QI Program Annual Evaluation Report and the FY2027 QI Program Description and Workplan will be presented to the PIHP Board for review, feedback, and approval.

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1. Michigan Mission Based Performance Indicator System (MMBPIS)

Overview
Below are the Quality Management Committee (QMC) goals and responsibilities for the Performance Indicators (PIs).
The main goal is to attain and maintain performance standards as set by the Michigan Department of Health and Human Services (MDHHS).

- Report indicator results to MDHHS quarterly
- 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.
- Discuss and prepare for the transition from MMBPIS to standardized measures.

Goal
This report summarizes performance indicators developed by the MDHHS and monitored by the PIHP using data aggregated from CMHSPs and SUD providers.

In the first quarter of FY2026, MDHHS updated the MMBPIS reporting methodology, revising the exclusion criteria and reducing state reporting requirements to Performance Indicator #2 only. To support regional performance improvement efforts, the PIHP continues to internally monitor SUD Performance Indicators #2e and #4. This report includes SUD Provider performance for the SUD-specific indicators.

The PIHP assumed full calculation of Performance Indicator #2e in the first quarter of FY2026, following its removal from the state reporting requirements. The PIHP's calculation logic mirrors that of MDHHS, and internal calculation by the PIHP enabled consistent application of the MDHHS-developed exclusion criteria across all event types. This includes excluding events for individuals who are medically or physically unable to receive services, and those who decline to receive services.

When a CMHSP or SUD Provider reports that the MDHHS standard for a performance indicator has not been achieved during a quarter, a root cause analysis and Continuous Improvement Plan (CIP) are submitted to Region 10 PIHP along with the respective PI data. The analysis is reviewed, and the plan of improvement is monitored over time by the PIHP along with the trend of scores on all the performance indicators.
If a set standard benchmark is not achieved for the region, the indicator is investigated further by various committees within the QAPIP structure such as QIC, QMC, and Improving Practices Leadership Team (IPLT) to increase input from CMHSP partners, identify contributing factors and systemic issues for the outliers, and review opportunities for improvement across the region.

At the time of preparation of this report, the PIHP has completed the first and second quarter MMBPIS reviews, and both quarterly submissions were submitted timely to MDHHS. The PIHP is currently working on the review of FY2026 Quarter 3 PI data.

Evaluation
Quarterly data and reports are submitted to the PIHP by CMHSPs for performance indicator 2. For the performance indicators measuring follow up with SUD providers, performance indicators 2e and 4b, PIHP staff use available data and follow up with SUD Providers to prepare the quarterly data and reports. SUD Provider performance is included in the report.

Below is the summary of the completed FY2026 quarterly MMBPIS reviews.

Performance Indicator 2: The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.

- In the first quarter of FY2026, Lapeer CMH and Sanilac CMH met/exceeded both established performance benchmarks; St. Clair CMH and Genesee Health System (GHS) did not meet either benchmark.
- In the second quarter of FY2026, all CMHSPs met/exceeded both performance benchmarks.
- Regional performance declined in the first quarter of FY2026 and improved in the second quarter.

Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. Standards = 57% and 62%		
	FY26 Q1	**FY26 Q2**
2a PIHP Total	54.08%	71.99%
2a.1 MI-Children	51.65%	67.31%
2a.2 MI-Adults	55.10%	82.83%
2a.3 DD-Children	50.34%	58.21%
2a.4 DD-Adults	75.76%	66.67%

Performance Indicator 2e: The percentage of new persons 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.

- In the first and second quarters of FY2026, the SUD network met/exceeded the first (lower) performance benchmark but did not meet/exceed the second (higher) benchmark.
- Regional performance declined in the first quarter of FY2026 and improved in the second quarter.

Ind. 2 – 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. Standards = 68.2% and 75.3%		
	FY26 Q1	**FY26 Q2**
2e SUD	72.22%	73.35%

Performance Indicator 4b: The percentage of persons discharged from a substance abuse detox unit who are seen for follow-up care within seven days.

- The SUD Network met/exceeded the performance standard in both quarters.

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%		
	FY26 Q1	**FY26 Q2**
4b SUD	98.25%	100.00%

Please note that at the time of preparation of this summary, the PIHP is currently reviewing the FY2026 Q3 PI data.

The PIHP requires the CMHSPs and SUD Providers to prepare and submit a plan indicating the categorized reasons for noncompliance, with specific focus on which evaluated and prioritized reasons the CMHSPs and SUD Providers will act on to improve individuals' access to care and services. The PIHP requests an initial, and annual plan with quarterly updates. The PIHP continues to encourage substantive root cause analyses and continuous improvement plans.

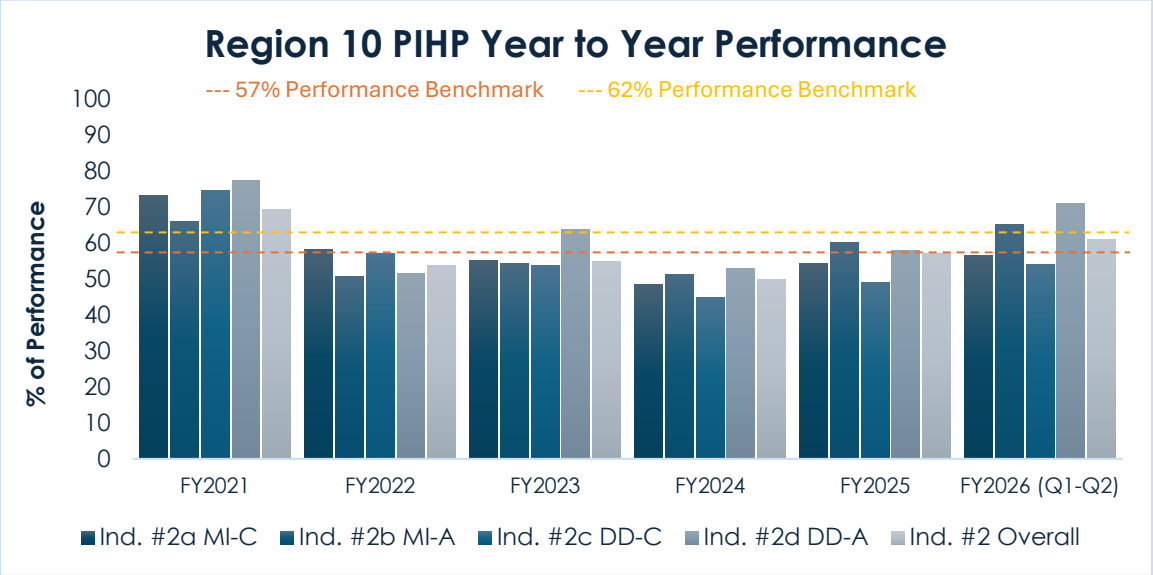
Indicator #2 Year to Year Regional Performance

The MMBPIS was implemented in FY1997 and has been revised periodically over time. In the first quarter of FY2026, MDHHS updated the MMBPIS reporting methodology, revising the exclusion criteria and reducing state reporting requirements to Performance Indicator #2 only. This includes excluding events for individuals who are medically or physically unable to receive services, those who decline to receive services and individuals receiving Certified Community Behavioral Health Clinic (CCBHC) only services. As a result, there is a significant decrease in the total number of events included in the indicators compared to previous years.

The indicators measure the performance of the PIHP for individuals served through the CMHSP. Since the indicators are a measure of performance, deviations from standards and negative statistical outliers may be addressed through contract action. Results for Performance Indicator #2 were published on the MDHHS website within 90 days of the close of the reporting period.

The graph below shows the year-to-year performance of Region 10 PIHP for Indicator #2. The PIHP's year-to-date performance as of FY2026 Q2 met/exceeded the first (lower) performance benchmark but did not meet/exceed the second (higher) benchmark.

Overall, this goal for FY2026 is considered met and will continue into FY2027. Due to the transition from MMBPIS to Behavioral Health Quality Transformation (BHQT), there will be a new goal added to meet and exceed the performance benchmarks set by MDHHS for BHQT measures in the FY2027 QI Workplan.


Region 10 PIHP Year to Year Performance
--- 57% Performance Benchmark
--- 62% Performance Benchmark
% of Performance
100
90
80
70
60
50
40
30
20
10
0
FY2021
FY2022
FY2023
FY2024
FY2025
FY2026 (Q1-Q2)
Ind. #2a MI-C
Ind. #2b MI-A
Ind. #2c DD-C
Ind. #2d DD-A
Ind. #2 Overall

2. Members' Experience

Overview
Below are the QMC goals and responsibilities for Members' Experience standard based on CMHSPs and SUD Provider's delegation agreement and contractual requirements.

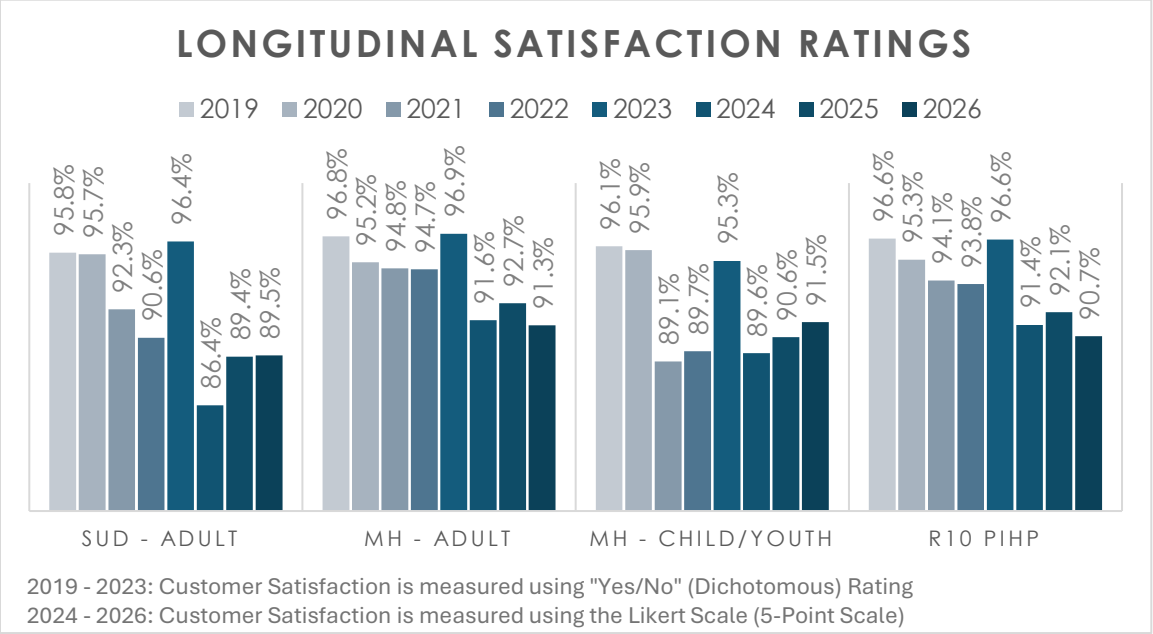
To conduct assessments of members' experience with services.

- Conduct annual regional customer satisfaction 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.
- Facilitate a workgroup consisting of members of the SUD Provider Network to inform future survey planning.
- Develop and implement action steps to address response rates / totals.

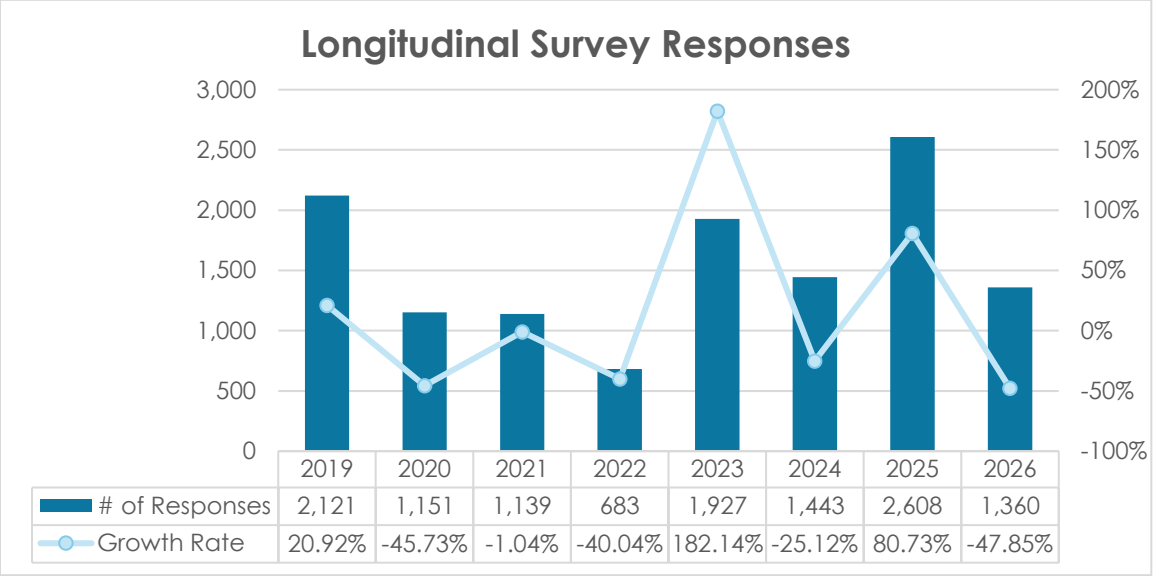
Goal
In FY2026 Members' Experience goal to conduct annual regional customer satisfaction survey was completed. The FY2026 Customer Satisfaction Survey was conducted from July 6 to August 7, 2026, throughout the Region 10 PIHP Provider Network. Despite the initiative to address response rates both the satisfaction and response ratings decreased this year. Individuals receiving only CCBHC Demonstration services were excluded from the target survey population as the PIHP no longer has oversight to consumers receiving CCBHC services. Action steps to address areas for improvement based on the survey were identified and will be observed throughout the following year.

Evaluation
In FY2026 there was a major change in the survey eligibility. The consumers receiving CCBHC only services were excluded from the target survey population, as the PIHP no longer has oversight to consumers receiving CCBHC services. This change affects both the satisfaction and response ratings for FY2026.

Region 10 PIHP's overall satisfaction ratings revealed favorable levels of customer satisfaction with an overall rate of 90.7%. Overall satisfaction rate for the adult population (MHSIP) was 90.5% and 91.5% for child/youth population (YSS-F). This year's overall satisfaction ratings are lower than last year's (Regional: 92.1%, with adult population: 92.7% and child/youth population: 90.6%). This may be attributed to the exclusion of consumers receiving CCBHC only services from the survey population.

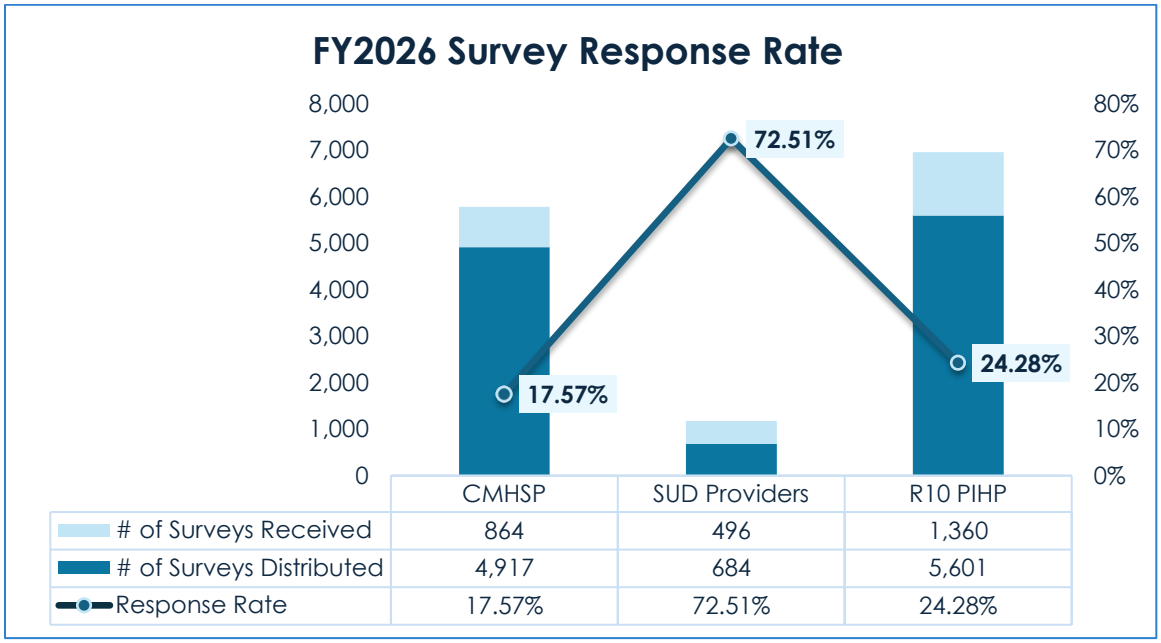


To reach more individuals the PIHP continues the five-week survey administration period and offered the survey in-person, by mail, and by phone. However, due to the change of survey eligibility this year, the number of survey responses decreased from 2,608 in FY2025 to 1,360 in FY2026 (47.85% decrease). The graph below shows the year after year number of survey responses received as well as the growth rate.



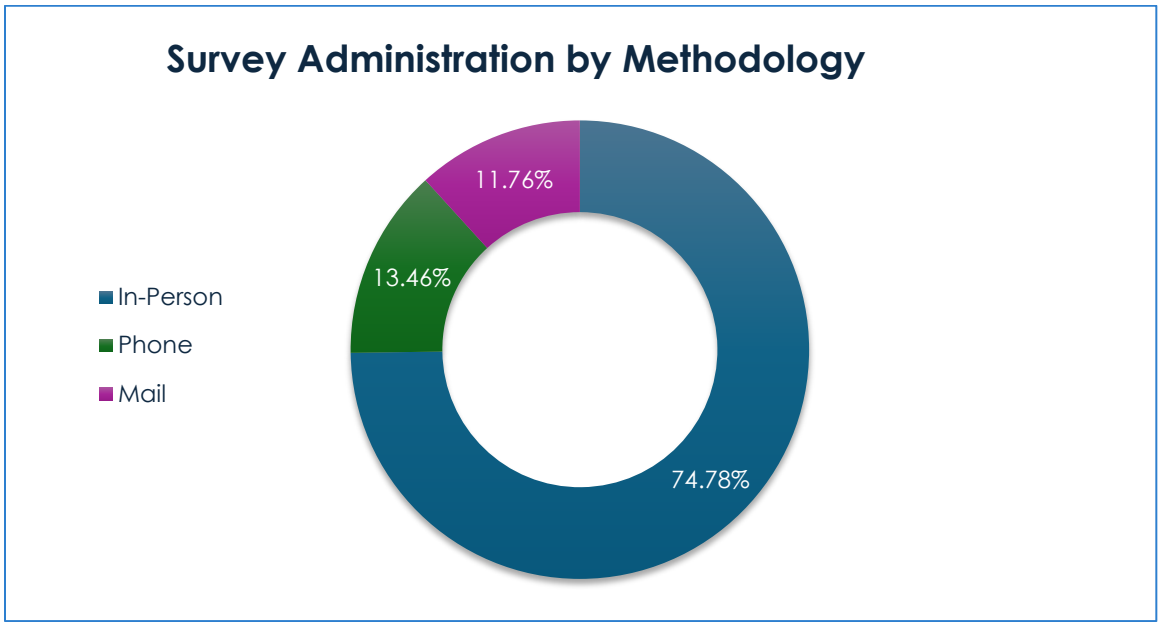
	2019	2020	2021	2022	2023	2024	2025	2026
# of Responses	2,121	1,151	1,139	683	1,927	1,443	2,608	1,360
Growth Rate	20.92%	-45.73%	-1.04%	-40.04%	182.14%	-25.12%	80.73%	-47.85%

Among the survey responses received, 864 responses were from the CMHSPs and 496 responses were from the Substance Use Disorder (SUD) Providers. This year's survey response rate is 24.28%. The graph below shows the details of the survey response rate in FY2026.

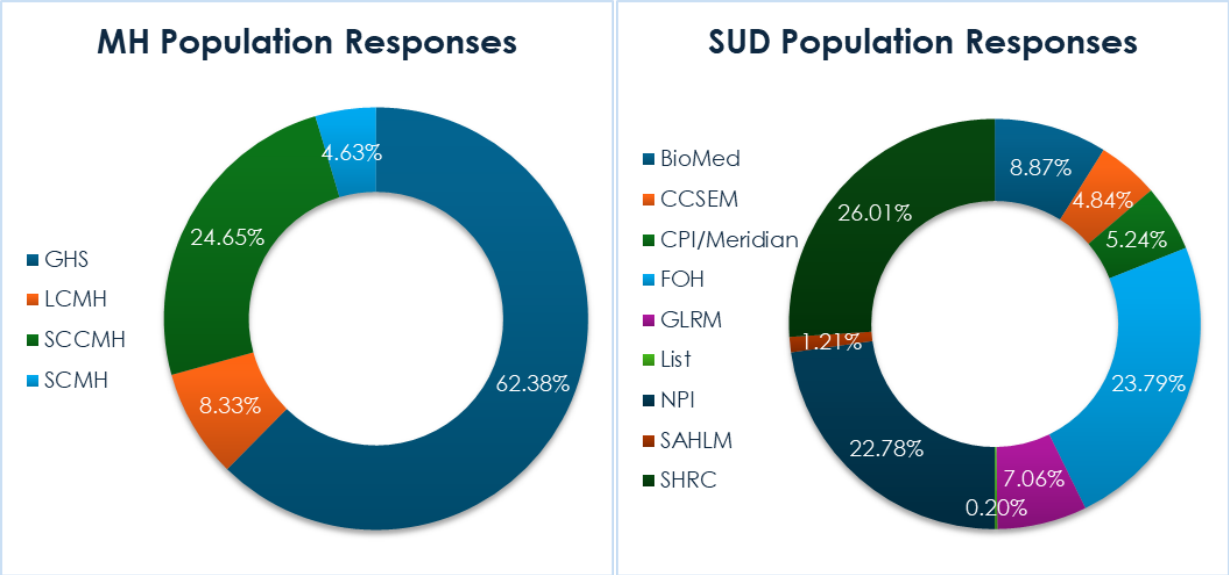


	CMHSP	SUD Providers	R10 PIHP
# of Surveys Received	864	496	1,360
# of Surveys Distributed	4,917	684	5,601
Response Rate	17.57%	72.51%	24.28%

Majority of the received survey responses are from in-person survey administration (1,017 responses) followed by phone (183 responses) and by mail survey (160 responses). The graph below shows the details of the distribution by the survey administration method.



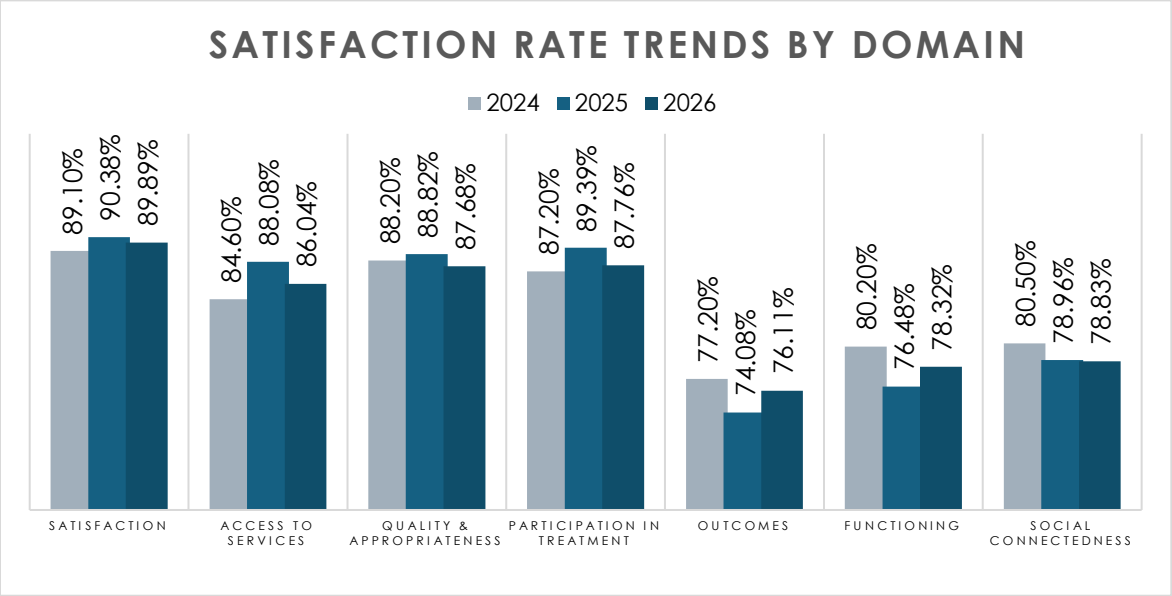
The graph below shows the details of the number of responses received by provider population type. GHS (539 survey responses or 62.38%) and St. Clair CMH (213 survey responses or 24.65%) had the highest number of received survey responses from the mental health population. While Sacred Heart (129 survey responses or 26.01%), Flint Odessey House (118 survey responses or 23.79%), and New Paths (113 survey responses or 22.78%) had the highest number of survey responses received from the substance use disorder population.



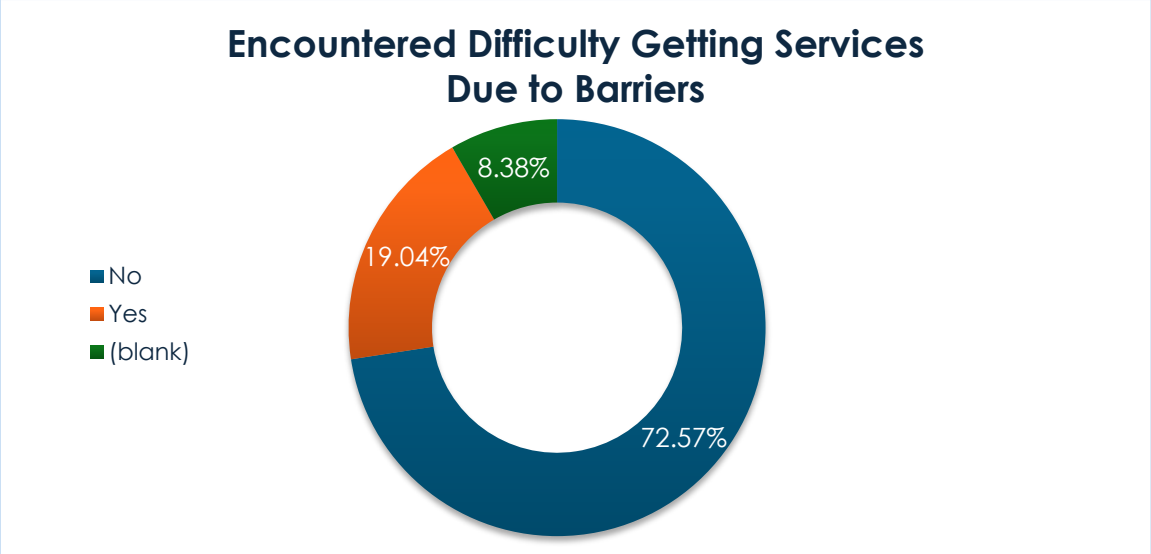
The survey scores were highest in domains capturing general satisfaction (89.89%), participation in treatment (87.76%), quality/appropriateness (87.68%), and access to services (86.04%), indicating that participants feel involved and well supported during their treatment/recovery journey. However, satisfaction rating for these domains this year is slightly lower than in FY 2025.

Respondents reported slightly lower rates on domains related to social connectedness (78.83%), functioning (78.32%), and outcomes (76.11%) from FY2025. Satisfaction rates of these domains, however, have higher percentages this year than the previous year.

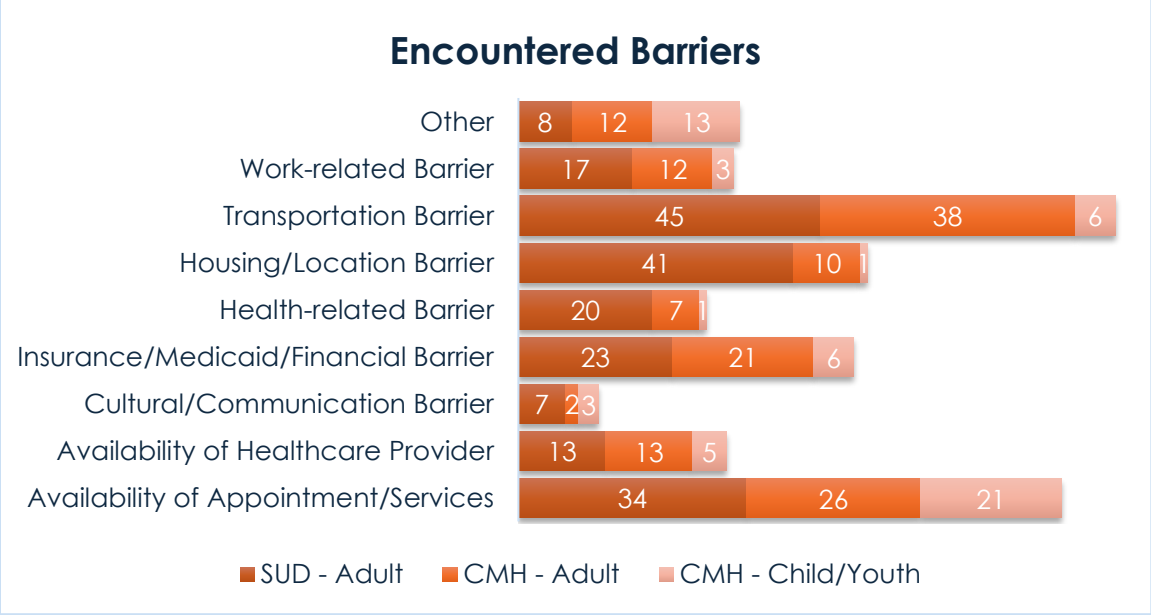
The below graph shows the yearly satisfaction trends by domain.



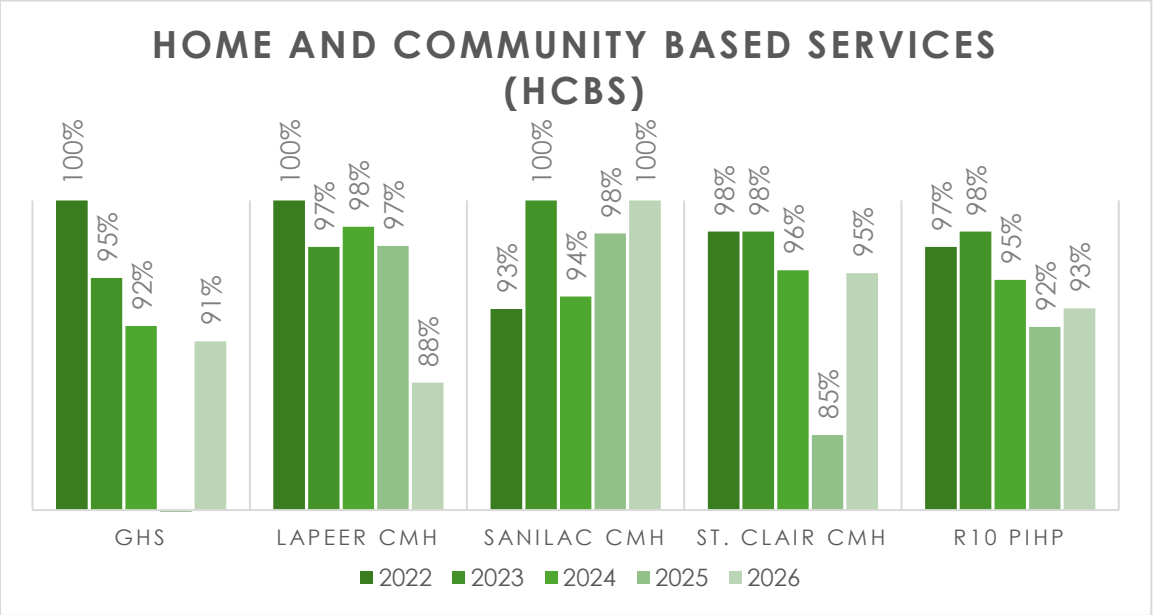
The PIHP measured barriers to services and the below graphs shows that the percentage of respondents who indicated that they did not have difficulty getting services due to any barriers is 72.57% or 987 individuals.19.04 % or 259 individuals indicated that they encountered difficulties, and 8.38% or 114 individuals did not answer this question.

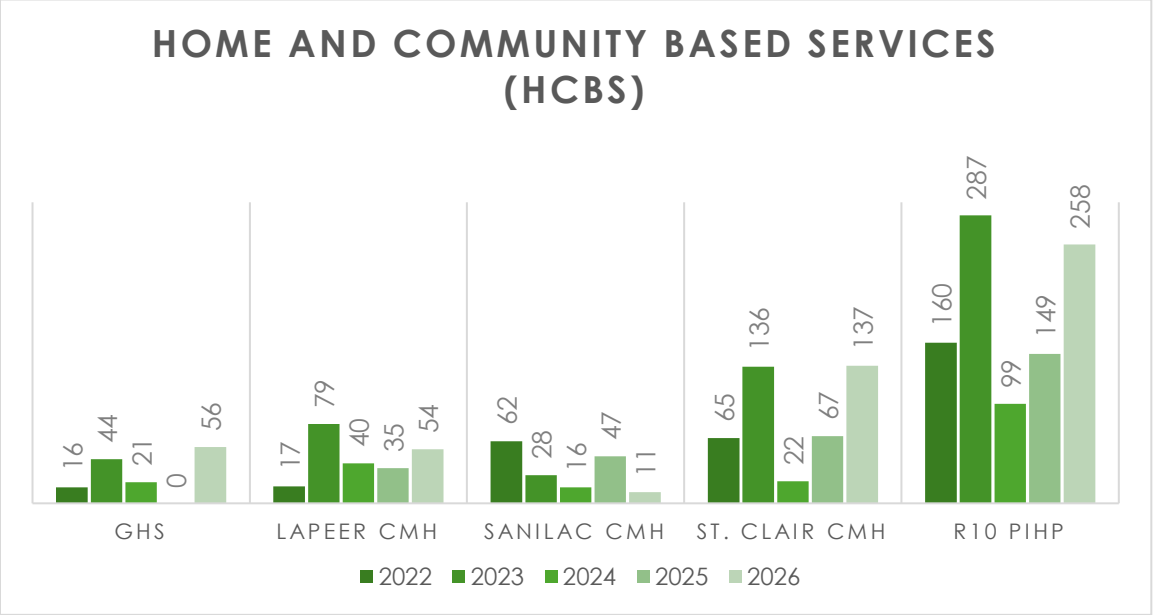


For the adult population, transportation remains the greatest barrier. The survey has also identified barriers with availability of appointment/services, housing/location, and insurance/Medicaid/financial. For child/youth population, top barriers are availability of appointment/services, other (includes difficulty with progress, incorrect paperwork, program cancellation, etc.), transportation and insurance/Medicaid/financial barriers. The below graph shows the details of identified barriers.



Each CMHSP was asked to identify survey respondents who are receiving Home and Community Based Services (HCBS). There were 258 HCBS responses from the adult population collected in FY2026. It is higher than 149 HCBS adult responses collected in FY2025. Adults receiving HCBS services indicated 93.0% satisfaction rate this year, which is a higher percentage than in FY2025 where the satisfaction rate was 91.8%. The below graphs shows the details of yearly satisfaction ratings and number of collected survey responses from respondents receiving HCBS.





Network Affiliates are responsible for reviewing results with individuals served and/or their family members to obtain input and feedback. Following the conclusion of the survey, affiliates are responsible for acting on specific cases as appropriate and identifying the source of dissatisfaction. Affiliates are also responsible for informing practitioners, providers, and individuals served, and their governing body of the survey results.

The results of these surveys are reported to numerous committees throughout the PIHP. These committees include QMC, QIC, advisory boards, and the PIHP Board of Directors. Survey results are also shared on the agency website. QMC will continue to review and discuss survey results, barriers to survey administration, response rates, and suggested changes to future survey processes.

Proposed Improvement Activities

The CMHSPs will continue to focus on key initiatives meant to target scores observed in areas related to symptom management, social engagement, relationships, family and connection and coping when faced with stressors. The need for additional focus on Social Determinants of Health needs, including housing, transportation, financial needs and access to healthcare, were again identified in this year's survey and support the need for continued initiatives. Planned activities also include continued use of Evidence based practices (EBPs), expanding health and wellness programming through a Community Health Worker, staff training on cultural awareness and trauma-informed concerns, continuing implementation of office coverage system to ensure staff availability in urgent and emergent calls, and improve and educate on the Customer Service role. Offering payment plan structure to assist individuals with the rising cost of services as well as patient advocates who can and will assist individuals with applying for Medicaid and/or helping them attain insurance approval for services as needed. Efforts will also include expanding education regarding available resources, support groups, crisis services, and community programs to ensure individuals are aware of the full range of services available to support recovery and independence.

The SUD Providers identified several opportunities for improvement that could enhance engagement, client-centered care, and continuity of recovery support. To incorporate discussions about individualized recovery and mental health goals into treatment planning and ongoing services. Improvement of education regarding available RSAT Phase II providers and program options. Strengthening referrals and encouragement to connect with Recovery Community Organizations (RCOs) and other recovery supports following release. Enhancing communication practices, including after-hours messaging, return-call expectations, and identification of outgoing phone numbers. Focusing on enhancing service accessibility, strengthening client education and communication, increasing referrals to community and peer supports, and promoting recovery-oriented services that improve community engagement and overall quality of life. Some providers will implement a new process and procedure in regard to all client medication to help eliminate the barriers and issues clients have experienced. Providers will continue to recognize and reinforce the positive support provided by staff to be more welcoming and comforting. Group schedules and lengths will be reviewed to determine whether adjustments can be made to improve participation and attention. Some providers are in the process of updating their client resource packet as well as exploring the possibility of implementing a "buddy system" to assign a current client with a new client to assist in navigating the structured day-to-day.

Overall, this goal is considered met for FY2026 and will be continued into FY2027.

3. State Mandated Performance Improvement Projects (PIPs)

Overview
The Region PIHP QAPIP ensures that two PIPs designed and implemented according to MDHHS and Health Services Advisory Group (HSAG) standards are always in place. The two current PIPs are described below.

Performance Improvement Project #1.
This PIP topic is on racial/ethnic disparities in access-to-service-engagement with SUD services. This PIP focuses on clinical service systems issues, and 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. This PIP is required for annual submission to HSAG for validation.

Performance Improvement Project #2.
This PIP topic 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 focuses on administrative systems issues and 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. This PIP is not required for annual submission for HSAG validation, but it is operated nonetheless by HSAG specifications and is available for validation review upon request.

Goal
Performance Improvement Project #1.
Baselining, root cause analysis, and systems improvement action planning activities were conducted during Calendar Year (CY) 2021 in preparation for implementation during CY2022 and beyond. During CY2025, the PIP's three-part comprehensive regional improvement plan was implemented, with most activities being put into operation. During March of this CY, analyses of CY2025 performance data were completed and shared with SUD provider programs to inform CY2026 activities currently underway.

Performance Improvement Project #2.
Baselining, root cause analysis, and systems improvement action planning activities were conducted during CY2018 and CY2019 in preparation for implementation during CY2020. During CY2025, the PIP's four-part comprehensive regional improvement plan was implemented, with all activities being put into operation. Analyses of performance data were completed during June of this year.

Evaluation
Performance Improvement Project #1.
Findings revealed progress toward target goals, though achievement of goals were not yet met. Nevertheless, statistically significant improvements were demonstrated, compared to Baseline. Analyses of performance data along with barrier analysis were shared with SUD provider programs to further inform CY2026 activities currently underway. Here, transportation challenges remain a significant concern, and some programs are still working on full implementation of their improvement action plans.

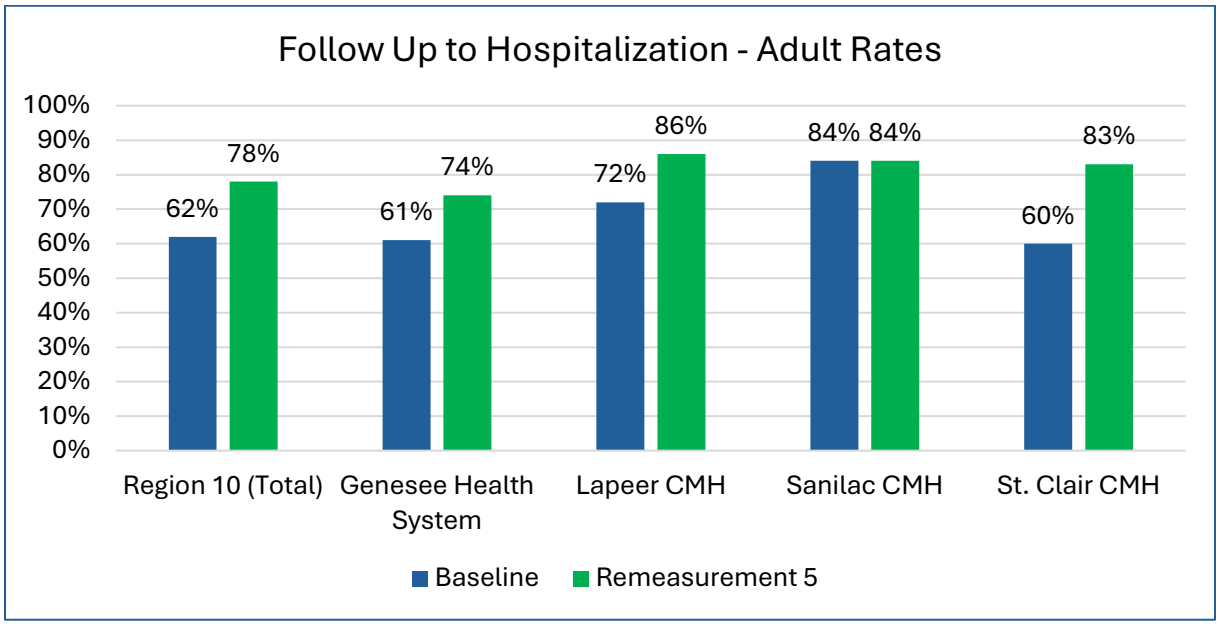
Performance Improvement Project #2.
Findings revealed that target goals were met, with statistically significant improvements demonstrated compared to Baseline. It was agreed that this PIP will be discontinued at EOCY2026 according to plan and to make way for the onboarding of a new PIP as required by

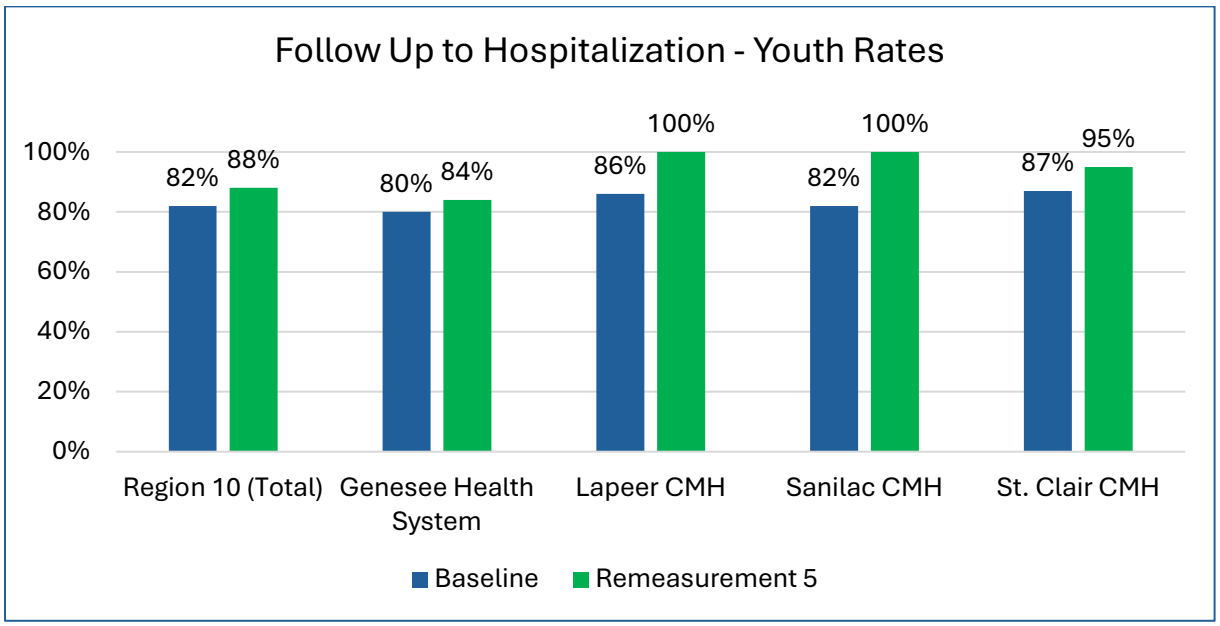
MDHHS. The table and graphs below summarize the results of this PIP at Remeasurement 5, the end of Calendar Year (CY) 2025.

Remeasurement 5 Findings Region 10 PIHP CMHSP Affiliates January 2025 – December 2025	*PIP Topic: The percentage of discharges for enrollees age six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.*			
	Adults Minimum **Target = 58%**		**Youth** Minimum **Target = 70%**	
	Yes (%)	All	**Yes (%)**	All
Region 10 PIHP (Total)	**1,299 (78%)**	1,673	**338 (88%)**	384
Genesee Health System	**817 (74%)**	1,097	**226 (84%)**	268
Lapeer CMH	**102 (86%)**	118	**20 (100%)**	20
Sanilac CMH	**66 (84%)**	79	**20 (100%)**	20
St. Clair CMH	**314 (83%)**	379	**72 (95%)**	76

Findings reveal high rates of consumers receiving a follow-up visit with a CMH practitioner within 30 days of discharge. This was evident across each CMH. These high rates are significantly higher than the PIP minimum targets for the Adult population (58%) and Youth population (70%).

The graphs below depict comparisons of Remeasurement 5 rates with Baseline rates at the regional level as well as for CMH breakouts. For the Adult population, significantly increased rates are evident. The only exception was Sanilac CMH, which demonstrated high rates to begin with at Baseline. For the Youth population, increased rates are evident both regionally as well as its CMH breakouts.





Overall, this goal is considered partially met for FY2026. This goal will be revised and continued into FY2027.

4. Monitoring of Quality Areas

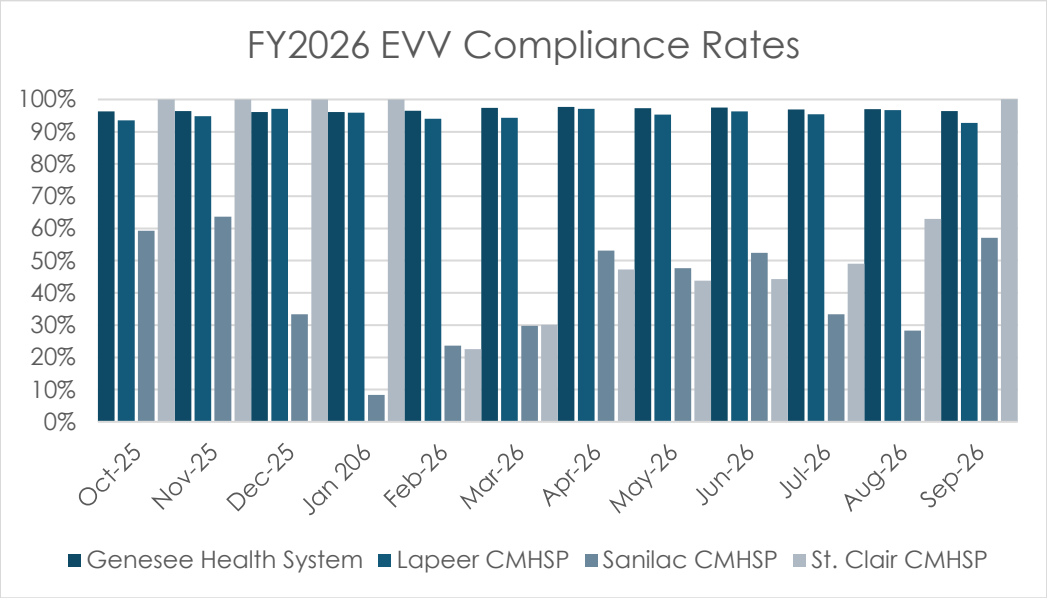
Overview
A primary responsibility of the QMC is to explore and promote quality and data practices within the region. Specific activities related to this goal for FY2026 included monitoring emerging quality and data initiatives or issues and requirements, monitoring and addressing Performance Bonus Incentive Program (PBIP) activities and indicators, monitoring and addressing changes to service codes, reviewing and analyzing various regional data reports, and reviewing and analyzing Behavioral Health Treatment Episode Data Set (BH TEDS) reports. The QMC discussed these topics during bimonthly meetings and also shared information between meetings when needed.

Goal
Throughout FY2026, QMC members representing CMHSPs were asked to report updates on any encounter barriers or challenges. Of note was that CMHSPs began reporting CCBHC Demonstration services directly to MDHHS as of October 1, 2025. CMHSPs reported ongoing reviews were conducted of services/encounters to ensure accurate reporting. It was also noted there were services provided by CMHSP subcontract providers that did not have a Designated Collaborating Organization (DCO) arrangement with the CMHSP/CCBHC, and those services would need to be reported to the PIHP. CMHSPs provided a list of their DCOs.

QMC members were regularly informed of the timeline and steps for Encounter Quality Initiative (EQI) reporting. The PIHP publishes a timeline for each EQI reporting period. The timeline includes a preliminary date pull, where the CMHSPs and PIHP share reports and conduct an analysis of differences and/or errors. The timeline includes a hard stop for data encounter corrections to be submitted to ensure the accuracy of the encounter period. The timeline also includes the date of the final data pull used to populate the period EQI template by the CMHSPs, along with when the template is due to the PIHP and finally it includes when the template is due to MDHHS. This assists with timely reporting.

Evaluation
Regarding Electronic Visit Verification (EVV), the 85% compliance rate went into effect in April 2026. The PIHP monitored the CMHSPs' EVV compliance rates the entire fiscal year, knowing MDHHS would be implementing an 85% compliance rate beginning in April 2026. CMHSPs worked with their subcontract providers to provide additional education and training to assist providers in maintaining or increasing their compliance rate to at least 85%. Sanilac CMH and St. Clair CMH developed a Plan of Correction with a provider that was challenged to meet the compliance threshold. The non-compliance of these providers was the reason their compliance numbers are under the 85% threshold. The PIHP continues oversight of and support to the CMHSPs, in their efforts to assist the providers compliance rate. For FY2027, the QMC approved a goal to achieve and maintain the 85% threshold for EVV records for verified visits without manual edits.

Below is a graph showing EVV compliance rates throughout FY2026.



Regarding PBIP activities and indicators, the QMC was regularly informed of progress on completion of FY2026 PBIP activities. The Patient-Centered Medical Home (PCMH) narrative was completed with contributions from the CMHSPs and submitted to MDHHS by the due date in November 2025. Additionally, updates from the PIHP/Medicaid Health Plan (MHP) Collaboration Workgroup and materials received from MDHHS were shared with the committee. The committee acknowledged there may be changes to the Joint Care Coordination Planning measure, as MDHHS indicated there would need to be collaboration with CCBHC Demonstration sites. Joint Care Coordination Planning activities will continue in FY2027, although this measure was removed from the FY2027 PBIP specifications table published by MDHHS.

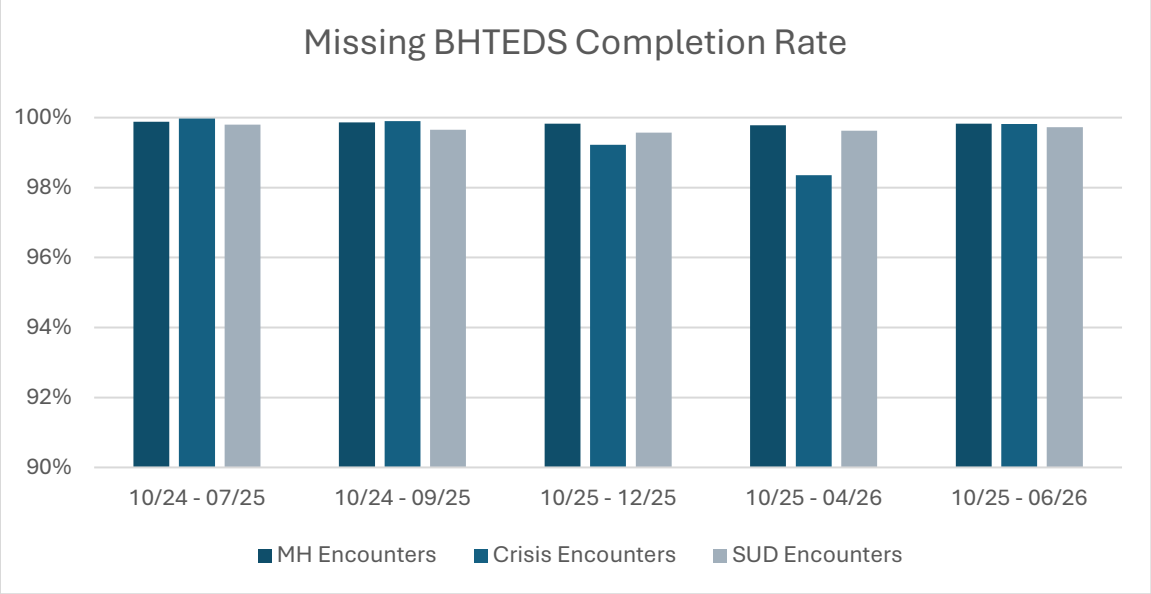
MDHHS Code Chart changes were shared with QMC members during meetings and between meetings as information was received from MDHHS. The PIHP ensured upcoming service code and/or provider qualification changes were shared timely. The PIHP wants to ensure staff have as much time as possible to make updates to the electronic health record and/or communication, and training can occur with staff as needed. Changes with PIHP and CMHSP systems and workflow processes must be aligned for accurate billing and encounter reporting to MDHHS.

Due to the inclusion of BH TEDS records for individuals receiving only CCBHC services, BH TEDS record submission was delayed in FY2026. Time was needed to discuss the technical needs to support BH TEDS submission, as it was determined the records could not be submitted directly to MDHHS as originally intended due to programming limitations. The Statewide BH TEDS Workgroup, along with the electronic health record vendors, met and developed a workplan to continue the CCBHCs to report CCBHC-only BH TEDS records to the PIHP, where then the PIHP would submit the file to MDHHS. As a result of this work, BH TEDS file submission began January 2, 2026.

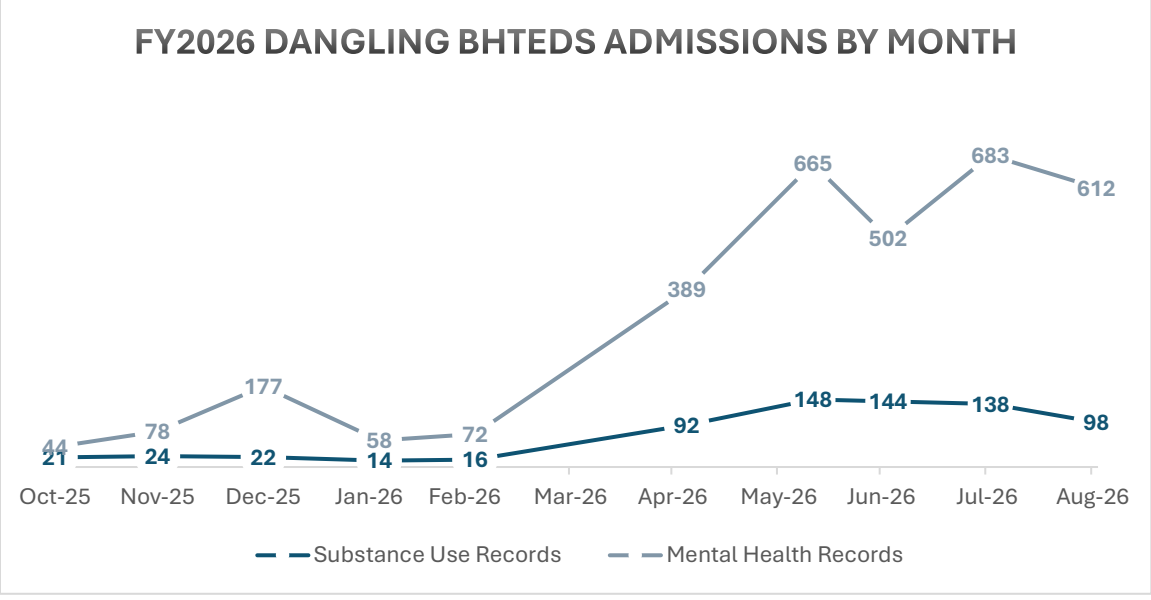
For the review and analysis of BH TEDS reports, the QMC focused on multiple areas. First, BH TEDS completion rates were reviewed with the committee, noting a high level of

performance across Mental Health (MH), Crisis (Q), and SUD records. Next, BH TEDS dangling admissions were discussed with the committee, and committee members identified methods to improve (reduce) the number of dangling admission records. The QMC also prepared for the transition to MH Client Level Detail (CLD) and SU TEDS for FY2027.

Below is a graph of BH TEDS completion rates.



The graph below shows BH-TEDS dangling admissions throughout FY2026.



Overall, this goal is considered met for FY2026. This goal will not be continued into FY2027. More specific, measurable goals will be implemented for FY2027.

5. Customer Relation Management (CRM) System

Overview
Region 10 actively monitors the implementation and integration of the CRM system and applications across the region based on MDHHS requirements. The CRM system goal is split into three sub-sections: Region 10 staff will provide technical assistance to users as needed, Region 10 will evaluate the implementation of the CRM system throughout the region, and Region 10 will maintain oversight of the businesses processes housed within the CRM.

Goal
Region 10's goal of monitoring the implementation and integration of the Customer Relationship Management (CRM) system and applications is based on MDHHS requirements.

- The PIHP lead IT System Administrator added/removed staff access and set permissions as identified for the task the staff was to complete.
- The PIHP lead IT System Administrator also provided technical assistance as needed or would refer staff to the Job Aid available within the CRM system.
- There was successful submission of Sanilac's CCBHC American Society of Addiction Medicine (ASAM) Level of Care (LOC), all CMHSPs Intensive Care Coordination with Wraparound (ICCW) applications and Schedule E Reports within the CRM system. There were minor technical issues during the rollout of Schedule E, which were promptly resolved by MDHHS.

Evaluation
The evaluation of the goal is considered met. The regional oversight and technical assistance were a success with the submission of Sanilac's CCBHC ASAM LOC, all CMHSPs ICCW applications and Schedule E Reports within the CRM system. The goal will not be included in SFY 2027 Quality Improvement Plan, however, Region 10 PIHP will continue to monitor, oversee and provide customer support for all existing applications and any new application/programs deployed to the Customer Relation Management system.

Overall, this goal was considered met for FY2026. This goal will not be continued into FY2027.

6. Sentinel Events Review Committee (SERC)

Overview
For FY2026 SERC operated under five committee goals listed below, which delineate the committee responsibilities. Standards applicable to the committee comprise the MDHHS Critical Incident Event Notification and Substance Use Disorder Sentinel Events Reporting Requirements as well as practice Standards stipulated in the PIHP/MDHHS Medicaid Contract.

1) To review and monitor CMHSP and SUD critical incidents, to ensure adherence to timeliness of data and reporting standards, and monitor for trends, to improve systems of care.

2) To review and monitor CMHSP and SUD Centinel Event reviews, to ensure adherence to timely determination of Sentinel Events, timely initiation of a Root Cause Analysis, comprehensive completion of Root Cause Analysis, and that individuals with appropriate credentials are involved in the review of Sentinel Events.

3) To review and monitor CMHSP and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary.

4) To review and monitor CMHSP and SUD Risk Events review processes and ensure follow-up as deemed necessary.

5) To conduct a longitudinal mortality evaluation and write a report annually to assess causes of death for beneficiaries and consider system improvements.

Goals
Below is a summary of actions completed, as noted across each goal.

1) Monthly monitoring of Critical Incident reports, both aggregate and detail, received from network provider programs, were completed, along with quarterly trending and analysis reports generated by the committee. Monitoring and analysis activities revealed broad adherence to standards. Detail reports revealed a small number of follow-up queries to provider programs to rule-out service systems issues. One CMHSP revealed a spike in one Critical Incident during one month in the quarterly analysis report, which prompted follow-up query to rule out service systems issues.

2) CMHSP and SUD Sentinel Event review monitoring was completed on a monthly basis, with one CMHSP reporting Sentinel Events. In all instances, adherence to timely determination of sentinel events, timely initiation of a Root with Cause Analysis, comprehensive completion of Root Cause Analysis, and individuals with appropriate credentials were involved in the review of Sentinel Events, were demonstrated.

3) SERC completed a regional assessment report based on the CMHSP and SUD unexpected deaths / mortality review reports. No concerning trends were noted, but an improvement recommendation was put into place to expand the clinical and demographic analysis processes for the committee annual evaluation report.

4) Monitoring of Risk Events reports received from network provider programs were completed, along with quarterly trending and analysis reports generated by the committee. Monitoring and analysis activities revealed broad adherence to standards, along with some issues regarding timely report submission experienced by some of the SUD provider programs. This issue was

resolved in consultation with Provider Network Management (PNM) and report training and advisories sent to the SUD provider programs.

5) SERC has been conferring with Data Management to create a data gathering and reporting system. It is expected to be in place during 1Q FY2027.

Evaluation
Overall, progress was achieved toward each goal. As examples, CI and RE reports identified no concerning trends and, where needed, further queries were conducted to programs to rule-out service systems issues, all Sentinel Events reviewed complied with BTPRC review requirements and reporting timeframes, Goals/Responsibilities will continue into FY2027. Regarding next steps the draft FY2027 committee workplan should be submitted for QAPIP review/approval.

Overall, four of five goals are considered met for FY2026. These four goals will be revised and continued into FY2027. One goal is considered to be partially met and will also be continued into FY2027.

7. Improving Practices Leadership Team (IPLT)

Overview
For FY2026 IPLT operated under six committee goals listed below, which delineate the committee responsibilities. Standards applicable to the committee comprise the Region 10 PIHP Clinical Practice Guidelines (CPGs), which include the Michigan Medicaid Provider Manual as well as practice Standards stipulated in the PIHP/MDHHS Medicaid Contract, along with various other national Standards, such as American Psychological Association (APA) and Substance Abuse and Mental Health Services Administration (SAMHSA).

1) To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service, as evidenced by a) monitoring utilization of the PIHP Clinical Practice Guidelines, and b) completing the annual and biennial evaluation reports as per policy.

2) To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service, as evidenced by a) review EBPs and related fidelity review activities, such as, Integrated Dual Disorders Treatment (IDDT), Level of Care Utilization System (LOCUS), Substance Use Disorder Health Home (SUDHH); facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan; and support CMHSP implementation of the nine core CCBHC EBPs.

3) Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC) / Encourage the provision of progressive employment services across the CMHSP network, as evidenced by a) conduct and monitor quarterly ESC meetings designed to facilitate share and learn discussions, b) benefit counseling and coaching under the Benefit-to-Work (B2W) model, c) CMHSP employment targets for competitive employment (community-based), d) standardized employment services data and report formats, e) in-service / informational materials for share and learn discussion, f) community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS]), g) tracking/trending vocational services utilization, h) discuss/support consideration of the Individual Placement and Support (IPS) service model.

4) Oversee CMHSP Network Implementation of the HCBS Transition Plan to Ensure quality of clinical care and service, as evidenced by a) monitor CMHSP network implementation of the HCBS Transition Plan to ensure adherence to and implementation of Corrective Action Workplan, b) monitor network completion of the HCBS assessment process, continue efforts to bring provider settings into compliance, and continue ongoing c) monitoring of service and settings for HCBS Final Rule Compliance, d) monitor and update on Behavioral Treatment Plan Review Committee (BTPRC) progress to ensure that Behavioral Treatment Plans (BTP) and Individuals Plans of Service (IPOS) are in compliance with the HCBS Final Rule.

5) Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan, as evidenced by a) 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 CC360 system, b) participate in PIHP/MHP Workgroup initiatives, and continue process for identifying members of the youth and foster care population who are appropriate for care coordination.

6) Implementation of the Behavioral Health Homes requirements for participating CMHSPs to enhance coordination of care for participating individuals with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) diagnosis, as evidenced by a) support CMHSP

implementation of the BHH through the program six core services, b) provide support and oversight to the CMHSPs through the onboarding and roll out of this program, c) increase and manage enrollment of BHH beneficiaries through the Waiver Support Application, and d) development of continuous utilization and quality improvement of the program.

Goals
Below is a summary of actions completed, as noted across each goal.

1) The annual PIHP Annual Clinical Practice Guidelines are scheduled for completion by end of fiscal year (EOFY). This was a partnered effort across the CMHSP and SUD provider networks, comprised service utilization monitoring, Standards monitoring and updates as appropriate, subject-matter expert surveys, and annual EBP updates submitted by the CMH network programs, all of which provided measures of service effective or service efficiency. All actions were carried out under the supervision of the Medical Director. The Biennial Evaluation Report is scheduled for FY2027.

2) CMHs periodically monitor their active EBPs and provide IPLT status updates. Two CMH Michigan Fidelity Assistance Support Team (MiFAST) reviews were provided to IPLT for share-and-learn discussion. The Mid-Year CMH LOCUS implantation evaluation reports were submitted for IPLT review and share and learn discussion. Progress was documented by each CMH in such areas as a) decrease over-ride rates and increase required periodic LOCUS remeasures. Supporting CMH implementation of the nine core CCBHC EBPs was not activated, once it was learned that PIHP oversight of CCBHC operations is required.

3) ESC meetings were held quarterly to provide collegial forums and share-and-learn activities. Topics covered were benefit counseling and coaching under the B2W model, c) CMHSP employment targets for competitive employment, two instances of sharing standardized employment services data and report formats per the IPS model, sharing notes and informational materials from each of the four state-wide supported employment workgroups. At the August ESC meeting, preferred practices standards were discussed regarding case record service plan development and contact note recording, as well as possible implications for the upcoming cuts to Medicaid funding.

The Home and Community Based goal, The Integrated Health Care - Care Coordination Plan goal, and The Behavioral Health Home goal will be discussed and evaluated in their own dedicated sections.

Evaluation
Overall, progress was achieved toward each goal. As examples, ensuring annual updates to the various sections in the CPGs, favorable trends in LOCUS implementation across all four CMHs, and expansion of IHC clientele in conjunction monitored reduction in Emergency Department overutilization. All of the above contribute toward quality clinical practice and service engagement. These six goals are continuation goals, given the multi—year effort to continuously improve member service experience. The CCBHC activity may be deleted. No significant barriers were identified. It is recommended that the workplan add another goal to develop a mechanism to longitudinally track and analyze a) quality of life improvement and b) trends in service delivery and health outcomes over time.

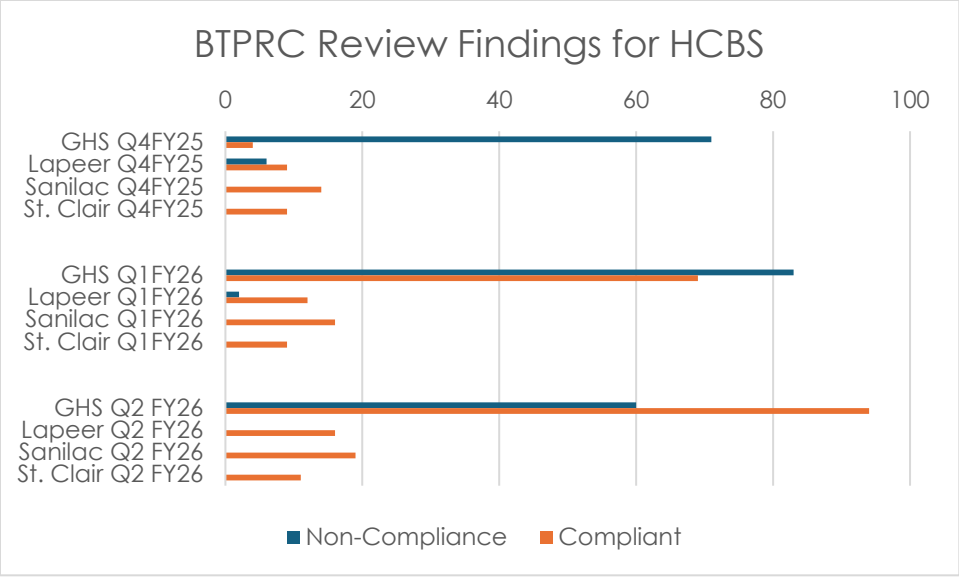
Overall, the goals relating to CPGs, EBPs, and Employment Services are considered met for FY2026. All goals will be revised and continued into FY2027.

8. IPLT: Home and Community Based Services (HCBS)

Overview
The FY2026 HCBS goal was reviewed and discussed through the IPLT committee monthly. The IPLT committee is comprised of Clinical leads from the CMHSPs who review the updates and can provide discussion and insight on the concerns or progress that has occurred within their CMH specific to HCBS transition planning. This program has had multiple changes and corrective action work that this group has discussed and shared feedback on.
Specific requests have been added to Region 10 policy around submission of BTPRC reviews quarterly and that this includes specific HCBS reviews. Discussion occurs quarterly on this progress with the committee.
Region 10 has policy specific to the Provisional Assessment, and language in contract on the CMHSPs completing an Annual Physical Assessment and reviewing Network providers for HCBS Compliance. This group reviews data from monthly submissions and committee meetings allow for opportunity to discuss and provide feedback.

Goal
In FY2026 this goal documented and tracked the CMH BTPRC reviews to ensure HCBS compliance with the final rule. The BTPRC is required to look at both the IPOS and the BTP to check for HCBS standards. Although the number of cases increased throughout the review process, we started to see a decline in cases found out of compliance. These findings tell us that the review committee incorporated more cases in their review due to this new standard, but also that corrections were being made to bring these cases into compliance.

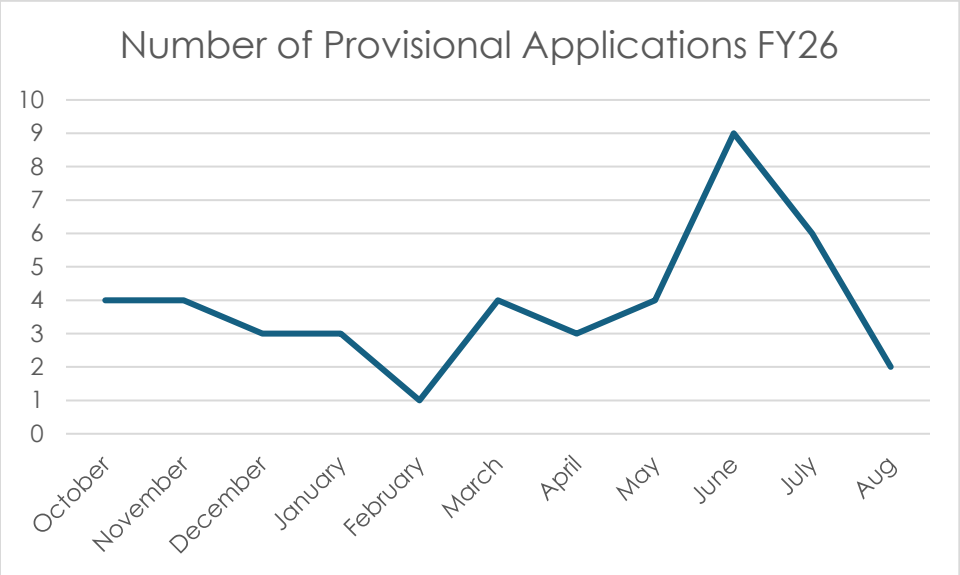
The below graph shows CMH submitted data from Q4FY25, Q1FY26, and Q2FY26.



As a part of the Corrective action steps to meet Center for Medicare and Medicaid (CMS) standards, Region 10 had to complete Case Manager training sessions on provided curriculum on the HCBS Final rule. These were completed quarterly by PIHP staff to capture all the new hires. Training requirements and corrective action steps were addressed with the IPLT committee and shared with the CMHSPs.

PIHP policy requires that the CMHSP complete a Provisional Assessment for approval on a provider setting prior to the implementation of any HCBS services. In FY2026 all cases followed

this process, below is data on how many provisional requests Region 10 received for review broke out by calendar month.



Evaluation
Overall, the network has worked hard in FY2026 to implement the HCBS transition plan. They have attended required training courses, participated in workgroup sessions, completed all Provisional Assessments according to policy and have had 100% approval on those assessments.

CMHSP's are regularly conducting Physical Annual Assessments, and reporting these reviews to the PIHP. All CMHSPs have established a process to meet this requirement and are set to review all their contracted providers on an annual basis.

The BTPRC review showed some great progress in FY2026. The IPOS and BTP were not historically reviewed by these committee members, this addition however helped the CMHs ensure HCBS compliance and further enforce the Final Rule. In the reported findings, we see that the number of cases increased, which showed further understanding of this request and improved oversight of cases. We also see the number of non-compliant cases decrease through the review periods.

These steps taken, show improved adherence to the Final Rule and increased work towards the Corrective Action Plan (CAP) to CMS. These steps have helped bring documentation into compliance, and the reviews continue to bring providers into compliance. This goal is marked as met and will carry over into FY2027 to continue to monitor the Final Rule adherence and implementation at the CMHSPs.

Overall, this goal is considered met for FY2026. This goal will be revised and continued into FY2027.

9. IPLT: Integrated Health Care (IHC) Care Coordination Plan

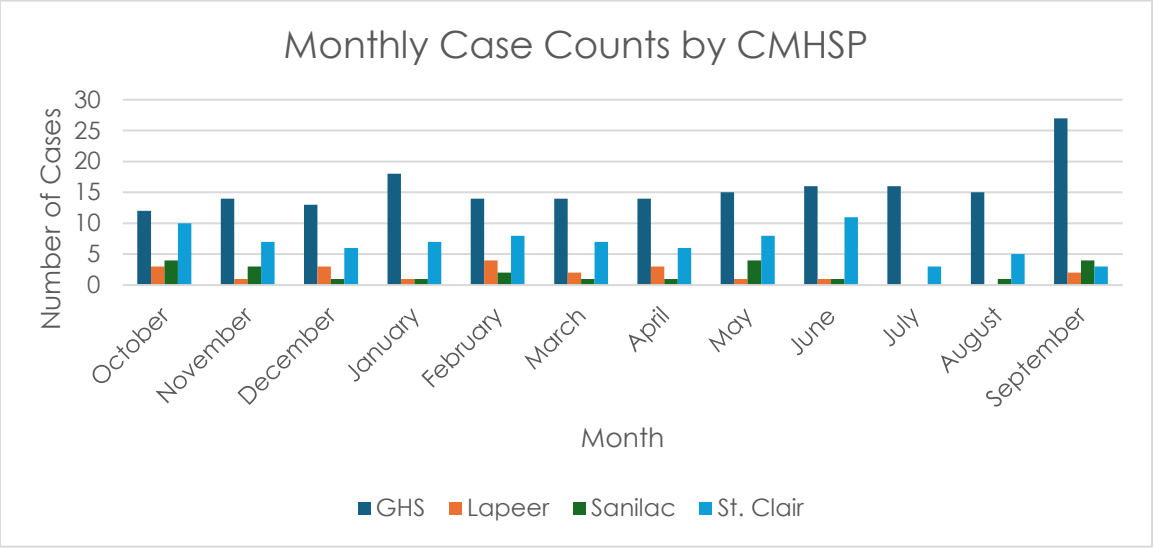
Overview
It is the goal of the PIHP to monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. Region 10 assists in aligning network care integration processes for people with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CC360 system. Region 10 actively participates in PIHP/MHP Workgroup initiatives. The PIHP Care Coordination Team continues to identify members of the youth and foster care population who are appropriate for care coordination.

Goal
Care Coordination meetings occurred each month. During FY2026, a total of three hundred thirteen (313) cases were brought to discussion during Care Coordination meetings. For quarters 1 through 3 a total of one hundred and thirteen (113) cases were closed with all goals being met. Quarter 4 totals have not been determined at the time of this report.

The PIHP Care Coordination team also participated in Workgroup initiatives in FY2026.

The PIHP Care Coordination team identified youth and foster care individuals for appropriate meetings. During FY2026 a total of thirty-one (31) foster care individuals were brought to the agenda for discussion. During FY2026 a total of twenty-five (25) children were brought to the agenda for discussion.

Evaluation
The PIHP Care Coordinator identified members each month via CC360 who met requirements for care coordination meetings. The PIHP Care Coordinator communicated with CMHSP's and Medical Health Providers (MHP)to organize and schedule meetings. The PIHP Care Coordinator managed cases in CC360 to ensure information was collected appropriately and timely each month. The goal for FY2026 is met as each objective was completed each month. The goal will be updated for the next fiscal year. The graph below details the number of open care coordination cases per month for each CMHSP.



Overall, this goal is considered met for FY2026. This goal will be revised and continued into FY2027.

10. IPLT: Behavioral Health Home (BHH)

Overview
The FY2026 BHH goal reviewed and discussed through the IPLT group monthly to cover the Implementation of the Behavioral Health Homes requirements for participating CMHSPs to enhance coordination of care for participating individuals with SMI/SED diagnosis and best support the CMHSP through this program implementation.
The BHH program was approved to start in Genesee, Sanilac and St. Clair counties in FY2026. Updates on the program progress continue to be discussed at monthly meetings.

Goal
FY2026 was an implementation year for this program. As a state, we had delays in the Centers for Medicare and Medicaid (CMS) approval of the State Plan Amendment (SPA). Some of the changes in this included expanding BHH to Region 10. Services and program initiation waited for this approval. The SPA was approved in January 2026, which was discussed and shared with this committee.
Mandatory trainings were completed in March 2026 with the CMHSP members present.
The PIHP met monthly with the Health Home leads to discuss implementation, hiring, and roll out of this program.
Region 10 had the first two enrollees start this program August 1st, with two more enrolled in September. All the region's first enrolment cases came from Sanilac CMH.

Evaluation
Overall, the network has worked hard in FY2026 to implement this new program. Initially there were barriers in the roll out process and waiting for CMS approval. Once that happened and all the staff were trained or hired to support this program, we saw enrollment start in one of the three CMHSPs. The other two participating CMHSPs are working hard to submit their first enrollees to this program as well. This goal is considered met, and will be carried into FY2027 as this program continues to expand.

Overall, this goal is considered met for FY2026. This goal will be revised and continued into FY2027.

11. Home and Community Based Services (HCBS)

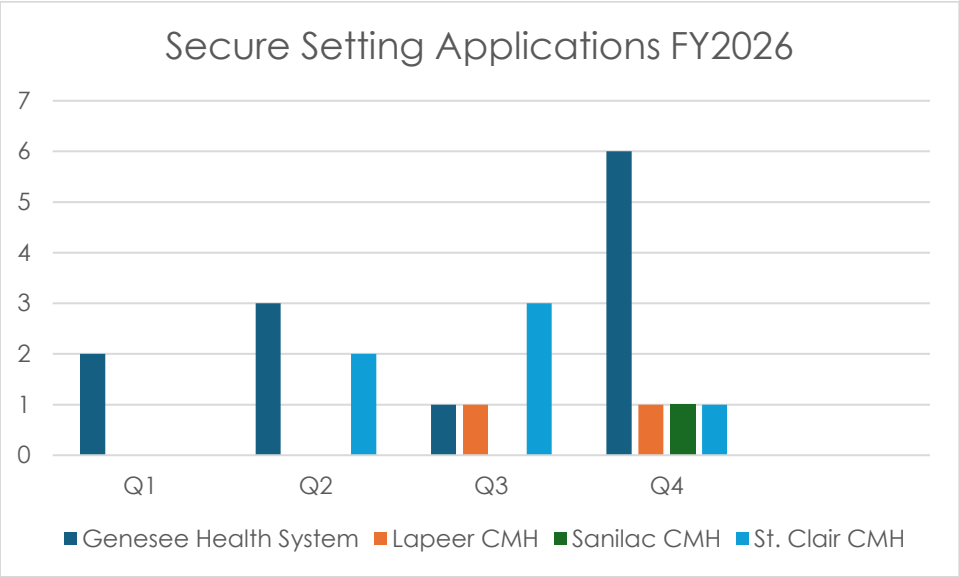
Overview
The FY2026 HCBS goal reviewed and discussed monthly was as follows:
Monitor the CMHSP progress and assessment process of Provider settings and ensure homes and plans are in compliance with the HCBS Final Rule.

- Monitor the Provisional Approval Process.
- Ensure compliance with the HCBS Final Rule by facilitating internal review of applications for secure settings.
- Monitor and Track CMHSP Annual Physical Assessment process.

This goal focused on the completed HCBS assessments in FY2026. It monitored the Annual Physical Assessment, The Provisional Assessment and the Secure Setting Application that is completed and approved by MDHHS. Some of these standards were further followed by other committees like the IPLT Committee as they identified HCBS work being completed and progress towards Corrective Action Work.
Provisionals were completed accurately and Region 10 had 100% approval rates for FY26. There were several cases that required Secure Setting Applications which were also completed and approved by MDHHS.

Goal
In FY2026, great progress was made towards this goal and CHSPs communicated requests efficiently.

All Provisional Applications were documented and followed Region 10 policy. Some cases were identified as living in a Secure setting which required a Secure Setting Application approval. When these cases were identified, additional documentation was requested and a Secure Setting Application was completed. Additionally, cases were identified that need Secure Setting Applications for individuals who have been living in secure settings prior to the Secure Setting process. The new Secure Setting Process was implemented in September of 2025, so through the rollout of this process Region 10 has worked with the CMHSPs to clean up and work through these cases. Below are the Secure Setting Applications that have been submitted and approved in FY2026 to date.



MDHHS requires that an Annual Physical Assessment be completed to assess the network of providers for HCBS compliance. Region 10 requires that all CMHSPs conduct annual site visits of their contracted providers and provide the PIHP with dates and findings of these reviews. Follow-up is required with corrective action or findings.

Evaluation
Overall, the network has worked hard in FY2026 to track and report on the assessments being completed throughout the Provider network and request Secure Setting Applications. A barrier identified with the Secure Settings is that this process is time consuming to review all the submitted documents and complete the application timely which has slowed down the process of getting approvals. CMHSPs have improved their process of providing complete packets and been attentive to respond to questions through this process.

All CMHSPs have completed the Annual Physical Assessment reviews and provided monthly updates to the PIHP. Reviews are set to be completed on an annual basis with no barriers identified. Provisional Applications also have been competed appropriately and according to policy. The Provisional Approval process was reviewed this year through contract monitoring as a new standard and all CMHSPs met all standards of this review. This goal was met in FY2026. This goal will be combined with the IPLT goal in FY2027.

Overall, this goal is considered met for FY2026. This goal will be revised and combined with another HCBS goal for FY2027.

12. Privileging and Credentialing Committee (P&C)

Overview
Region 10 PIHP maintains extensive credentialing policies and procedures to ensure that all members of the Provider Network are appropriately credentialed to provide services to our consumers. Region 10 Credentialing and Privileging Policy sets standards and guidelines for Region 10, CMHSPs, and SUD Providers to follow and ensure that services are delivered by providers who are fully qualified, competent, and in good standings. To confirm that CMHSPs and SUD Providers are following Region 10 policy, oversight and monitoring of their credentialing activities are completed on an ongoing basis. Region 10 uses the information gathered from monitoring to improve the credentialing and re-credentialing process across the Region.

Region 10 PIHP directly performs or delegates to the CMHSPs and SUD Providers credentialing and re-credentialing activities for organizations and practitioners.

Credentialing Organization	Responsible for Credentialing
Region 10 PIHP	Direct-Hire Practitioners
	Organizational Providers contracted with Region 10 PIHP
CMHSP	Practitioners
	Sub-contracted Providers
SUD Provider	Practitioners

Region 10 monitors the delegated credentialing and re-credentialing process of the CMHPs and SUD Providers during Annual Contract Monitoring. Members of the P&C team go on-site to review the credentialing records of selected practitioners and organizations to confirm compliance with Region 10 Credentialing and Privileging Policy and MDHHS Credentialing Policy. The P&C team reviewed eighty (80) practitioner applications and twenty (20) organizational applications from the CMHSPs in addition to reviewing eighty (80) practitioner applications from SUD Providers. The P&C team had discussions with staff on-site about credentialing requirements and areas for improvement. Three (3) SUD Provider had a plan of correction issued due to non-compliance with credentialing requirements.
The Region 10 P&C Committee is responsible for reviewing organizational and practitioner credentialing applications. The P&C Committee ensures that organizations and practitioners within the Region 10 network are qualified to provide services to consumers. The qualifications of organizations and practitioners are reviewed according to Region 10 PIHP Credentialing and Privileging Policy and the MDHHS Credentialing Policy and a credentialing decision is made based on the appropriate standards.

Goals
The first credentialing goal states that Region 10 will complete reviews of organizational credentialing applications timely. It is the responsibility of the Region 10 PIHP P&C Committee to meet regularly to review submitted organizational applications from the CMHSPs and SUD Providers. The committee reviews organizational applications for new and existing providers. The P&C Committee reviews organizational applications to ensure that the organizational providers within the Region 10 network are fully qualified to provide services to consumers. Within FY2026, the P&C Committee approved one (1) organizational application for a SUD Provider and two (2) additional location credentialing applications for a SUD Provider. All credentialing applications were reviewed timely, and all applicants were informed of their credentialing decision within the required timeframe. This goal is considered met.

The second credentialing goal states that Region 10 will complete P&C Reviews of practitioner applications. The Region 10 PIHP P&C Committee meets regularly to review submitted practitioner applications of Region 10 staff. The P&C Committee reviews organizational applications to ensure that the organizational providers within the Region 10 network are fully qualified to provide services to consumers. Within FY2026, the P&C Committee approved two (2) practitioner applications. All credentialing applications were reviewed timely, and all applicants were informed of their credentialing decisions within the required timeframe. This goal is considered met.

The third credentialing goal states that Region 10 will maintain a current and comprehensive policy on Privileging and Credentialing that follows MDHHS Policy, Medicaid Contract requirements, Code of Federal Regulations(CRF), and the Medicaid Provider Manual. In February, 01.06.05 Credentialing and Privileging Policy was approved by the Region 10 PIHP Board. The policy was revised to align with MDHHS Credentialing Policy, the CRF, and recommendations from the FY2025 HSAG Compliance Review. The P&C Team has informed the CMHSPs and SUD Providers about the revised Credentialing and Privileging Policy and plans to host an information session to further discuss the policy updates and credentialing requirements.

The fourth credentialing goal states that Region 10 will participate in MDHHS' Universal Credentialing initiative. Region 10 is an active participant in the MDHHS Universal Credentialing initiative. Members of the Privileging and Credentialing team regularly attend and participate in Universal Credentialing Leads meetings along with routinely notifying the credentialing leads from the CMHSPs and SUD Providers of relevant updates. As the Responsible Credentialing Coordinator (RCC), Region 10 works with our CMHSPs and SUD Providers to ensure their credentialing profiles on the CRM System are in a complete state and documentation is updated as needed. Region 10 is the RCC for the four (4) CMHSPs and three (3) SUD Providers whose home offices are located within our region. Region 10 made a request to become the RCC for one (1) SUD Provider whose home office is located within our region, this request is still being processed. This goal is considered met.

Provider Type	Complete	Pending Provider Edits
CMHSP	2	2
SUD Provider	1	2

Evaluation

During FY2026, the Region 10 P&C Committee met regularly to review organizational and practitioner credentialing applications. All credentialing decisions made by the Region 10 P&C Committee were made in accordance with Region 10 Credentialing and Privileging Policy and MDHHS Credentialing Policy. All Organizational Providers and Individual Practitioners were notified in writing within thirty (30) days of the committee's decision. Region 10 Credentialing and Privileging Policy was revised to align with MDHHS Policy, Medicaid Contract requirements, the Medicaid Provider Manual, and the CFR. The PIHP has been an active participant in the Universal Credentialing initiative. The Region 10 P&C team regularly attends MDHHS hosted Universal Credentialing Leads meetings and passes along relevant information to the CMHSPs and SUD Providers. As the RCC, Region 10 assists our CMHSPs and SUD Providers in creating and maintaining their Credentialing Profile on the CRM system. During Annual Contract Monitoring, Region 10 reviewed the delegated credentialing activities of the CMHSPs and SUD Providers. During the On-Site visits, the P&C team had conversations and discussions with providers on proper credentialing practices. Starting in FY2027, the P&C team will begin to conduct Semi-Annual credentialing reviews in addition to the credentialing review completed during Annual Contract Monitoring. By maintaining and following comprehensive credentialing policies and procedures, Region 10

ensures that services provided to our consumers are delivered by qualified providers who are in good standing. The Credentialing goals have been revised and will be continued on the FY2027 Quality Improvement Workplan.

Overall, these goals are considered met for FY2026. These goals will be revised and continued into FY2027.

13. Verification of Services

Overview
Region 10 conducts Claims Verification audits to verify services billed to the PIHP were completed and documented in compliance with Region 10, MDHHS, and Medicaid standards. Region 10 completes an audit of a random sampling of services per quarter from the CMHSPs and SUD Providers. Region 10 uses the random number function of the Officer of Inspector General (OIG) statistical software package, RATS-STATs, to select random samples of claims submitted to review. To demonstrate full compliance, services must be supported by documentation that meet the following standards:

- For Medicaid Beneficiaries, the Beneficiary must have active Medicaid Eligibility on the date of service.
- Service Code such as the Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) Code or Service Description must be present. Service Code (such as HCPCS/CPT code) or Service Description on the supporting documentation must be from the MDHHS Behavioral Health Code Chart.
- Per the Medicaid Provider Manual, documentation must be sufficiently detailed to allow reconstruction of events and services.
- Service code is approved under the contract.
- Services fall within the scope of billed/paid service code and amount does not exceed contracted amount.
- Service is provided by a qualified individual credentialed to provide the service as required by MDHHS Behavioral Health Code Charts and Provider Qualifications. Provider credentials must be present on the documentation and must clearly belong to the provider.
- All elements of the documentation must be legible.
- All elements of the documentation must have the same details as the service details submitted to the PIHP.

If the supporting documentation is non-compliant with the above standards, it will result in a CAP and a reconsideration of claims payment. Claims Verification Audits help ensure improvements in the quality of healthcare, healthcare outcomes, services for consumers, and service delivery.

Goal
During FY2026, Region 10 completed an audit for the following periods: FY2024Q4 and FY2025 Q1. In Addition, during FY2026, Region 10 initiated audits for the following periods: FY2025 Q2, FY2025 Q3, and FY2025 Q4. The Claims Verification audits focused on services billed from four (4) CMHSPs and thirteen (13) SUD Provider. In FY2026, Region 10 reviewed 12,862 claim lines billed to the PIHP with a total dollar amount of $1,254,818.53.

Claim Lines Reviewed	Units Reviewed	Total Dollar Amount
12,862	103,689	$1,254,818.53

Region 10 hosted a Claims Verification audit information session for the CMHSPs and SUD Providers in February. The documentation standards and requirements were reviewed during this information session. CMHSPs and SUD Providers were also notified of common non-compliant findings from pervious audits that were completed in FY2025. During the information session, The Claims Verification team introduced a process update to the documentation review section of the audit called the re-examination period. During the re-examination period, Region 10 would notify CMHSPs and SUD Provider with the details of the initial review and potential findings. CMHSPs and SUD Providers would be encouraged to

provide additional information and follow-up documentation for the Claims Verification Audit team to review. The re-examination period was implemented to allow CMHSPs and SUD Providers an opportunity to respond to findings and concerns ahead of the Appeal process.
In July, The Region 10 PIHP Board approved 04.03.01 Denial of Claims Payment Appeal Process policy and 04.03.02 Claims Verification policy. These policies were revised to better align with MDHHS Medicaid Service Verification Process, Michigan Medicaid Provider Manual, and the MDHHS Behavioral Health Code Charts and Provider Qualifications. In addition, documentation standards, required documentation elements, and the appeal process were more clearly defined.

Evaluation
Over the course of FY2026, Region 10 performed Claims Verification audits and revised the audit process to better address deficiencies and improve service documentation. The goal of the Claims Verification team has been to improve communication and collaboration with the CMHSPs and SUD Providers. The Claims Verification team regularly meets with providers during the audit process to discuss findings and potential areas for improvement. Several CMHSPs and SUD Providers have demonstrated notable improvement in their audit participation and service documentation after these meetings. Region 10 is committed to continuously improving our audit process as the Claims Verification Audit leads to promote an improvement in services and quality of care for our consumers. The Claims Verification Audit goal has been revised and will continue into FY2027 Quality Improvement Workplan.

Overall, this goal is considered met for FY2026. This goal will be revised and continued into FY2027.

14. Utilization Management Committee (UMC)

Overview
For FY2026 UMC operated under seven committee goals listed below, which delineate the committee responsibilities. Standards applicable to the committee comprise the Region 10 PIHP CPGs, which include the Michigan Medicaid Provider Manual as well as practice Standards stipulated in the PIHP/MDHHS Medicaid Contract, along with various other national Standards, such as APA and SAMHSA.

1) Provide oversight on CMHSP affiliate crisis services utilization, as evidenced by monitoring and advising on CMHSP affiliate crisis service utilization reports per committee discussion of findings, trends, potential systems improvement opportunities, and adherence to standards (quarterly).

2) Provide oversight on CMHSP affiliate BTPRC management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement, as evidenced by monitoring and advising on BTPRC data spreadsheet reports, and evaluating reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).

3) Provide oversight of regional Utilization Review (UR), as evidenced by a) the PIHP UM Department conducting UR (e.g. regional Indicia fidelity, Utilization Management (UM) Redesign fidelity, b) SUD network provider programs (quarterly), c) CMHSP OASIS-user affiliates (quarterly), and d) delegated CMHSP (GHS) UR activity reports (quarterly).

4) Promote aligned care management activities across key areas of provider network operations: a) implementation of the Centralized UM System (UM Redesign Project), b) oversight of the Mi.X Users Workgroup, scheduled UM monitoring/ management reports and analysis, c) monitoring of the GHS UM/UR Delegation to ensure alignment of operations, d) monitor/manage the Adverse Benefit Determination (ABD) system in the Service Exception Request (SER) system e) monitor and advise on the MDHHS/Region 10 Parity Compliance Plan, e) oversight of the Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability System, f) oversight of Region 10 participation on the UM Directors Group.

5) Provide oversight of the decentralized Access operations across the region while maintaining adherence to Access Management System (AMS) Standards, as evidenced by a) scheduled UM monitoring/management reports and analysis, b) scheduled retrospective utilization review, c) CMHSP mid-year and end-of-year Access operations accountability reporting, d) AMS-mid-year and end-of-year aggregate reporting with system improvement recommendations and remediation.

6) Provide oversight of the CMHSP affiliate community access / care management activities, as evidenced by conducting quarterly monitoring of and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly).

7) Provide oversight of the regional ABD operations and reporting processes, as evidenced by monitoring and advising on provider ABD reports: Access Management System AMS, CMHSP affiliates, SUD network provider programs (quarterly).

Goals
Below is a summary of actions completed, as noted across each goal.

1) CMHSPs provided monthly reports to UMC for quarterly analysis and committee discussion. No concerning trends were observed. Inpatient psychiatric unit (IPU) admissions and continuing stay reviews trended similarly across CMHSPs given the use of the Indicia system. Crisis services revealed minor variation. Committee discussion overall identified adherence to standards and no systems improvement opportunities.

2) Quarterly BTPRC data spreadsheet reports and committee discussion of findings noted adherence to standards as well as no concerning trends or potential system improvement opportunities.

3) Regional Utilization Review (UR) activities for Indicia fidelity and UM Redesign fidelity identified marginal systems issues along with improvement recommendations to two of the CMHSP. Regional Utilization Review (UR) activities for SUD network provider programs were tied to the Provider Network Management review system. Overall adherence to standards were noted, with one program exception, which was resolved per UR feedback on data submissions. Regional Utilization Review (UR) activities for quarterly OASIS-user affiliates revealed broad adherence to standards, along with service systems improvement recommendations regarding person-centered planning requirements and diagnostic narratives. UMC monitoring of delegated CMHSP (GHS) UR activity reports revealed similar findings and recommendations as those generated by the OASIS-user UR.

4) Regarding implementation of the UM System (UM Redesign Project), the PowerBI SER analysis report was activated, with the remaining UM reports coming online as service utilization data are available. Quarterly Mi.X Users Workgroup meetings have taken place mainly to review SER analysis reports and to complete two updates to the service authorization grids. Monitoring of the GHS UM/UR delegation has revealed adherence to requirements. Also, an UR alignment workgroup has been formed with GHS and R10 UM to review current case record selection methods and scope in preparation for FY2027. Quarterly monitoring of the ABD system revealed no concerning trends or improvement opportunities. The Milliman Care Guidelines Indicia System was completed with the remaining CMHSP coming online in July. Also, Indicia Inter-Rater Reliability System evaluation process was initiated in August. The UMC Chair has participated on the monthly UM Directors Group, and a broad range of issues and operational matters have been discussed, such as medical necessity determination tools, county of financial responsibility (COFR) determinations, and MDHHS guidance documents regarding such areas as ABD tracking/reporting, and psychiatric evaluations.

5) Oversight of the decentralized Access operations has taken place so far in terms of completing the CMHSP mid-year Access operations accountability reports. The EOY report is in process. Findings indicate broad adherence to AMS Standards, and improvement opportunities and corrective feedback have been directed back to the CMHSPs regarding accurate data definition, tracking, and reporting.

6) Oversight of the CMHSP affiliate community access / care management activities, as evidenced by conducting quarterly monitoring of and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly), have revealed a broad range of progressive and comprehensive outreach and education activities across the region.

7) Oversight of the regional Adverse Benefit Determination (ABD) operations and reporting processes, as evidenced by monitoring and advising on provider ABD reports have revealed adherence to standards as well as no concerning trends or potential system improvement opportunities.

Evaluation

Overall, progress was achieved toward each goal. As examples, Access operations were decentralized and delegated as per plan, expanded UM/UR activities and reporting were put into place, and SUD UR was aligned with the SUD PNM monitoring system. In terms of systems improvements, CMHSP Access is now easier for members to engage in services, BTPRC activities have continued to adhere to and provide service based on high quality standards, and practitioners are more aware of adherence to person-centered planning principles and comprehensive diagnostics documentation. That said, current Goals/UMC Responsibilities remain relevant for FY2027, although it is also recommended that the workplan add two activities pertaining the BTPRC and the development of a mechanism to longitudinally track and analyze a) quality of life improvement and b) trends in service delivery and health outcomes over time. Regarding next steps the draft FY2027 committee workplan should be submitted for QAPIP review/approval.

Overall, these goals are considered met for FY2026. These goals will be revised and continued into FY2027.

15. Long-Term Services and Supports (LTSS)

Overview
For FY2026 the LTSS improvement action plan operated under an HSAG systems improvement plan Recommendation as noted in HSAG Standard VI, *Coverage and Authorization of Services*. Monitoring this project has been undertaken by the Region 10 UMC. Service Standards for LTSS are also noted in the Medicaid Provider Manual, the PIHP/MDHHS Contract, and the applicable CFRs.*

1) The PIHP will define LTSS, as evidenced by assessing the quality and appropriateness of care, 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 for assessment include a) periodic reviews of plans of service, utilization reviews, claims verification reviews, clinical case record reviews, customer satisfaction surveys, identification of ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring; such mechanisms include Biopsychosocial assessments and Ancillary assessments. At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.

Goal
Not all MDHHS authoritative/guidance documents were available at the time the Recommendation was issued. Obtained over the course of the year were MDHHS final-draft documents pertaining to service scope, service descriptions and service codes assigned to LTSS. During August, a near-final draft of the MDHHS Comprehensive Quality Strategy (CQS) FY27-29 was received for final review, and in July the NorthCare Network Annual Evaluation was incorporated as an additional reference. Also, beginning in May, GHS was outreached to participate in regional assessment and planning.

Evaluation
Given the importance of moving forward once the required and essential project planning documents incorporated, detailed planning has only begun during September. As a result, the impact and effectiveness cannot yet be measured. A brief conclusion about the goals and improvement actions taken throughout the year. Formal planning for the project will incorporate outcome measures for FY2027. The current goal will be continued into FY2027, with an additional activity of monitoring PIHP support for community integration for members using LTSS.

Overall, this goal is considered not met. This goal will be revised and continued into FY2027, and moved under the purview of the Utilization Management Committee.

* 42 CFR 438.208; 42 CFR 441.301, 42 CFR 457.123

16. Provider Network Management

Overview
During Fiscal Year 2026, the Prepaid Inpatient Health Plan (PIHP) demonstrated vigilant regulatory oversight, active contract compliance, and targeted network expansion. Navigating system-wide workforce shortages and shifting consumer preferences, the PIHP collaborated closely with its CMHSP network, the Provider Network Committee (PNC), and SUD partners to manage capacity, evaluate network adequacy, and modernize contract monitoring practices.

Goals
Provider Network Management (PNM) Goal 1:
Address service capacity concerns and support resolution of identified gaps in the network.

- Review and address CMH Network gaps and capacity concerns.
- Review and address SUD Network gaps and capacity concerns.

This was a goal of the PNC. The PIHP actively monitored and managed regional network capacity for Autism and Applied Behavior Analysis (ABA) services across all CMHSPs throughout fiscal year 2026. System-wide workforce shortages and a high density of school-aged consumers requiring evening appointments created persistent scheduling bottlenecks. Workforce deficiencies remain the primary systemic barrier to full optimization. Contracted providers face intense market competition in recruiting and retaining qualified personnel willing or available to work non-traditional evening hours. This creates an ongoing misalignment between provider operational hours and consumer availability.

To address these and other systemic issues, the PNC reviewed regional network concerns, distributed updates to guidelines and service array quarterly. The PIHP demonstrated vigilant oversight, regulatory alignment, and steady network expansion throughout FY26. CMHSPs responded dynamically to workforce constraints by onboarding new vendors, expanding physical infrastructure, and stabilizing clinical leadership. However, regional capacity deficits remain an active concern. The network is currently navigating a significant structural shift in consumer demand, characterized by a declining interest in home-based ABA and an increased preference for center-based care.

While Sanilac CMH (SCMH) maintained optimal capacity with no service gaps all year, Genesee (GHS), Lapeer (LCMH), and St. Clair (SCCCMH) CMHSPs executed aggressive mitigation strategies—including facility relocations, targeted recruitment, and new vendor onboarding—to stabilize the network.

To address severe shortages in evening and after-school slots for school-aged children, GHS focused heavily on network expansion. Over the fiscal year, they approved several in-home providers, positioned a center-based group for review, onboarded two new vendors, and advanced a third provider into the formal contracting pipeline.

SCCCMH proactively mitigated workforce shortages and shifting consumer demands through targeted hiring, network expansion, and strategic procurement. To combat provider recruitment challenges, the agency successfully hired daytime and after-hours staff via their ABA Liaison Lead team and onboarded new Board-Certified Behavior Analysts (BCBA) opening immediate referral availability. Additionally, they completed a successful site visit

and advanced to formal contract development with the Center for TLC, a multidisciplinary Macomb County provider. Recognizing a consumer shift away from home-based care, St. Clair also issued a Request for Information (RFI) for center-based ABA services while actively pursuing an additional in-home provider.

LCMH resolved critical facility and staffing constraints by successfully relocating its internal ABA program to a new location (1505 Suncrest Dr.) on May 18. This move, combined with hiring and training new staff, was strategically designed to unlock evening capacity for families waiting for internal services over external contractors. Despite a brief staffing dip in November, LCMH maintained steady clinical operations, managing 15 internal and 12 contracted cases by July and advancing its Autism Diagnostic Observation Schedule (ADOS) assessment pipeline. While onboarding is progressing smoothly, staff are actively troubleshooting newly identified student busing coordination issues with parents and local school districts.

The goal of addressing CMH Network gaps and capacity concerns has been met.
The goal address SUD Network gaps and capacity concerns is expanded upon in PNM Goal 4.

PNM Goal 2:
Review Network Adequacy requirements and address compliance with standards.

- Review requirements.
- Identify and document responsible entities.
- Identify and document supporting evidence / practice.
- Policy review.

This was a goal of the PNC. Throughout the fiscal year, the Prepaid Inpatient Health Plan (PIHP) successfully managed the submission, validation, and analysis of its Network Adequacy requirements. While the region met state standards for high-acuity services like Inpatient Psychiatric and Crisis Residential care, the final MDHHS report identified three specialized service lines that narrowly missed required provider-to-enrollee ratios. The narrow margins of these deficits suggest that minimal staffing fluctuations or provider capacity shifts directly impact the region's compliance posture.

The PIHP coordinated with MDHHS and CMHSPs through the year to integrate new state compliance metrics, aggregate local data, and draft supporting narratives. In July, the PIHP participated in a formal Network Adequacy Validation (NAV) review with the HSAG to audit calculation methodologies, satisfying all follow-up data requests by August. Concurrently, regional monitoring innovations progressed, with the PIHP requesting a copy of a brand-new internal geographic tracking report developed by St. Clair CMH. The cycle concluded in August with the receipt and analysis of the official MDHHS FY25 Network Adequacy Data Summary.

The region failed to meet the required Provider-to-Enrollee ratios for Psychosocial Rehabilitation, Home-Based, and Wraparound services. The primary barrier is an insufficient volume of credentialed personnel specialized in these community-based modalities, preventing the network from keeping pace with fluctuating regional enrollment numbers. The PIHP intends to utilize the newly received MDHHS data summary to isolate exact geographic pockets driving the deficits in Psychosocial Rehabilitation, Home-Based, and Wraparound services.

The PIHP also intends to continue refining internal data-collection workflows to ensure real-time visibility into provider ratios before final annual state submission as well as evaluating St. Clair CMH's new geographic tracking report once finalized to determine if it can be scaled regionally to better track localized capacity throughout the region.

This goal has been met.

PNM Goal 3:
Assess annual contract monitoring practices and outcomes.

- Collaborate on monitoring process improvement.
- Review most recent FY PIHP Contract Monitoring results.
- Review FY Contract Monitoring Aggregate Report.
- Address identified trends and improvement opportunities.

This was a goal of the PNC. The PIHP efficiently executed its Fiscal Year 2026 Contract Monitoring cycle within targeted timelines, successfully progressing from tool development and platform deployment to audit execution and governance approval.

Outstanding Fiscal Year 2025 Plans of Correction (POC) were resolved and closed while updates were made to each monitoring tool. Contract Monitoring staff refined and updated the internal CMHSP monitoring tool using feedback from PNC members and internal subject matter experts (SMEs). They also provided feedback regarding the SUD Standardized Reciprocity Tool from network providers to the Statewide Reciprocity Workgroup, as well as making updates to the SUD Companion Tool.

The PIHP transitioned from the ZIX email system to the fully secure and encrypted ShareFile digital platform. All monitoring tools and documentation were delivered with high operational efficiency, streamlining the submission process. The transition to a cloud-based file exchange platform modernized workflows and secured data compliance.

SMEs conducted comprehensive desk audits, and the monitoring team completed 39 on-site compliance visits across the provider and subcontractor network by the end of June. All Final Summary and POC reports were generated and issued to providers within the required 30-day timeframe. In August, the resulting FY26 Annual Contract Monitoring Aggregate Report was reviewed by the PIHP Management Team and received official approval from the PIHP Board. SMEs continue to evaluate incoming provider remediation plans, with a significant portion already finalized and closed.

This monitoring cycle indicated CMHSPs maintained "Not Met" compliance scores within the Autism and ABA service lines, while SUD providers performed poorly regarding personnel training metrics. To remediate these gaps, the PNM team will collaborate with the Quality Department to align CMHSPs with active clinical standards, while simultaneously reevaluating and clarifying SUD training mandates ahead of the FY27 monitoring cycle.

This goal has been met.

PNM Goal 4:
Review and Address SUD Network Adequacy gaps and capacity concerns.

- Create standing Agenda Item for discussion at SUD provider Network Meetings.
- Evaluate and update PIHP Policies and processes for Requests for Information (RFIs) and Request for Proposals (RFPs).
- Issue RFIs and RFPs as necessary to fill identified gaps.

This goal is overseen by the PNM Department. Throughout the fiscal year, the PNM team focused on addressing transportation barriers, mitigating Medicaid eligibility coverage gaps, and expanding specialized network options. While critical milestones were achieved in out-of-region residential and adolescent service access, local transportation recruitment stalled, and administrative timelines for new provider onboarding are still in progress.

In alignment with the SUD Strategic Plan, PNM drafted a Non-Emergency Transportation RFP to resolve treatment transit gaps in St. Clair County. However, the RFP closed with zero provider responses. During the second quarter, the RFP was formally placed on hold to allow for ongoing network needs monitoring. PNM continues to monitor the network for this service need.

Regional capacity concerns and network adequacy gaps were evaluated through internal discussions and reviewed during the quarterly SUD Provider Network meeting. It was determined that the PIHP would extend a full contract to Great Lakes Recovery Center (GLRC) in the upper peninsula to secure specialized adolescent treatment services for juvenile consumers in the region. In addition, PNM staff completed a site visit to an interested faith-based treatment provider in Flint to potentially secure a second regional faith-based care option for Region 10 consumers.

In preparation for onboarding a new provider, PNM focused on updating the PIHP's Pre-Delegation and Assessment Tool. The completed tool is positioned for immediate submission to the Management Team for formal review and approval. Upon approval, the tool will be deployed to the prospective faith-based provider to launch an onboarding process targeted for completion by December 31, 2026.

During the quarterly SUD Provider Network meeting, Medication-Assisted Treatment (MAT) providers highlighted a rise in beneficiary coverage losses driven by state-level Medicaid eligibility shifts, which directly interrupted critical recovery medications. In response, the PIHP initiated internal discussion which aligned with the PNM Goal: *Ensure individuals served apply for Medicaid.*

This goal has been met.

PNM Goal 5:
Ensure individuals served apply for Medicaid.

- Facilitate ongoing share-and-learn discussions of best practices with Network Providers
- Evaluate the use of MDHHS integrated staff at CMHSPs.
- Evaluate and update contract language.
- Develop mechanism for monitoring contract compliance.

This goal is overseen by the PNM Department. The PIHP maintained intensive oversight throughout the fiscal year to ensure regional SUD treatment providers consistently executed workflows for client enrollment, eligibility verification, and legislative alignment.

During the fiscal year, PNM evaluated provider-level procedures for Medicaid applications. During the PNC CMHSP outlined their specific local workflows and confirmed active

protocols to verify Medicaid eligibility for every individual at the point of admission are in place.

During SUD Provider Network Meetings, SUD treatment providers detailed their internal processes and discussions were held throughout the year on how they could improve and best implement active protocols to confirm Medicaid eligibility for every individual at intake. Discussions were focused on expanding capacity by offering consumers hands-on enrollment support and direct advocacy to resolve coverage denials, effectively reducing barriers to treatment access.

In addition, eligibility protocol discussions were integrated into all SUD treatment provider site visits during contract monitoring. The conversations confirmed that providers possess structured processes to verify client coverage prior to admission, assist uninsured individuals in securing plans, and run monthly status checks to capture coverage changes.

The fourth quarter SUD Network Meeting focused heavily on the upcoming implementation of H.R. 1 Medicaid legislation. Details of upcoming changes were reviewed, and an information packet was distributed to all treatment providers immediately following the meeting.

Region 10's SUD provider network is fully informed of the upcoming regulatory changes and the best practices for ensuring uninterrupted coverage for consumers.
This goal has been met.

Evaluation
Throughout Fiscal Year 2026, the PNM department demonstrated strong operational resilience and achieved a 100% completion rate on its defined annual goals (Goals 1 through 5 met). The PIHP successfully modernized its data compliance infrastructure via the ShareFile migration, maintained statutory oversight by completing 39 on-site audits within mandatory timelines, and achieved full validation during the HSAG review.

The year was characterized by highly proactive, localized mitigation strategies implemented by individual CMHSPs to support the network, expand physical facilities, onboard new vendors, and secure highly specialized out-of-region care contracts. Furthermore, the network demonstrated strong systemic alignment by immediately connecting real-world provider feedback regarding Medicaid coverage disruptions (Goal 4) into actionable, network-wide enrollment and advocacy workflows (Goal 5).

Overall, these goals were considered met for FY2026. These goals will be revised and continued into FY2027.

17. Substance Use Disorder Health Home

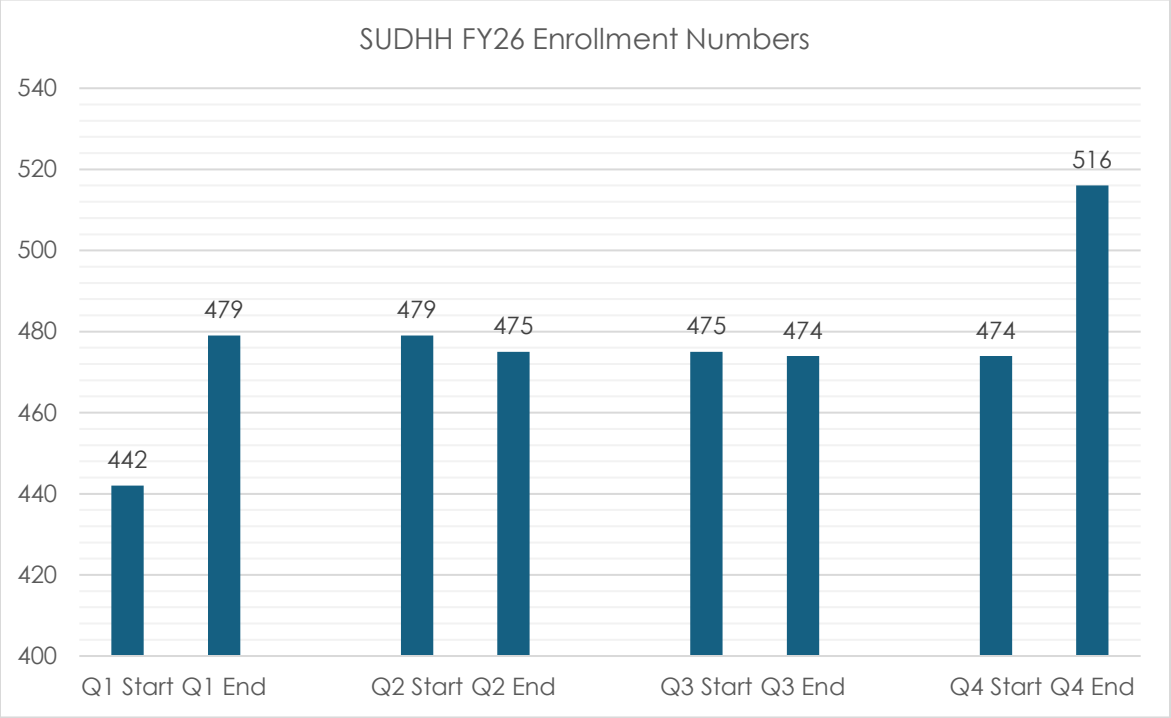
Overview
QIC established a FY2026 goal to provide oversight of the SUDHH model within Region 10. To achieve this, the committee focused on three core objectives:

- Identify, enroll and onboard potential Health Home Partners (HHPs).
- Increase and manage enrollment of SUDHH beneficiaries.
- Develop a continuous utilization and quality improvement program.

Goal
For our first objective, Region 10 aimed to identify, enroll, and onboard potential SUDHH HHPs in FY26. While we did not enroll any new providers, we identified key areas for improvement that would benefit the program. Currently, Genesee County has four SUDHH Providers, St. Clair County has one SUDHH provider while Lapeer County and Sanilac County have none.

Our second objective focused on expanding SUDHH enrollment, which increased from 442 to 516 beneficiaries year-to-date. Providers noted staff turnover and new staffing requirements, which made enrolling new beneficiaries difficult at the beginning of the year. However, noting mid-year staffing improvements (one Provider onboarded two additional Peer Recovery Coaches) successfully increased enrollment. Other Providers reported they are actively recruiting staff to meet SUDHH requirements and expand capacity.

Below is a graph detailing the enrollment numbers for SUDHH per quarter.



Our third objective focused on continuous utilization and improving program quality. In December, we surveyed our HHPs to gather feedback on their expectations and goals for our meetings. Feedback was received and implemented immediately. To support providers with SUDHH requirements, the SUDHH Coordinator sends monthly reports, such as missing care plans, expiring or expired consents, recoupments, ER visits, and potential disenrollments.

These reports help Providers manage the SUDHH program and meet the Michigan Department of Health and Human Services (MDHHS) requirements. In FY26, all Providers successfully met these metrics resulting in all Providers receiving the Pay for Performance (P4P) funds.

Evaluation
This goal is considered partially met. We successfully increased our enrollment numbers by 94 beneficiaries, growing from 422 to 516. Additionally, all SUDHH Providers met the MDHHS SUDHH metrics. Looking ahead to FY27, our focus will shift to helping Providers navigate program updates, including new staffing requirements, a new CPT code, and an increased emphasis on Z-codes. Moving forward, this goal will be discontinued to allow our team to focus on other areas requiring improvement.

Overall, this goal is considered partially met. This goal will not be continued into FY2027.

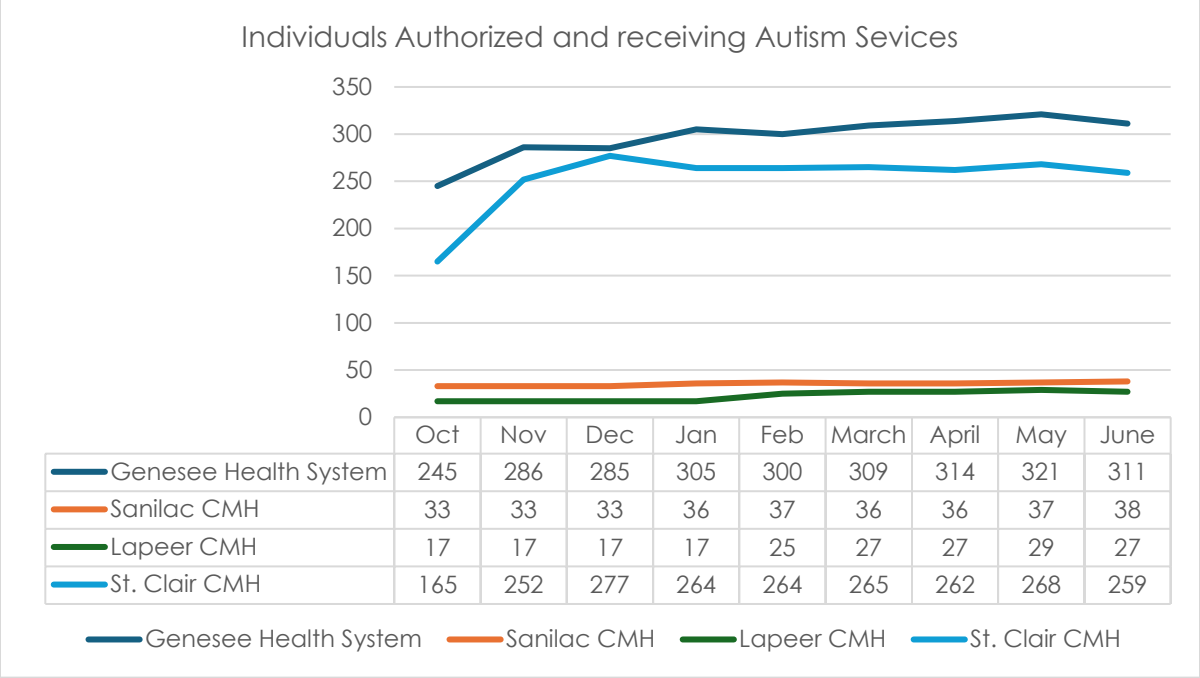
18. Autism Program

Overview
The FY2026 Autism goal reviewed and discussed monthly was as follows:
Reduce and monitor the number of beneficiaries waiting to start ABA services. as reported monthly on the Autism Monthly Reporting Form.

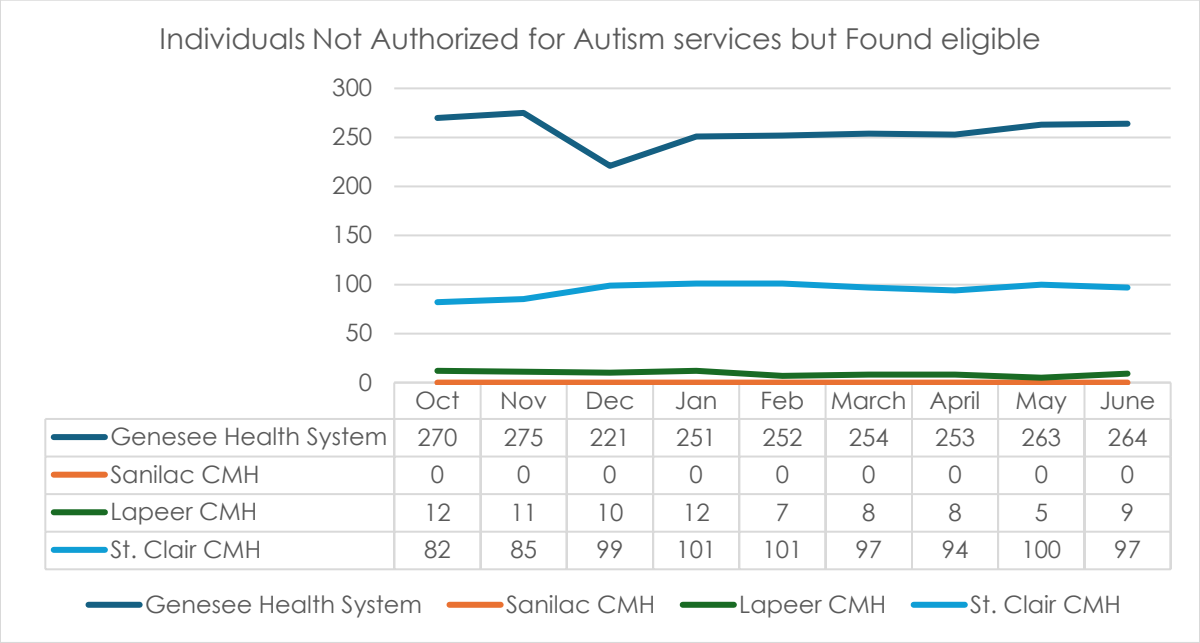
- Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form.
- Monitor timely submission of the Autism Monthly Reporting Form and timely communication from the CMHSP Autism Leads.

It is a contractual obligation of our Provider Network that the CMHSPs ensure they have adequate capacity and services available for those we serve.
Monthly the CMHSPs report to the PIHP updates on the Autism program which includes numbers of those individuals eligible and not authorized for service. The CMHSP also provides the PIHP with monthly updates on efforts to address network capacity issues and staffing changes.

Goal
In FY2026 this goal documented network capacity issues in Genesee Health System, Lapeer CMH and St. Clair CMH. Major barriers identified include staffing struggles, and high demands for after-hour services for school age individuals. Below is the data provided by the CMHSPs on individuals enrolled in autism services and in the second graph data on individuals found eligible and not authorized for autism services.



	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Genesee Health System	245	286	285	305	300	309	314	321	311
Sanilac CMH	33	33	33	36	37	36	36	37	38
Lapeer CMH	17	17	17	17	25	27	27	29	27
St. Clair CMH	165	252	277	264	264	265	262	268	259



	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Genesee Health System	270	275	221	251	252	254	253	263	264
Sanilac CMH	0	0	0	0	0	0	0	0	0
Lapeer CMH	12	11	10	12	7	8	8	5	9
St. Clair CMH	82	85	99	101	101	97	94	100	97

Genesee Health System Sanilac CMH Lapeer CMH St. Clair CMH

Evaluation
Overall, there is an increase in individuals presenting and being served in our network for Autism services. Our CMHSPs have taken on multiple new providers this year to help work on the capacity issues that they are seeing, however demand for ABA services continues to increase throughout the region.

There was a slight decline in those not authorized for Autism services in Genesee County this year. It has also been reported that Lapeer has in the month of August been able to serve all their individuals who were waiting to start services leaving their unauthorized number zero. Although there has been some progress towards this goal, it is ongoing and not met as there are still two CMHSPs who have individuals eligible and not authorized for these services. This goal will continue into FY2027 with the intention of continuing to follow the progress of this goal and allow the CMHSPs to collaborate and help work through this barrier.

Overall, this goal is considered partially met. This goal will be revised and continued into FY2027.

19. External Monitoring – MDHHS Annual Site Reviews

Overview
The FY2026 Quality of Services goal reviewed and discussed monthly was as follows:

Prepare, report, and monitor processes to ensure compliance standards are met for MDHHS annual site review which include the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), Children with Serious Emotional Disturbances Waiver (SEDW), and the 1915(i)State Plan Amendment (iSPA).

- Continue to facilitate quarterly meetings with CMHSPs to gather updates on previous CAP work
- Education on the HCBS final rule requirements for future Site Review.

In FY2026 MDHHS switched to doing site reviews of the Waivers and iSPA on an annual basis. Our review is currently underway. The FY2026 goal focused on the support the PIHP provides the CMHSPs to have continued work on the CAPs and focusing on HCBS education.

Goal
In FY2026 Region added multiple standards to the Annual Contract Monitoring Waiver Clinical Case reviews to enhance a focus on repeat citations from the previous year's MDHHS Waiver Site Review findings to ensure compliance and to incorporate HCBS standards. If there are areas of non-compliance the PIHP issued a POC to address necessary areas of improvement. The 2024 MDHHS Site Review CAPs were added to the PIHPs CMHSPs POC reports for tracking and monitoring CAPs identified in the MDHHS site review were discussed and monitored through Region 10's QI workplan and the QMC.

Region 10 conducted quarterly meetings with the CMHSP site review leads to discuss the CAPs and the expectations, progress, and any barriers at that time. These meetings were productive and informative and kept the CAP work a focus in the region.
The PIHP Waiver and iSPA program leads also added a standing agenda item in their regional meetings to discuss CAP work for the MDHHS site review and requested progress and barriers with program staff.

Evaluation
Overall, there was a lot of support and discussion around the FY2024 State Site review and the CAP action around these findings.
A barrier noted is that there were several standards added to the site review in FY26 which will make it challenging to compare year over year progress.
With this review moving to an annual basis there is hope that the CMHSPs will have more progress towards these CAPs more direction on certain standards and Region 10 can start to see more year-over-year data that we can improve upon.

Overall, this goal is considered met for FY2026. The goal will be revised and continued into FY2027.

20. External Monitoring – 1915(c) Waivers & 1915(i) State Plan Amendment (SPA)

Overview
It is the goal of the PIHP to increase efficiencies and enrollment activities related to the PIHP Waiver Programs HSW, CWP, SEDW and the 1915(i)SPA. The PIHP will encourage and provide education to the CMHSP's to increase enrollment in the HSW program. The PIHP will identify potential iSPA participants quarterly and collaborate with CMHSP's to encourage enrollment.

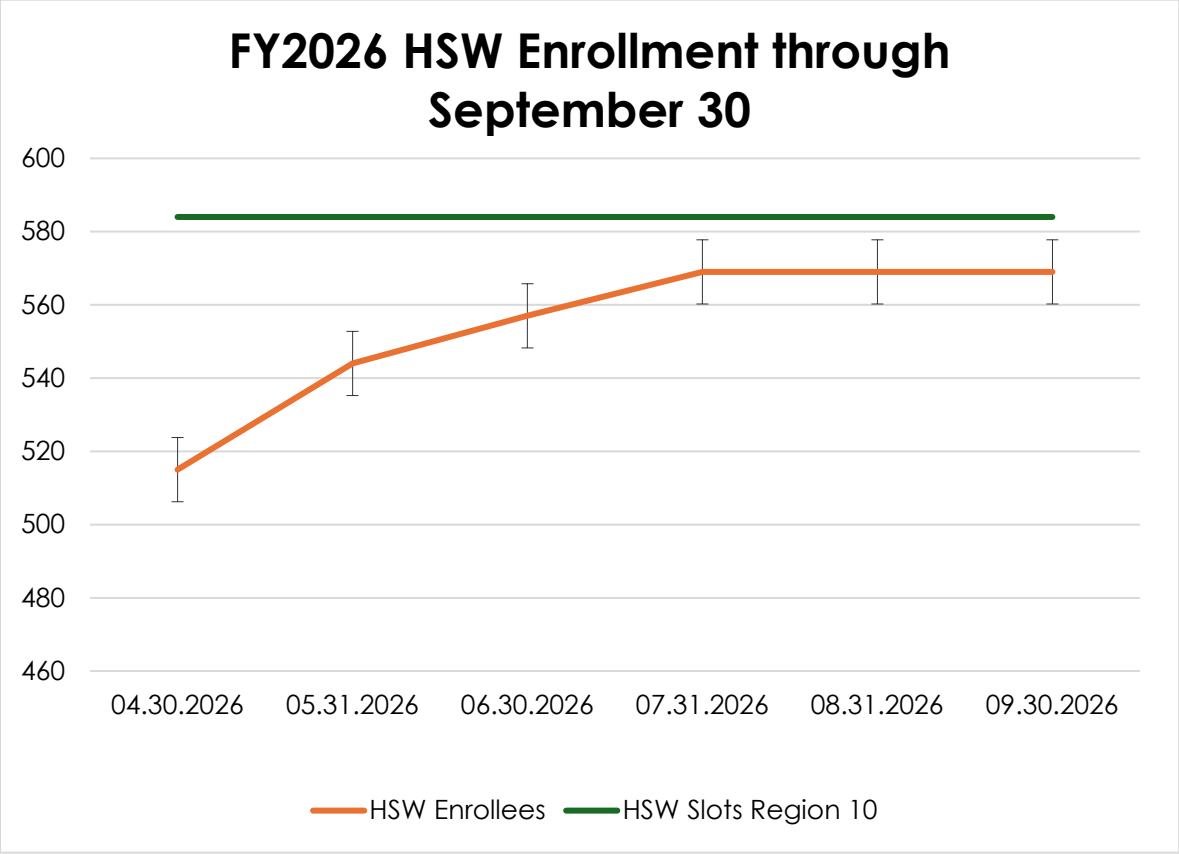
Goal
In April 2026 MDHHS notified Region 10 that slot utilization for the HSW program had fallen well below the 95% utilization threshold. Region 10 developed a work plan to increase the slot utilization for the HSW program. The work plan is made up of the following steps:

- Identify potential HSW enrollee
- Share with the CMHSP's the data collected regarding potential enrollees
- Ask for development of strategies to increase slot utilization from each CMHSP.
- Discuss barriers to enrollment with the CMHSPs.
- Discussed with CMHSP's potential number of HSW program enrollees at each CMH.
- Develop educational materials for the HSW program.
- Increase scrutiny of individuals who are planning on disenrolling from the program.
- Increase communication with Region 10 board members.
- Continue to assist CMHSP's with meeting HCBS standards.

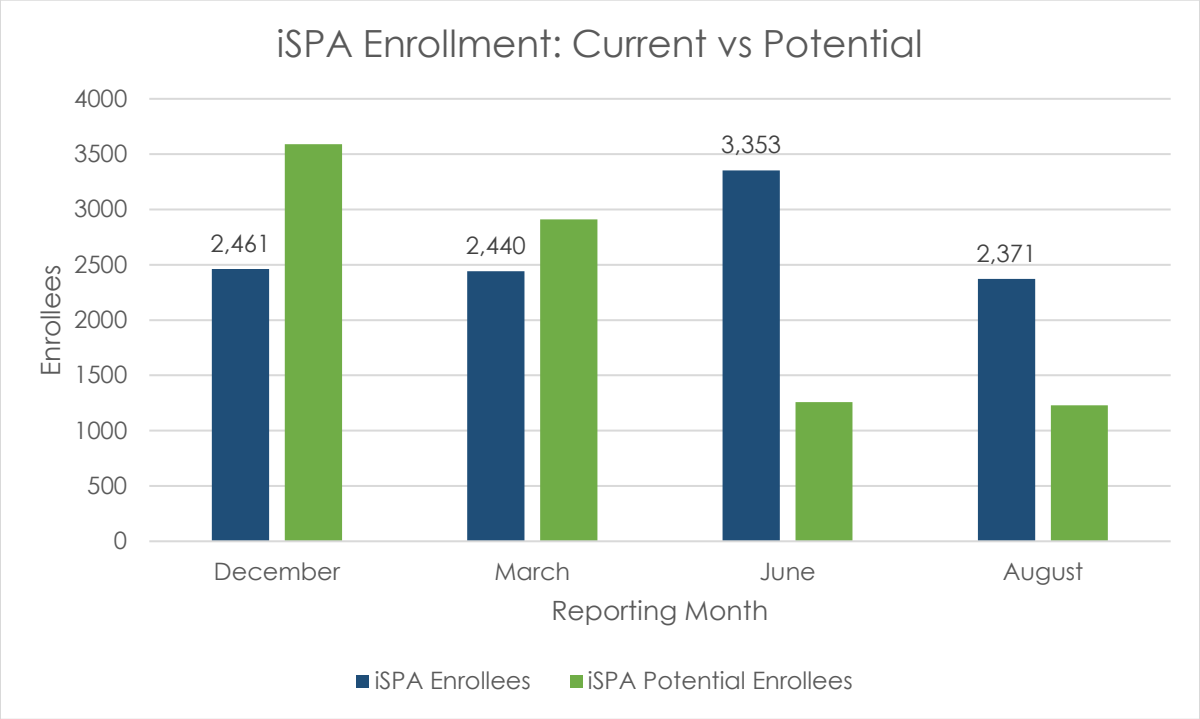
Potential iSPA participants data was rendered monthly and evaluated quarterly. Data reports identifying potential iSPA participants were shared with the CMHSPs during the third quarter for review and consideration of enrollment. Data reports will be shared again in the 4th quarter for enrollment assistance. MDHHS shared outstanding recertification reports throughout the fiscal year, which in turn was shared with the CMHSP's to bring these cases up to date or disenroll.

Evaluation
For the HSW Program, all CMHSP's submitted work plans to increase the slot utilization for the region. With the data they gave, the 95% benchmark could be achievable. The target number for the 95% slot utilization was calculated to be 555 individuals. The total number of individuals now enrolled in the HSW program is 569, which is 97.4% utilization. There were additional individuals eligible for enrollment, however in August the State of Michigan put a statewide pause on new enrollments to the HSW program, as they were noting increases across the state. This goal for the HSW program is considered met. FY2027 goal will focus on timely documentation submissions and maintaining this utilization rate to ensure our slot utilization remains consistent.

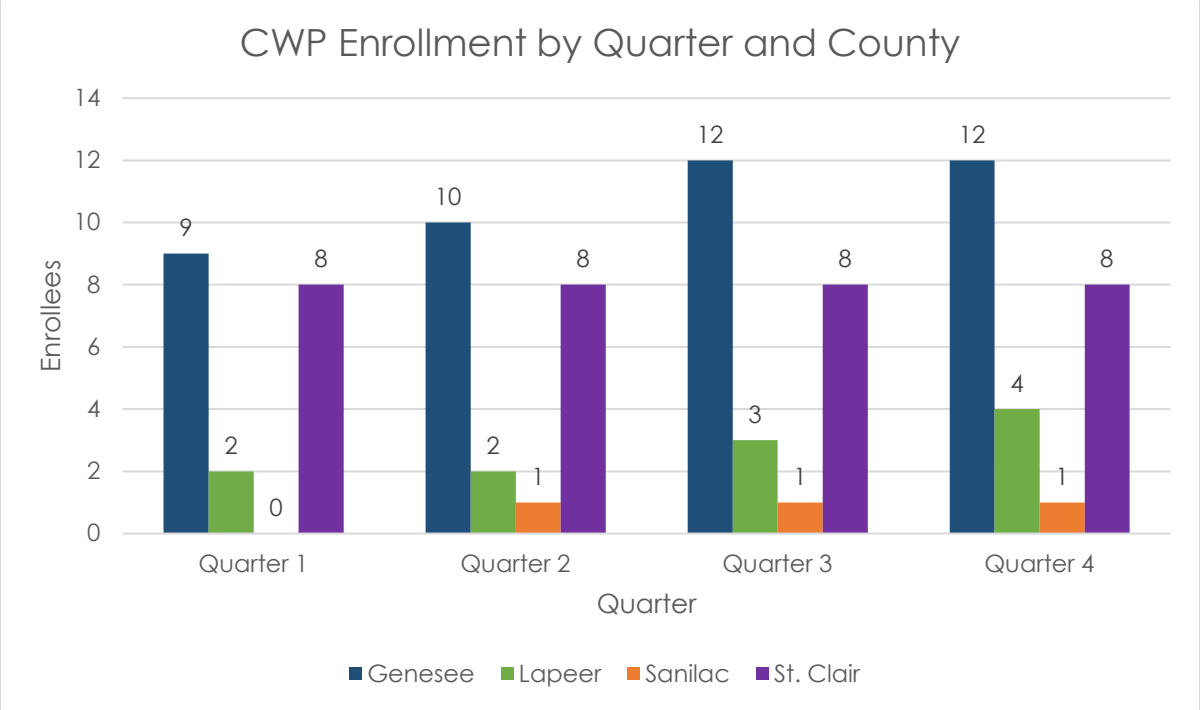
Monitoring enrollment and program progress for 1915(i)SPA, SEDW program and the CWP will continue in the FY2027 goal with a focus on timely recertification submissions.

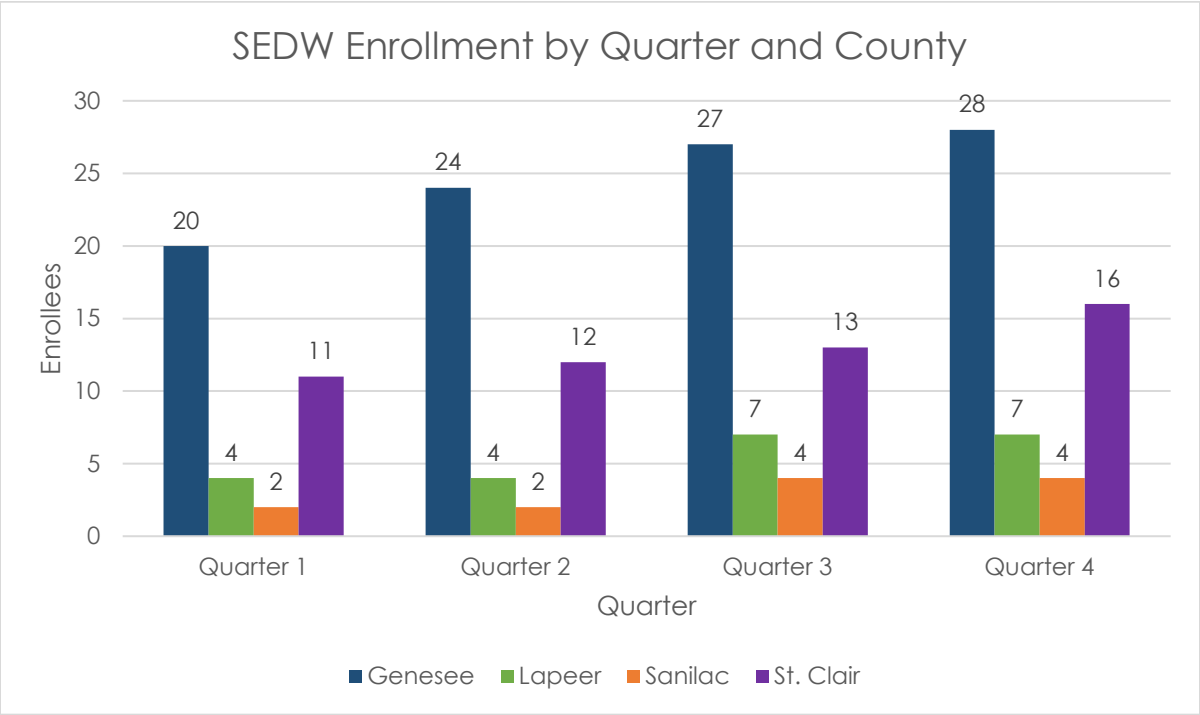


Region 10 has a total of 584 slots, as defined by MDHHS, to utilize for the HSW program. This graph shows the increase in slot utilization from April through the end of FY2026 when Region 10 was identified as falling below the 95% utilization standard.



Potential Enrollees are those individuals who show claims for 1915(i)SPA services but are not enrolled in the 1915(i)SPA program.





Overall, this goal is considered met for FY2026. This goal will be revised and continued into FY2027.

21. External Quality Review Corrective Action

Overview
Per the MDHHS / PIHP Contract, the PIHP must address findings from External Quality Review (EQR) activities through its QAPIP. Region 10 PIHP established a QI Workplan goal focused on implementing CAPs and addressing recommendations from EQR activities. The EQR activities include the Compliance Review, Performance Measure Validation (PMV), NAV, and Encounter Data Validation (EDV). PIPs are addressed in a separate QAPIP goal. More details and information regarding State Fiscal Year (SFY) 2025 EQR activities can be found in the SFY2025 EQR Technical Report, as well as the Annual EQR Technical Report Follow-Up Responses to Prior Year EQR Recommendations template completed by Region 10 PIHP and submitted to HSAG in September 2026.

Goal
For the SFY2024 and SFY2025 Compliance Reviews, Region 10 PIHP developed CAP and Recommendation Tracking Templates to assist with ongoing monitoring of CAP and Recommendation follow up. Monthly, Standard Leads (Subject Matter Experts) are asked to provide updates on progress of work done to address the CAPs and Recommendations from recent Compliance Reviews.

For the SFY2025 Compliance Review specifically, two program areas were highlighted on the Annual EQR Technical Report Follow-Up Responses to Prior Year EQR Recommendations template provided by HSAG. The first program area was Provider Selection, as Region 10 PIHP received a score of 76%. The second program area was health Information Systems, as Region 10 PIHP received a score of 78%.

Regarding recommendations for the Provider Selection program area, Region 10 revised its Credentialing and Privileging Policy to include the missing elements of the Michigan Public Sex Offender Registry and National Sex Offender Registry checks. The section covering delegation of credentialing and monitoring was expanded. Region 10 expanded our monitoring efforts to focus on deficiencies noted in previous reviews. Region 10 also began to review CRM credentialing applications for CMHSPs practitioners and sub-contracted providers.

If a deficiency in the credentialing process was noted during a credentialing record review, Region 10 would notify the CMHSPs and SUD Provider of the deficiency and discuss methods to improve their credentialing process. The Region 10 Privileging and Credentialing (P&C) Team has been able to increase communication with CMHSPs and SUD Providers on delegated credentialing responsibilities and requirements. The P&C Team meets with CMHSPs and SUD Providers as necessary when questions or concerns arise. For significant deficiencies identified during a credentialing record review, a POC was issued. Three POCs were issued during the FY2026 Annual Contract Monitoring credentialing record review. Region 10 PIHP will increase the monitoring for impacted providers to record if POCs were successful in resolving the deficiency.

Regarding the Health Information Systems program area, additional fields were added to the organization profile in the electronic health record (EHR) to meet reporting requirements. A prototype user interface was developed incorporating all required 42 CFR §431.70 elements, also including searchable text fields and functional filtering capabilities. Staff obtained access to established Application Programming Interface (API) endpoints (test and production) to begin validating integration of provider record data into the prototype interface. The PIHP worked with the vendor on an identified bug, which was resolved. Region

10's interactive Provider Directory webpage was launched. Ongoing work is occurring to include the CMHSP sub-contractor data to the API and defining the "source of truth" document for reporting APIs. Additionally, we are discussing options to add more information for ADA compliance, such as ramps, grab bars, etc.

For the Health Information Systems program area, Electronic Health Record enhancements to the Provider profile set-up were completed to include the required reportable fields and are available for any new providers and new locations for existing network providers. However, work continues to obtain and add the sub-contractor data.

Recommendations from the SFY2025 PMV Review included that Region 10 PIHP apply updates to overridden cases with notes prior to submitting Member Level Detail files to HSAG, Region 10 PIHP continue improvement efforts related to indicator #2 (assessment within 14 days of request, and Region 10 PIHP continue improvement efforts related to indicator #4b (follow up care within seven days of discharge from a SUD detox unit).

To address the recommendation regarding overridden events, the PIHP utilized HSAG's member-level detail file template for its PMV submission. Region 10 continued its standard practice of reviewing all overridden events to ensure event disposition, override notes, and supporting source documentation are consistent and aligned. For Indicator #2, Region 10 continues to require CIPs from all CMHSPs, regardless of performance, to support ongoing improvement in timely access to care. Last, although Indicator #4b is no longer required for reporting to MDHHS, Region 10 PIHP continues to internally monitor this indicator to support regional performance improvement across the SUD provider network. CIPs are required for SUD providers that do not meet the performance standard.

An area of performance improvement as a result of the initiatives described above is during the most recent reporting quarter, FY2026 Q2. All four CMHSP affiliates exceeded both MDHHS-established performance benchmarks for indicator #2. For Indicator #4b, the SUD network met or exceeded the 95% performance standard each quarter since FY2025 Q3, including achieving 100% compliance in FY2026 Q2.

There were numerous barriers to implementing initiatives related to PMV Review findings and recommendations. First, significant updates to the MMBPIS methodology in FY2026 required the PIHP and CMHSPs to adapt existing reporting, validation, and review processes to align with the revised requirements. Next, multiple additional updates to the FY2026 MMBPIS Codebook occurred during the review period. These updates required repeated recalibration and reduced time available for the PIHP and CMHSPs to adjust workflows and update underlying coding logic used to identify reportable events. This resulted in increased reliance on manual staff review. Further, the updated FY2026 MMBPIS methodology restricts the PIHP's ability to independently validate the identification of reportable events, as CMHSPs interpret and apply exclusion criteria prior to submitting data to the PIHP. As a result, events may be excluded upstream and are therefore never visible to the PIHP. This results in limited ability of the PIHP to confirm dataset completeness and consistent interpretation/application of the updated FY2026 methodology across the region. Last, the exclusion of individuals receiving only CCBHC-funded services reduced the number of reportable events in FY2026 Q1 by more than 50% compared to FY2025 Q1. This substantially smaller reporting population increased the impact of individual noncompliant events on overall performance rates. Established benchmarks continue to be based on historical data collected under the previous methodology which may not be directly comparable to performance under the FY2026 methodology.

From the SFY2025 NAV Review, HSAG recommended Region 10 PIHP to seek clarification and detailed guidance from MDHHS on the correct methodology for calculating full-time employees (FTEs) within the reporting template. Further, HSAG recommended Region 10 PIHP collaborate with CMHSPs and MDHHS to identify and evaluate gaps in the provider network, with a focus on significantly underserved service types.

Region 10 PIHP requested clarification and detailed guidance from MDHHS regarding FTE calculation. Ongoing collaboration continues between the PIHP and CMHSPs to discuss gaps in network. However, MDHHS has not responded with clarification regarding the methodology used to calculate Network Adequacy indicators, so the PIHP is unable to replicate. The PIHP is working with the regional Provider Network Committee (PNC), which includes representation from each CMHSP to develop a standardized internal methodology for calculating indicators as a way to potentially validate results provided by MDHHS. CMHSPs have noted that strategies such as telehealth are not practical or relevant to the gaps in the network such as inpatient beds and ABA services. However, the PNC quarterly meetings continue to serve as a platform for CMHSPs to share potential subcontractor information, discuss strategies for mitigating gaps, and collaborate on service capacity issues. In FY2027, the Committee decided to implement a standing Agenda item for the purpose of sharing new interested providers with one another.

An identified area of improvement is that Lapeer CMH has noted improvements in ABA availability. Further, the PIHP has seen improvements since the previous FY Network Adequacy Report Results Summary in the areas of Adult Crisis Residential Programs (Beds) and Opioid Treatment Programs which now meet their respective Standard.

As a result of the SFY2025 EDV activity, HSAG recommended Region 10 PIHP and MDHHS collaborate to clarify and standardize expectations related to Medicaid eligibility criteria for the EDV data extracts. Further, it was recommended Region 10 update its extraction and submission processes accordingly and implement pre-submission quality checks to ensure that all applicable encounters are included, thereby improving alignment between the Region 10-submitted and the MDHHS-submitted data in future EDV activities. HSAG also provided recommendations relating to specific data elements, including Secondary Diagnosis Code(s) and Rendering Provider NPI. In response to these recommendations and review of the SFY 2025 EDV Report, Region 10 PIHP prepared a summary document to track the identified recommendations with notes from communications and findings related to the EDV activity.

To prepare the data extract submission to HSAG, Region 10 PIHP ensured a clear understanding of the instructions by requesting technical assistance from HSAG and by seeking written clarification via email from HSAG. Throughout the review, Region 10 proactively sought clarification from HSAG regarding data extract requirements, including written clarification of Medicaid inclusion criteria. Following receipt of the initial discrepancy report, Region 10 provided specific encounter examples and requested additional technical assistance to better understand and reconcile identified differences.

As outlined in the SFY 2025 EDV Report, Region 10 PIHP had the highest all-element accuracy among PIHPs for both institutional and professional encounters for records that were found in both the PIHP and MDHHS data sets. Additionally, Region 10 continues to review monthly MDHHS reconciliation files to monitor encounter data quality and correct identified discrepancies. Several data elements evaluated during the EDV review are not reflected in MDHHS's monthly reconciliation file. Region 10 is committed to reconciling additional fields if they become available and welcomes opportunities for continued collaboration with MDHHS to support the highest data quality.

For future EDV activities, Region 10 will continue to seek clarification of data extract requirements as needed and work collaboratively with HSAG and MDHHS to support consistent interpretation, validation, and alignment of encounter data.

Regarding performance improvement, the SFY 2025 HSAG EDV review introduced the need for point-in-time encounter data reporting. In response, Region 10 successfully developed processes for reconstructing encounter data as of a specified anchor date, including any records that were active at the time but subsequently voided. This enhancement builds upon Region 10's existing reporting infrastructure, further strengthening our historical reporting and validation capabilities.

Regarding barriers, per the SFY 2025 EDV Report, there were "confirmed errors in the MDHHS extract or differences in interpretation of the data extract requirements between MDHHS and the PIHPs," which negatively impacted Region 10's reported results. This included differences in exclusion criteria based on Medicaid coverage, and data elements that HSAG identified as being affected by variations in reporting methodology, derivation logic, or extract specifications. These differences limited Region 10's ability to fully reconcile certain review findings.

Although the reported MDHHS-record-surplus rates for Region 10 were 8.1% for Professional encounters and 6.5% for Institutional encounters, these rates reflect Region 10's exclusion of 154,593 Professional and 465 Institutional records based on confirmed guidance to exclude services for non-Medicaid individuals. Accounting for these records suggests corrected surplus rates of <0.2% for Professional and 0.0% for Institutional encounters. This is consistent with Region 10's strong performance in other measures of data quality, including MDHHS-record-omission-rates of <0.1% for Professional and 0.0% for Institutional encounters (notably, MDHHS-record-omission rates would not have been impacted by Region 10's exclusion of individuals lacking Medicaid coverage). Region 10 also achieved the highest all-element accuracy rate among the PIHPs for both Professional (99.4%) and Institutional (99.6%) encounters. Collectively, these findings suggest strong alignment between Region 10 and MDHHS encounter data.

Evaluation
For FY2027, Region 10 PIHP will continue the goal to implement CAPs and address recommendations from EQR activities. Efforts in FY2027 will address any outstanding remediation tasks from SFY2025 EQR activities, as well as any new findings from SFY2026 EQR activities.

Overall, this goal is considered met. This goal will be revised and continued into FY2027.

22. Corporate Compliance Committee

Overview
The Corporate Compliance Committee is designated by the Region 10 PIHP QIC to address Region 10's compliance goals. Members include PIHP Corporate Compliance Officer and administrative staff, representation from each CMH provider within the region, and a representative for the regional SUD provider network. Committee functions are further outlined in the PIHP Corporate Compliance Program Policy. The Corporate Compliance Committee focuses on regulatory compliance as well as corporate compliance issues to ensure service provision in network as required.

The Corporate Compliance Committee had three goals for FY2026. The first goal was to ensure compliance with 42 CFR 438.608 Program Integrity requirements and to support reporting requirements as defined by MDHHS, OIG, Medicaid Fraud Control Unit (MFCU), and the PIHP. The second goal was to ensure compliance with 45 CFR 164.520 Notice of Privacy Practices. The third goal was to review regional Corporate Compliance monitoring standards, reports, and outcomes.

Goal
The Corporate Compliance Committee's first goal was to ensure compliance with 42 CFR 438.608 Program Integrity requirements and to support reporting requirements as defined by MDHHS, OIG, MFCU, and the PIHP. The PIHP Compliance Committee representatives regularly provided information regarding upcoming reports and report due dates to ensure timely submissions. The PIHP committee representatives also provided information about OIG report template updates.

For FY2027, the Corporate Compliance Committee approved a goal to submit OIG-required reports to the OIG in accordance with guidance documents with defined due dates. It is anticipated that additional data reports or processes will need to be developed to ensure accurate and complete reporting on the new FY2027 OIG Report templates. The PIHP Compliance Officer will convene a meeting with internal staff to discuss report changes. The PIHP Compliance Officer will also continue participating in statewide groups and discussions relating to OIG report requirements.

The Corporate Compliance Committee's second goal was to ensure compliance with 45 CFR 164.520 Notice of Privacy Practices. The committee discussed Region 10 PIHP's Privacy Notice and Providers' Privacy Notices and related processes. During FY2026, Region 10 PIHP updated its Privacy Notice and distributed the revised Privacy Notice to Medicaid beneficiaries (and guardians of Medicaid beneficiaries) who received PIHP-covered services. All mailings were completed before the conclusion of the fiscal year. In FY2027, the PIHP Compliance Team will complete a review of PIHP Privacy Policies to ensure policies align with all federal requirements.

The Corporate Compliance Committee's third goal was to review regional Corporate Compliance monitoring standards, reports, and outcomes. Annual Contract Monitoring was completed during FY2026 with CMHSPs and SUD Providers. Some of the compliance-related standards reviewed for both CMHSPs and SUD Treatment Providers were related to timely and accurate report submissions, breach tracking and reporting, and Privacy Notice requirements. Plans of correction were issued to providers for any "not met" performance standards. Throughout the fiscal year, the Compliance Committee was apprised of the status of FY2026 Annual Contract Monitoring.

Evaluation
For FY2027, reviewing Corporate Compliance monitoring standards, reports, and outcomes will not be a goal of the Compliance Committee. However, Corporate Compliance monitoring will remain a committee responsibility. The PIHP Compliance Department will review and update, if necessary, the Compliance performance standards for FY2027 Contract Monitoring Review Tools.

Overall, these goals are considered met. Different goals will be implemented for FY2027.

23. Information and Technology

Overview
The 2025 Network Security Audit and Assessment revealed improvement opportunities for Region 10 PIHP in the areas of oversight and governance of Information Technology (IT) functions and security, including reporting to the PIHP Board. There were numerous findings from the 2025 Network Security Audit and Assessment requiring remediation.

To improve reporting and to keep a focus on remediation items from Network Security Audits and Assessments, a goal was added to the FY2026 Quality Improvement Program and Workplan. The goal specifically was to continue collaborating with the IT Managed Service Provider (MSP) as part of the special project created to address findings from the 2025 Security Audit and Assessment. Planned activities included development and maintenance of a workplan to address findings from the 2025 Security Audit and Assessment as well as conducting biweekly meetings with the IT MSP to discuss the workplan activities and identify progress, measure risk reduction, and remain engaged in the organization's technology strategy.

Goal
At the beginning of the fiscal year, Region 10 PIHP developed a workplan with the 2025 Security Audit and Assessment findings and presented the workplan to the IT MSP. During the first and second quarters of FY2026, the PIHP-developed workplan was used to document progress on efforts to address findings from the audit. In the second quarter, two significant remediation items from the 2025 Security Audit and Assessment were completed, the Disaster Recovery testing and the installation of a new firewall.

During the third quarter, the 2026 Network Security Audit and Assessment was conducted. During and following the audit, the auditor noted there were many repeat findings from the 2025 Network Security Audit and Assessment. These repeat findings became a major focus for Region 10 PIHP and the IT MSP. During the fourth quarter, a new workplan was created to better track Network Security Audit and Assessment remediation items. Weekly project status meetings were scheduled, and a team of staff from Region 10 PIHP and the IT MSP discussed status of projects and prioritization of tasks.

At the July PIHP Board meeting, an executive summary of the 2026 Network Security Audit and Assessment was presented. Additionally, Network Security Audit and Assessment highlights were included in the first, second, and third quarter QI Workplan executive summaries presented to the PIHP Board.

Throughout the fiscal year, there were many focused discussions on audit findings and specific projects to address the findings. While there was progress on remediating some audit findings, not all repeat findings were addressed prior to the end of FY2026. However, the team of staff from Region 10 PIHP and the IT MSP will continue weekly project status meetings for the remainder of CY2026 to ensure completion of remediation activities and related projects.

Evaluation
Further, for FY2027, a new IT Committee will be established under Region 10 PIHP's QAPIP structure. The IT Committee had its first meeting in September 2026 and approved goals and responsibilities for FY2027. The first goal of the IT Committee will be to complete remediation activities to address priority, repeat citations from the 2026 Network Security Audit and Assessment by December 31, 2026. The second goal of the IT Committee will be to complete a business impact analysis, risk assessment, incident response plan, and business continuity

plan by September 30, 2027. The IT Committee's responsibilities will be more comprehensive than the two measurable goals and will include activities such as developing reports to the PIHP Board and reviewing the annual IT budget.

Overall, this goal is considered partially met. This goal will be revised and continued into FY2027.

24. Customer Service Inquiries

Overview
Throughout Fiscal Year 26, the PIHP Customer Service Department received requests for customer service inquiries. A customer service inquiry is a request from an enrollee for assistance with an issue. Subjects for inquiries include, but are not limited to, Medicaid appeals, questions surrounding the content of ABD Notices, and other general inquiries regarding services and enrollee rights. It is outlined in the MDHHS Customer Service Standards that the PIHP must help individuals with problems and inquiries regarding benefits, including how to file an appeal and/or grievance. The PIHP has tracked and analyzed inquiry resolution data for FY26.

Goal
The goal is to review and analyze baseline customer service inquiry data for the region. The PIHP will track and trend inquires on a monthly basis, identify consistent patterns related to customer service inquiries, and develop interventions as necessary to address critical issues within the Network. Throughout FY26 the PIHP has been tracking data inquiries monthly, the preliminary analysis of Q1-Q3 data shows that the PIHP has processed thirty-nine (39) inquiries.

Evaluation
We anticipate that the number of inquiries processed by the PIHP will be a decrease from FY25, this can be attributed to the decentralization of Access. In FY2025 the PIHP processed a total of ninety-three (93) inquiries for the year, as of 9/10/26 the PIHP processed thirty-nine (39). Of the thirty-nine (39) inquiries (please note: one inquiry led to two inquiry resolutions) processed in FY26 the inquiry resolutions were as follows:

Reporting Period: FY2026	
Inquiry Resolution Categories:	**Total**
Appeal	9
Grievance	7
Referral to Access	1
Rights Complaint	0
Referral to Provider	13
Other	3
Pending	3
Unable to Reach	4

The PIHP did not identify any barriers to analyzing inquiry data. Additionally, there have not been any established patterns in inquiry resolutions for inquiries processed in FY2026. At the time of this report, the data for FY2026 Q4 data is currently not available.

Overall, this goal is considered met. This goal will be revised and continued into FY2027.

25. Appeals

Overview
Throughout Fiscal Year 26, the PIHP Customer Service Department received requests for appeals. An appeal is a review at the local level by the PIHP of an ABD. It is outlined in the MDHHS policies and the CFR that the PIHP must process appeals regarding adverse actions to Medicaid services. The PIHP has tracked and analyzed appeal data for FY26.

Goal
The goal is to review and analyze baseline appeals data for the region. The PIHP will track and trend appeals on a monthly basis, identify consistent patterns related to appeals, and develop interventions necessary to address critical issues within the network. Throughout FY2026 the PIHP has been tracking appeals data monthly, the preliminary analysis of Q1-Q3 data shows that the PIHP has processed nine (9) appeals.

Evaluation
We anticipate that the number of appeals processed by the PIHP will be a decrease from FY25, this can be attributed to the CCBHC program. In FY25 the PIHP processed a total of thirteen (13) appeals, as of 9/10/26 the PIHP processed nine (9).Of the nine (9) appeals processed in FY26 the reason for appeals were as follows:

Reporting Period: FY2026					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
GHS	3	0	2	-	5
Lapeer	0	0	1	-	1
PIHP	0	0	0	-	0
Sanilac	0	1	1	-	2
St. Clair	0	0	0	-	0
SUD	0	0	1	-	1
TOTAL	3	1	5	-	9
Reason for Appeal:					**Total**
Service Denial					7
Service not started within 14 days					0
Service Reduction					1
Service Suspension					0
Service Termination					1

The PIHP has not identified any barriers to analyzing appeals data. Additionally, there have not been any established patterns for appeals across the region in FY2026. At the time of this report, the data for FY2026 Q4 data is currently not available.

Overall, this goal is considered met. This goal will be revised and continued into FY2027.

26. Grievances

Overview
Throughout Fiscal Year2026, the PIHP Customer Service Department received grievances from across the provider network. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. A grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make an authorization decision. It is outlined in the MDHHS policies and the CFR that the PIHP must process grievances from Medicaid Beneficiaries from across the provider network. The PIHP has tracked and analyzed grievance data for FY26.

Goal
The goal is to review and analyze baseline grievance data for the region. The PIHP will track and trend appeals on a monthly basis, identify consistent patterns related to grievance, and develop interventions as necessary to address critical issues within the network. Throughout FY26 the PIHP has been tracking grievance data monthly, the preliminary analysis of Q1-Q3 data shows that the PIHP has processed fourteen (14) grievances.

Evaluation
We anticipate that the number of grievances processed by the PIHP will be a decrease from FY25, this can be attributed to two (2) factors. As of October 1, 2025, all four CMHSPs became CCBHCs. CCBHCs are responsible for reporting and processing their own CCBHC service-related grievances to MDHHS, this in turn decreased the number of grievances processed through the PIHP. Additionally, the PIHP provided training on what constitutes a grievance to the CMHSP provider network in FY25. This training led to a decrease in the number of grievances processed by the PIHP in FY26.

In FY2025, the PIHP processed a total of seventy (70) grievances, as of September 10, 2026 the PIHP processed sixteen (16). Of the sixteen (16) grievances processed in FY2026, the reasons for grievances were as follows:

Reporting Period: FY2026					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
GHS	2	1	1	-	4
Lapeer	0	0	0	-	0
PIHP	0	0	0	-	0
Sanilac	0	0	1	-	1
St. Clair	0	3	0	-	3
SUD	5	1	2	-	8
TOTAL	7	5	4	-	16
Reason for Grievance:					**Total**
Financial Matters					0
Quality of Care					4
Service Concerns/ Availability					8
Service Environment					1
Suggestions/ Recommendations					0
Interaction with a Provider or Plan					3

The PIHP has not identified any barriers to analyzing grievance data. Additionally, there have not been any established patterns for grievances across the region in FY2026. At the time of this report, the data for FY2026 Q4 data is currently not available.

Overall, this goal is considered met. This goal will be revised and continued into FY2027.

27. Finance Committee

Overview
To improve financial reporting overall and to align with MDHHS requirements Region 10 adopted the following goals:

- Modify processes and procedures to align with MDHHS changes with CCBHC reporting and oversight.
- Update CMHSP monthly reporting to implement a narrative component and a comparison between budget amounts and actual trends.
- Enhance financial reporting mechanisms for SUD Programs.

Goal
Region 10 management modified its financial reporting practice and guidelines to eliminate the reporting of CCBHC activities from the monthly financial statements. However, there was also ongoing discussion regarding the appropriate costing of service to ensure that the CMHSPs had the tools during the transition to appropriately exclude CCBHC cost from amounts reported in traditional Medicaid and Healthy Michigan capitation costs. These discussions took place throughout the year. Additionally, budget to actual discussions took place monthly to discuss changes in operations that were outside of budgeted plans that could explain fluctuations from month over month and from budget. Region 10 financial management brought these discussions to internal management team meetings to share this knowledge.

SUD reporting was enhanced to provide greater transparency both internally and externally. Monthly financial reports have been presented to the SUD Oversight policy Board and the Region 10 Board of Directors. A SUD Block Grant Waiting List policy has been revisited and updated by Region 10 management. A SUD Funding presentation has been shared with both the Region 10 Board of Directors and SUD Oversight Policy Board.

Evaluation
These goals have resulted in better financial transparency and understanding both internally and externally. The changes to reports to add necessary information and the increased frequency of reporting will continue. In 2027, the goals related to costing and CMHSP monthly reporting will continue but will have an additional component.

Overall, these goals are considered met for FY2026. Two goals will be revised and continued into FY2027. One goal will not be continued into FY2027.

28. Conclusion

Using our QI Workplan as a guide, Region 10 was able to improve the quality of services received by our consumers across the region. Highlights from improvement activities throughout FY2026 include:

- Performance Indicators from the CMHSPs and SUD providers have been received and reviewed by Region 10. For Indicator #2 all CMHSPs met/exceeded both performance benchmarks in FY2026. The SUD providers met/exceeded the first (lower) benchmarks with areas of improvement noted to meet the second (higher) benchmark.
- The FY2026 Consumer Satisfaction Survey was conducted timely, and the results showed satisfaction in the areas of overall satisfaction, participation in treatment, quality/appropriateness and access to services. FY2026 Consumer Satisfaction Survey overall satisfaction rate was 90.7%.
- Region 10 continued work on our State Mandated PIPs. While the disparity was not fully resolved in PIP # 1, statistically significant improvements were demonstrated compared to Baseline. PIP #2 is complete also showing significant improvements demonstrated compared to Baseline. Region 10 will have a new PIP to replace PIP #2 for FY2027.
- Region 10 successfully implemented the EVV 85% compliance rate beginning in April of 2026. Showing improved compliance in this area throughout the implementation process. Continued work in partnership with our CMHSPs and SUD Providers occurred in FY2026 to reduce the number of dangling Admissions for BH-TEDs.
- Analysis of Critical Incident Reporting identified no concerning trends. All Sentinel Events reviewed complied with BTPRC review requirements and reporting timeframes.
- Region 10 made progress on the HCBS transition plan by improving tracking requirements for Physical Annual Assessment successfully across the region, demonstrated increased understanding of the HCBS Final Rule through increased case reviews and compliance in plans reviewed through the CMH BTPRCs and reporting that all completed Provisional Assessments submitted in FY2026 followed policy and had 100% approval rates.
- The Behavioral Health Home Program was initiated and successfully started in FY2026.
- During Annual Contract Monitoring, Region 10 reviewed 80 practitioner credentialing applications and 20 organizational credentialing applications from our CMHSPs. In Addition, 80 practitioners credentialing applications were reviewed from our SUD Providers. The P&C team used the findings from the review to guide conversations about process improvements.
- In the FY2026 Claims Verification Audit, Region 10 reviewed 12,862 claim lines billed to the PIHP with a total dollar amount of $1,254,818.53.
- Access operations for the CMHSPs were decentralized and delegated. UMC expanded UM/UR activities and reporting. The SUD UR was aligned with the SUD reviews conducted during Annual Contract Monitoring.
- There were efforts throughout the year to address network gaps and capacity for Autism Services which showed progress in all CMHSP.
- FY2026 Annual Contract Monitoring was completed timely, and the monitoring team completed 39 on-site compliance visits across the provider and subcontractor network.
- SUDHH successfully increased enrollment numbers in FY2026, and all SUDHH Providers met the MDHHS SUDHH metrics.
- HSW enrollment increased, and the region successfully reached the 95% slot utilization standard.

- Region 10 made substantial progress towards Information and Technology safety in FY2026 by implementing a workplan from feedback from the 2025 Security Audit and Assessment findings. Changes include programs and processes to better improve our network and data security. A new IT Committee will be established under the Region 10 PIHP QAPIP structure to track and monitor ongoing monitoring.
- In FY2026 Region 10 modified a financial reporting practice and guidelines to eliminate the reporting the reporting of CCBHC activities from monthly financial statements, and collaborative discussion helped improve this process throughout the year. The Finance team worked closely this FY with the SUD providers on reporting, which was enhanced to provide greater transparency with the network.
- Using feedback received from MDHHS, Region 10 revised our QAPIP Annual Evaluation to summarize and evaluate the improvement actions and activities that took place throughout the year.

Region 10 PIHP is committed to continuous improvement and collaboration with our CMHSPs, SUD Providers, and our consumers. For FY2027, The QI Workplan goals have been revised to be measurable and the PIHP is committed to gathering data annually to allow for a year-over-year analysis. This year-over-year analysis will allow the PIHP to track trends, identify patterns, and measure the performance of our initiatives and programs.

29. Acronym List

ABA- Applied Behavior Analysis
ADB- Adverse Benefit Determination
ADOS- Autism Diagnostic Observation Schedule
AMS- Access Management System
APA- American Psychological Association
API- Application Programming Interface
ASAM- American Society of Addiction Medicine
B2W- Benefit-to-Work
BCBA- Board-Certified Behavior Analyst
BH TEDS- Behavioral Health Treatment Episode Data Set
BHASA- Behavioral Health and Aging Services Administration
BHH- Behavioral Health Home
BHQT- Behavioral Health Quality Transformation
BTP- Behavioral Treatment Plan
BTPRC- Behavioral Treatment Plan Review Committee
CAP- Corrective Action Plan
CC360- CareConnect360
CCBHC- Certified Community Behavioral Health Clinic
CFR- Code of Federal Regulations
CIPs- Continuous Improvement Plans
CLD- Client Level Detail
CMHSP- Community Mental Health Service Provider
CMS- Center for Medicare and Medicaid
CORF- County of Financial Responsibility
CPGs- Clinical Practice Guidelines
CPT- Common Procedural Terminology
CQS- Comprehensive Quality Strategy
CRM- Customer Relation Management System
CWP- Children's Waiver Program
CY-Calendar Year
DCO- Designated Collaborating Organization
EBPs- Evidence-Based Practices
EDV- Encounter Data Validation
EHR- Electronic Health Record
EOFY- End of Financial Year/ End of Fiscal Year
EQI- Encounter Quality Initiative
EQR- External Quality Review
ESC- Employment Services Committee
EVV- Electronic Visit Verification
FTE- Full-time Employee
FY-Financial Year / Fiscal Year
HCBS- Home and Community Based Services
HCPCS- Healthcare Common Procedure Coding System
HHPs- Health Home Partners
HSAG- Health Services Advisory Group
HSW- Habilitation Supports Waiver
ICCW- Intensive Care Coordination with Wraparound
IDDT- Integrated Dual Disorders
IHC- Integrated Health Care
IPLT- Improving Practices Leadership Team
IPOS- Individual Plan of Service
IPS- Individual Placement and Support
IPU- Inpatient Psychiatric Unit
iSPA- 1915 (i) State Plan Amendment
IT- Information and Technology
LOC- Level of Care
LOCUS- Level of Care Utilization System
LTSS- Long-Term Services and Supports
MAT- Medication-Assisted Treatment
MDHHS- Michigan Department of Health and Human Services
MFCU- Medicaid Fraud Control Unit
MH- Mental Health
MHP- Medicaid Health Plan
MiCAL- Michigan Crisis and Access Line
MiFAST- Michigan Fidelity Assistance Support Team
MMBPIS- Michigan Mission Based Performance Indicator System
MRS- Michigan Rehabilitation Services
MSP- Managed Service Provider
NAV- Network Adequacy Validation
NPI- National Provider Identifier
OIG- Officer of Inspector General
P&C- Privileging and Credentialing
PBIP- Performance Bonus Incentive Program
PCMH- Patient-Centered Medical Home
PI- Performance Indicator
PIHP- Prepaid Inpatient Health Plan
PIPs- Performance Improvement Projects
PMV- Performance Measure Validation
PNC- Provider Network Committee
PNM- Provider Network Management
POC- Plan of Correction
Q- BH TEDS Crisis Record
QAPIP- Quality Assessment and Performance Improvement Program
QI- Quality Improvement
QIC- Quality Improvement Committee
QMC- Quality Management Committee
RCC- Responsible Credentialing Coordinator
RCO- Recovery Community Organization
RFI- Request for Information
RFP- Request for Proposal
SAMSHA- Substance Abuse and Mental Health Services Administration
SDI- Serious Emotional Disturbance
SEDW- Serious Emotional Disturbances Waiver
SER- Service Exception Request
SERC- Sentinel Events Review Committee
SMEs- Subject Matter Experts
SMI- Serious Mental Illness
SPA- State Plan Amendment
SU TEDS- Substance Use Treatment Episode Data Set
SUD- Substance Use Disorder
SUDHH- Substance Use Disorder Health Home
UM- Utilization Management
UMC- Utilization Management Committee
UR- Utilization Review
WSA- Waiver Support Application



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Quality Improvement Workplan Quarterly Updates

FY2026 Quality Improvement Workplan (October 1, 2025 – September 30, 2026)

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/ Department/ Committee</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>

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

Report indicator results to MDHHS quarterly
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.
Discuss and prepare for the transition from MMBPIS to standardized measures.

<table>
<tr><th></th><th>FY25 Q3</th><th>FY25 Q4</th><th>FY26 Q1</th><th>FY26 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>99.64%</td><td>98.42%</td><td>--</td><td>--</td></tr>
<tr><td>1.2 Adults</td><td>97.77%</td><td>98.17%</td><td>--</td><td>--</td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. Standards = 57% and 62%</td></tr>
<tr><td>2a PIHP Total</td><td>57.96%</td><td>62.10%</td><td>54.08%</td><td>71.99%</td></tr>
<tr><td>2a.1 MI-Children</td><td>57.91%</td><td>62.41%</td><td>51.65%</td><td>67.31%</td></tr>
</table>
</td>
<td>Brooke Ryan/ Divine May

Quality Management Committee (QMC)</td>
<td>Q1 (Oct-Dec):
The FY2025 Q3 Performance Indicator (PI) Report was prepared, finalized, and approved. Results were presented to the Quality Management Committee (QMC), Quality Improvement Committee (QIC), and PIHP Board.

MMBPIS data for FY2025 Q4 was submitted timely to MDHHS on December 30, 2025.

Results and feedback from the HSAG FY2025 Performance Measure Validation (PMV) review were shared with the QMC, QIC, and PIHP Board.

The Behavioral Health Quality Transformation (BHQT) workgroup did not meet in November or December. The October meeting featured discussions about FY2026 updates, including anticipated reporting changes due to the change in CCBHC oversight.

Q2 (Jan-March):
The FY2025 Q4 Performance Indicator (PI) Report was prepared, finalized, and approved. Results were presented to the Quality Management Committee (QMC),</td>
</tr>
</table>

Component	Goal/Activity/Timeframe					Responsible Staff/ Department/ Committee	Status Update & Analysis
	2a.2 MI-Adults	58.87%	65.03%	55.10%	82.83%		Quality Improvement Committee (QIC), and PIHP Board. MDHHS confirmed that FY26 Q1 data will be included in the Summer 2026 HSAG PMV review and provided clarification regarding the updated exclusion criteria. In response to numerous questions raised by PIHPs and CMHs, MDHHS released updated versions of the FY2026 MMBPIS Codebook on 2/19/2026, and again on 2/25/2026, which included additional clarification regarding the exclusion criteria for CCBHC-only events. To allow adequate time for CMHs to review and implement these updates, Region 10 secured an extension from MDHHS to submit FY26 Q1 data by 4/30/2026 and coordinated a regional call with CMH PI leads to review and discuss the Codebook updates. **Q3 (April-June):** FY2026 Q1 and Q2 MMBPIS reviews were completed, and both quarterly submissions were submitted timely to MDHHS. Member-level data was also submitted timely to HSAG in preparation for the FY2026 PMV/NAV review. A combined FY2026 Q1–Q2 Performance Indicator (PI) Report was prepared.
	2a.3 DD-Children	51.39%	55.19%	50.34%	58.21%		
	2a.4 DD-Adults	64.63%	56.52%	75.76%	66.67%		
	Ind. 2 – 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. Standards = 68.2% and 75.3%						
	2e SUD	76.44%	75.88%	72.22%	73.35%		
	Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. Standards = 72.9% and 83.8%						
	3 PIHP Total	77.47%	80.70%	--	--		
	3.1 MI-Children	78.33%	79.64%	--	--		
	3.2 MI-Adults	74.05%	78.31%	--	--		
	3.3 DD-Children	88.37%	89.80%	--	--		
	3.4 DD-Adults	88.71%	92.73%	--	--		
	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	98.68%	98.57%	--	--		
	4a.2 Adults	96.35%	95.86%	--	--		
	4b SUD	95.51%	96.77%	98.25%	100.00%		
	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	7.14%	14.42%	--	--		
	10.2 Adults	12.76%	13.72%	--	--		

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			The CMHs report revised programming logic (aligned with the FY2026 updated methodology) is currently undergoing testing. While it is no longer a state reporting requirement, the PIHP PI Team continues to review SUD PI events. **Q4 (July-Sept):** The FY2026 Q1 and Q2 Performance Indicator (PI) Report presented to the Quality Management Committee (QMC), Quality Improvement Committee (QIC), and PIHP Board. The report is also posted on Region 10 PIHP's website. The PIHP PI Team finished the review of the FY2026 Q1 and Q2 Continuous Improvement Plan (CIP) submissions of the CMHs and continued with the process of the review of the SUD Provider Continuous Improvement Plan submissions. The PIHP PI team review of the CMH and SUD Q3 events is ongoing. **Evaluation:** During FY2026, the PIHP successfully reported indicator results to MDHHS, reviewed quarterly MMBPIS data, ensured follow-up on recommendations and guidance from External Quality Reviews, and provided status updates to relevant committees. The PIHP did not meet/exceed the performance benchmark in the first

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			quarter but met/exceeded the first lower performance benchmark in the second quarter for indicator 2 and 2e. In addition, the PIHP met/exceeded the first lower performance benchmark in first and second quarters for indicator 4b. CMHs and SUD Providers were asked to provide an initial root cause analysis and plan of correction quarterly updates. **Barrier Analysis:** Navigating the process for reviewing PI events according to the updated FY26 MMBPIS Codebook. **Next Steps:** Submission of FY2026 Q3 PI data to MDHHS and preparation the FY2026 Q3 PI Report.
Members' Experience	• Conduct assessments of members' experience with services. o Conduct annual regional customer satisfaction survey. o Conduct qualitative assessments (e.g., focus groups). o Conduct other assessments of members' experience as needed. o Develop action steps to implement interventions to address areas for improvement based on member satisfaction survey. o Facilitate a workgroup consisting of members of the SUD Provider Network to inform future survey planning. o Develop and implement action steps to address response rates / totals.	Divine May Quality Management Committee (QMC)	**Q1 (Oct-Dec):** The FY2025 Customer Satisfaction Survey Report was completed and presented to the Quality Management Committee (QMC) in December and will be presented to the Quality Improvement Committee (QIC) and PIHP Board in January. **Q2 (Jan-Mar):** The FY2025 Customer Satisfaction Survey Report was approved by the Quality Improvement Committee (QIC) and PIHP Board. It was added to the Region 10 website and notifications were sent to the provider network and PIHP staff.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			The details of the FY2026 Customer Satisfaction Survey were shared to the survey leads. The leads did not express any concerns and identified no issues with the timeline. **Q3 (April-June):** The Quality Team shared the revised survey tool(s) to the CMH and SUD survey leads. There were no concerns received from the survey leads. In the first week of June, the survey memo and guidance document were sent out to the network providers. Pre-printed survey were mailed to the SUD Providers. **Q4 (July-Sept):** The Annual Customer Satisfaction Survey went live on July 6 and ran through August 7. The providers submitted the survey data, response rate details and brief survey narrative in mid-September. The QA team have aggregated the survey data and are currently preparing the draft survey report. Despite the initiative to address the goal regarding response rate and total, the numbers this year significantly decrease due to the exclusion of the consumers receiving CCBHC only services to the eligible

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			population as the PIHP no longer has oversight to CCBHC services. **Evaluation:** This goal is considered met. The Annual Customer Satisfaction Survey was conducted in FY2026 across the Region 10 Provider Network. The Quality Management Committee (QMC) will continue to discuss efforts aimed to increasing response rate and interventions to address areas for improvement based on FY2026 survey result findings. **Barrier Analysis:** The changes on the survey eligibility significantly affect both the number of gathered responses and response rate. Both numbers decreased in FY2026 due to the exclusion of the individuals receiving CCBHC services. **Next Steps:** This goal is ongoing and will be carried over into FY2027. Draft survey report will be finalized in October.
State Mandated Performance Improvement Projects (PIPs)	• 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.	Tom Seilheimer Quality Management Committee (QMC)	**Q1 (Oct-Dec):** PIP 1 and PIP 2 implementation monitoring report submissions and CY improvement action planning are in process. **Q2 (Jan-Mar):** PIP 1 and PIP 2 annual evaluation activities are underway. A preliminary report on PIP 1 was shared at the March SUD Network quarterly meeting to inform assessment of

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
	Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards. • Review Health Services Advisory Group (HSAG) report on PIP interventions and baseline. • Provide / review PIP status updates to Quality Management Committee. • QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality.		possible barriers and implementation activities. **Q3 (April-June):** PIP 1 annual evaluation activities are completed, and the HSAG validation report results were recently received, noting 100% compliance on all review elements. PIP 2 evaluation activities are underway and pended to the receipt of CY2025 data, not yet received as this entry date. **Q4 (July-Sept):** In Q4, PIP1 analysis and performance data was discussed at the August SUD network meeting to further inform on CY2026 activities. Transportation challenges remain a concern, and some programs are still implementing their improvement action plans. PIP 2 findings revealed that target goals were met and the Summary Report was prepared. This PIP will be discontinuing and in Q4 the new PIP selection process was completed and approved by MDHHS. **Evaluation:** PIP1 Findings revealed progress towards target goals, though achievement of goals were not yet met. Statistically significant improvements were demonstrated compared to baseline.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			PIP2 findings revealed that the target goal was met, with statistically significant improvements demonstrated compared to Baseline. It was agreed that this PIP will be discontinued and a new PIP was selected as required by MDHHS. **Barrier Analysis:** None Identified **Next Steps:** Revising this goal and continuing it into FY2027.
Monitoring of Quality Areas	• To explore and promote quality and data practices within the region. 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)	**Q1 (Oct-Dec):** There was no update reported on the integration of LOCUS/CALOCUS reporting that PCE and Deerfield are developing. MDHHS Code changes were shared and went into effect October 1, 2025. There was concern/confusion around the removal of HMP coverage for Skill Building (H2014). The department clarified during the meeting that the service is covered by HMP. Awaiting written clarification and code chart updates. CMHSPs had no encounter barriers or challenges to report. The PIHP identified duplicate services and are providing examples for CMHSP follow-up. Related to Performance Bonus Incentive Pool (PBIP) activities, the Patient-Centered medical Home (PCMH) narrative was prepared using information submitted by each CMH. Updates from the PIHP/Medicaid Health Plan (MHP) Collaboration Workgroup were shared. It was noted there will be

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			impacts from the Certified Community Behavioral Health Clinic (CCBHC) Demonstration oversight changes. The FY25 P2 EQI reports were reviewed and submitted. Hospital discharge dates were discussed with additional follow-up required. Work on the FY25 Period 3 EQI report began. Staff are working on identifying data issues and will be correcting them until the final data pull January 29, 2026. The updated BH TEDS Error specifications were shared with the QMC Committee. During the December QMC meeting, the BH TEDS completions rates were reviewed, MH 99.86%, Q 99.90%, and SUD 99.65%. BH TEDS records through FY25 will continue to be reported, while FY26 records are on hold until January 2026. CMH committee members provided updates on FY26 encounter reporting to ensure only specialty benefit, non-CCBHC services are being reported to the PIHP. **Q2 (Jan-Mar):** The Quality Management Committee (QMC) met in February. During the QMC Committee meeting, we discussed the FY2026 BH TEDS record submission that includes the CCBHC records that began in January 2026 due to the reposting pause as specifications were

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			developed. There are some dangling admission records and missing BH TEDS records that need to be submitted. A new statewide workgroup has convened discussing the new client level detail (CLD) records for mental health (SUD will continue reporting BH TEDS) and the process for the CLD records to be reported to the PIHP for those receiving specialty cases and to MDHHS for those receiving CCBHC only services. The workgroup has 30 participants and invites others to participate in a monthly workgroup update meeting. The first occurred February 9, 2026 and future meetings are scheduled for March 9th, March 30th, and May 4th. It's recommended that one or more staff attend the update meeting to find out how things are changing and progressing. The PIHP Finance staff are currently working on the FY2025 P3 Encounter Quality Initiative (EQI) reports and will advise the CMHSPs when to submit February 27, 2026. A draft FY2026 P1 schedule has been presented with an initial pull date of Thursday, April 3, 2026. When approved, the schedule will be sent out. CMSPS are all reviewing encounter data to ensure services are accurately reported to the PIHP. Services provided by a self-directed arrangement are onboarding the HHAX Exchange system for electronic Visit

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Verification (EVV). This is scheduled to go-live on 3/23/2026. At the February meeting, the committee revisited the discussion related to skill-building and supported employment services, and ensuring individuals are enrolled in either the 1915(i)SPA or CCBHC. Committee members were uncertain if 1915(i)SPA denial issues were resolved. In February, the QMC was informed of a letter from CMS describing core set changes, which could have a future impact on the Performance Bonus Incentive Pool (PBIP) measures. The QMC Committee did not meet in March and will reconvene in April. FY26 BH TEDS Error description updates were shared with the committee members. **Q3 (April-June):** The Quality Management Committee reviewed BH TEDS completion rates, discussed the upcoming changes to for mental health records moving to Client Level Detail from BH TEDS. The group also reviewed the new compliance standard of 85% for Electronic Visit Verification. Discussion related to MDHHS proposed change to the 20902 encounter edit and concerns. This is

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			temporarily paused. Another addition to encounter reporting is the PWK segment to meet CMS requirements, reporting how the claim was received, e.g. 837, paper, direct, etc.) **Q4 (July-Sept):** August was the Quality Management Committee meeting where BH TEDS completion rates, dangling admissions, and upcoming virtual trainings for Mental Health Client Level Detail (CLD) and Substance Use Treatment Episode Data Set (SU-TEDS) changes effective October 1, 2026 were discussed. The FY2026 Period 2 Encounter Quality Initiative (EQI) timeline and due dates were reviewed. **Evaluation:** The PIHP explored and promoted quality and data practices within the region. Discussion occurred during bimonthly QMC meetings, with additional information shared via email between meetings. The committee monitored and addressed Performance Bonus Incentive Pool activities and indicators, changes to services codes, various regional data reports, and BH-TEDS reports. Regarding the planned activity to monitor emerging quality and data initiative / issues and requirements, committee members also discussed electronic visit verification (EVV).

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Barrier Analysis: No barriers were identified. **Next Steps:** The committee will not continue with this same goal for FY2027, although the committee will uphold the responsibility to explore and promote quality and data practices within the region. For FY2027, the Quality Management Committee has approved adding a goal to achieve and maintain the 85% threshold for EVV records for verified visits without manual edits. The committee will also review and analyze SU-TED and Mental Health CLD reports with changes effective October 1st.
Customer Relationship Management (CRM) System	• Monitor the implementation and integration of the Customer Relationship Management (CRM) System and those business processes that are housed within the platform. o Provide technical assistance to users as needed. o Evaluate implementation throughout Region 10. o Maintain oversight of business processes within the CRM, including: ▪ American Society of Addiction Medicine (ASAM) Level of Care ▪ Certified Community Behavioral Health Clinic (CCBHC) Certification ▪ CMHSP Certification ▪ CMHSP Programs & Services Certification ▪ Contract Management ▪ Critical Incident Reporting ▪ Customer Service Inquiry ▪ First Responder Line ▪ Michigan Crisis and Access Line (MiCAL)	Laurie Story-Walker Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** There were no requests for technical assistance during the quarter. Sanilac CCBHC site was able to complete their SUD ASAM LOC. Awaiting information on the Fourth Edition ASAM LOC. **Q2 (Jan-Mar):** The PIHP staff are working on the certification process for the Intensive Care Coordination with Wraparound (ICCW). ICCW program applications are to be submitted in the CRM by April 1, 2026, and approvals completed by June 1, 2026. **Q3 (April-June):** The CMHSPS and PIHP completed the Intensive Care Coordination with Wraparound (ICCW) applications; all were

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
	▪ Universal Credentialing ▪ Warmline		approved by MDHHS. The PIHP will begin using the CRM for reporting Schedule E in July 2026. MDHHS will offer Training sessions to include login support, help with navigation and review of schedule E, how to submit, complete revisions, troubleshoot issues, review of outstanding issues and answer any questions/concerns to ensure participants are comfortable with the reporting process. Awaiting an update to the system for the ASAM Fourth Edition Levels of Care. **Q4 (July-Sept):** During quarter 4, the piloted Schedule E reports were successfully submitted during the quarter. **Evaluation:** The evaluation of the goal is considered met due to the success of Sanilac's CCBHC ASAM LOC, all CNHSPs ICCW applications and the piloted Schedule E reports within the CRM system. The goal will not continue for FY2027. **Barrier Analysis:** None Identified **Next Steps:** Oversight and monitoring of the CRM system will continue, and customer support will be provided by IT Administrators for all existing applications and any new applications/programs for the region.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	• To review and monitor the safety of clinical care. o Review CMHSP and SUD critical incidents, to ensure adherence to timeliness of data and reporting standards and to monitor trends, to improve systems of care.	Tom Seilheimer Sentinel Event Review Committee	**Q1 (Oct-Dec):** Critical incident (CI) reports have been received as required and have been reviewed for timeliness and content. No concerning trends were observed. The EOFY2025 4Q CI Report was presented and discussed. No significant service systems issues were identified. This report will be offered to the next QIC for review and will be made available as needed to Contract Management. **Q2 (Jan-Mar):** The monthly CI report and 1Q CI report were reviewed and no concerning trends were noted. **Q3 (April-June):** The monthly CI report and 2Q CI reports were reviewed and no concerning trends were noted. **Q4 (July-Sept):** The monthly CI report and 3Q CI reports were reviewed, and no concerning trends were noted. EOFY2026 Q4 reports will be reviewed during Q1 of FY2027. **Evaluation:** Monitoring and analysis activities revealed broad adherence to standards. Detail reports revealed a small number of follow-up queries to provider programs to

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			rule-out service systems issues. Follow-up was completed if appropriate. This goal is considered met for FY2026. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue into FY2027.
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	• To review and monitor the safety of clinical care. o Monitor CMHSP and SUD sentinel event review, to ensure adherence to timely determination of sentinel events, timely initiation of a Root Cause Analysis, comprehensive completion of Root Cause Analysis, and that individuals with appropriate credentials are involved in the review of Sentinel Events.	Tom Seilheimer Sentinel Event Review Committee	**Q1 (Oct-Dec):** Sentinel events were reviewed, and all were processed and submitted in compliance within required time frames. Monthly reviews will be in place to monitor Root Cause Analyses and as needed follow up activities. **Q2 (Jan-Mar):** Monthly review of sentinel events indicated that root cause analysis (RCA) activities proceeded as required, with findings and recommendations pending. Four sentinel events remain in-process at their CMH Behavior Treatment Plan Review Committees (BTPRCs); will continue monitoring. **Q3 (April-June):** One SE was reported by St. Clair, for review. Initial monitoring indicated program adherence to review standards. This case will be reviewed monthly to ensure CMH adherence to follow up tasks. **Q4 (July-Sept):** Monthly review of sentinel events indicated that root cause analysis (RCA) activities

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			proceeded as required, with findings and recommendations pending. Two new SE were reported by St. Clair for review. Monthly reviews continue. **Evaluation:** Overall progress was achieved towards this goal with it considered met. CMHSP and SUD Sentinel Event review monitoring was completed on a monthly basis, with one CMHSP reporting Sentinel Events. In all instances, adherence to timely determination of sentinel events, timely initiation of a Root with Cause Analysis, comprehensive completion of Root Cause Analysis, and individuals with appropriate credentials were involved in the review of Sentinel Events, were demonstrated. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue into FY2027.
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	• To review and monitor the safety of clinical care. o Monitor CMHSP and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**Q1 (Oct-Dec):** No scheduled activities to report at this time. **Q2 (Jan-Mar):** This is a semi-annual reporting cycle with no scheduled reports to review at this time. **Q3 (April-June):** This is a semi-annual reporting cycle with scheduled reports to review in July.

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			Q4 (July-Sept): Semi-Annual mortality report was reviewed during Q3. Semi-annual reporting cycle to continue. **Evaluation:** No concerning trends were noted with this report, but an improvement recommendation was put into place to expand the clinical and demographic analysis processes for the committee annual evaluation report. This goal is considered met. **Barrier Analysis:** None Identified **Next Steps:** Revise goals and continue in FY202
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	• To review and monitor the safety of clinical care. o Monitor CMHSP and SUD risk events review processes and ensure follow-up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**Q1 (Oct-Dec):** Quarterly/EOFY reporting is scheduled for the January meeting. **Q2 (Jan-Mar):** Quarterly reporting is still pending some SUD network provider quarterly reports and PNM have been informed. **Q3 (April-June):** Quarterly reporting is still pending some SUD network provider quarterly reports. SERC and PNM members developed a remediation plan in late May which was well received by SUD programs to help ensure timely reporting.

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			Q4 (July-Sept): Quarterly reporting is still pending some SUD network provider quarterly reports. Overall, there was an increase in reports from providers received, which is favorable. **Evaluation:** Monitoring of Risk Events reports received from network provider programs were completed, along with quarterly trending and analysis reports generated by the committee. Monitoring and analysis activities revealed broad adherence to standards, along with some issues which were resolved in consultation with Provider Network Management and report training. **Barrier Analysis:** Some issues regarding timely report submission by some SUD providers were identified. **Next Steps:** Revise and continue in FY2027
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	• To review and monitor the safety of clinical care. o Conduct a longitudinal mortality evaluation and write a report annually to assess causes of death for beneficiaries and consider system improvements.	Tom Seilheimer Sentinel Event Review Committee	**Q1 (Oct-Dec):** The inaugural Annual Mortality Longitudinal Report was presented. Follow up discussion regarding report dissemination and content expansion for next year's report was finalized. This report will be offered to the next QIC for review. **Q2 (Jan-Mar):** This is scheduled for a later date. In the meantime, an outreach letter has been drafted, and data gathering tasks have

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			been identified for follow up with DM before proceeding. **Q3 (April-June):** The outreach letter was finalized, but it has been tabled, pending current discussions with DM to determine whether the expanded report elements can be generated internally rather than add administrative burden to programs. Follow up is scheduled for the July meeting. **Q4 (July-Sept):** Region 10 worked on internal options to acquire additional demographic data related to the Annual Mortality Report which is slated to be completed and reviewed during Q1 of FY2027. **Evaluation:** Overall, progress was achieved toward this goal and it was considered met. The committee completed a regional assessment report based on CMHSP and SUD unexpected deaths/mortality data. No concerning trends were identified, and further improvement was put into place to expand the clinical and demographic analysis. **Barrier Analysis:** None identified **Next Steps:** Revising this goal and continuing it into FY2027

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Aligned System of Care	• To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service. o Monitor utilization of the PIHP Clinical Practice Guidelines. o Complete annual and biennial evaluation reports as per policy.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Q1 (Oct-Dec):** The Clinical Practice Guidelines (CPG) Annual Evaluation Report was presented and endorsed at the November meeting, and the CPG Biennial Evaluation Report was presented and endorsed at the December meeting. Members were encouraged to disseminate/discuss report findings and recommendations at their respective programs. **Q2 (Jan-Mar):** The Clinical Practice Guidelines (CPG) Biennial Report was completed. The service selection process for this year's CPG Annual Evaluation Report has been complete: CLS, Applied Behavior Analysis (ABA) Treatment, Skill Building Assistance. **Q3 (April-June):** The service selection process for this year's CPG Annual Evaluation Report has been completed, and evaluation activities have begun: CLS, Applied Behavior Analysis (ABA) Treatment, Skill Building Assistance. **Q4 (July-Sept):** CLS, Applied Behavior Analysis (ABA) Treatment, Skill Building Assistance were the services selected for the CPG Annual Evaluation Report. The SME survey questions regarding these services were developed,

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			sent out to the respective CMHSP's and their responses were gathered and summarized. The UR review of these services has begun, and the survey responses are being used to guide the utilization review. **Evaluation:** The annual PIHP Annual Clinical Practice Guidelines are scheduled for completion by end of fiscal year (EOFY). This was a partnered effort across the CMHSP and SUD provider networks, comprised service utilization monitoring, Standards monitoring and updates as appropriate, subject-matter expert surveys, and annual EBP updates submitted by the CMH network programs, all of which provided measures of service effective or service efficiency. All actions were carried out under the supervision of the Medical Director. The Biennial Evaluation Report is scheduled for FY2027. This goal was considered met for FY2026. **Barrier Analysis:** None Identified **Next Steps:** Revise the goal and continue into FY2027.
Aligned System of Care	• 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 Review Evidence-Based Practices (EBPs) and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., Integrated Dual Disorders	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Q1 (Oct-Dec):** The MDHHS quarterly MIFAST LOCUS participation report was presented, and corrective feedback was communicated back to the MHDDS LOCUS coordinator. The EOFY2025 LOCUS Implementation Report was completed, and the FY2026 Implementation

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	Treatment (IDDT), Level of Care Utilization System (LOCUS), Substance Use Disorder Health Home (SUDHH). o Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan. o Support CMHSP implementation of the nine core Certified Community Behavioral Health Clinic (CCBHC) EBPs.		Report is scheduled for discussion at the December meeting. **Q2 (Jan-Mar):** The FY2025 Implementation Plan Evaluation Report is complete, and the FY2026 Implementation Plan is complete. Findings have been discussed as share-and-learn activities. Information regarding special LOCUS training for FY2026 was shared. Status discussion at IPLT indicated, yet no upcoming scheduled MIFAST activities. **Q3 (April-June):** LOCUS mid-year reports are completed, with all CMHs achieving their program objectives. **Q4 (July-Sept):** LOCUS implementation activities continue among all the CMHSP's which include monitoring of completion and override rates and ongoing training of staff. The EOFY2026 LOCUS Implementation Report and FY2027 LOCUS Implementation Plan will be completed and shared soon. **Evaluation:** CMHs periodically monitor their active EBPs and provide IPLT status updates. Two CMH Michigan Fidelity Assistance

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			Support Team (MiFAST) reviews were provided to IPLT for share-and-learn discussion. The Mid-Year CMH LOCUS implantation evaluation reports were submitted for IPLT review and share and learn discussion. Progress was documented by each CMH in such areas as a) decrease over-ride rates and increase required periodic LOCUS remeasures. **Barrier Analysis:** Supporting CMH implementation of the nine core CCBHC EBPs was not activated as a purpose of this goal, once it was learned that PIHP oversight of CCBHC operations is required. **Next Steps:** Revise goal and continue into FY2027
Employment Services	• Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC) / Encourage the provision of progressive employment services across the CMHSP network: o Monitor quarterly ESC meetings designed to facilitate share and learn discussions: o Benefit counseling and coaching under the Benefit-to-Work (B2W) model. o CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) o Standardized employment services data and report formats	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Q1 (Oct-Dec):** The November meeting notes were presented at this quarterly meeting, highlighting field successes and conference updates. GHS continues its planning for implementation of IPS. **Q2 (Jan-Mar):** Celebrations of success were shared, and discussion took place regarding Individual Placement and Support (IPS) for the I/DD population and the challenges of rate restructuring for this special programming, as noted at the CMHA Winter Conference presentation.

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	○ In-service / informational materials for share and learn discussion. ○ Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS]) ○ Centralized UM Redesign Implementation: tracking/trending vocational services utilization ○ Discuss/support consideration of Individual Placement and Support (IPS) service model.		**Q3 (April-June):** Quarterly Recharging Competitive Employment meeting materials were shared and discussed, along with St. Clair's IPS 2Q report. Lapeer's IPS is being showcased by MDHHS as a preferred practice in collaborating with MRS. **Q4 (July-Sept):** Employment Services Committee held its quarterly meeting on August 11, 2026. Much of the meeting focused on Mr. Mountz and Ms. Rice's preparations for the upcoming IPS Conference. St. Clair CMH and Lapeer CMH were recognized for developing routine, standardized reports that align with the IPS model. These reports have been helpful in tracking program progress, service engagement, and appropriate discharges. **Evaluation:** Regional attendance and collaboration was provided at the ESC quarterly meetings and discussed with the committee on CMHSP employment targets for competitive employment, two instances of sharing standardized employment services data and report formats per the IPS model. Preferred practice models continue to be discussed regarding case record service plan development and contact not recording.

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			Barrier Analysis: Discussion and focus on the implications for the upcoming changes and cuts to Medicaid funding **Next Steps:** Revise the goal and continue into FY2027.
Home & Community Based Services	• CMHSP Network Implementation of the Home and Community Based Services (HCBS) Transition Plan to Ensure quality of clinical care and service. o Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure adherence to and implementation of Corrective Action Workplan. o Monitor network completion of the HCBS assessment process, continue efforts to bring provider settings into compliance, and continue ongoing monitoring of service and settings for HCBS Final Rule Compliance. o Monitor and update on Behavioral Treatment Plan Review Committee progress to ensure that Behavioral Treatment Plans and Individuals Plans of Service are in compliance with the HCBS Final Rule.	Shannon Jackson / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Q1 (Oct-Dec):** Region 10 received timely review documentation from CMH BTPRC reviews that occurred, capturing FY25 Q4 data. GHS reported substantial findings - 71 cases were found to not be compliant with the final rule requesting recommendations of HCBS elements be added to either the Individual Plan of Service (IPOS) or the Behavior Treatment Plan (BTP). Lapeer CMH reported 6 cases that were identified as either the IPOS or BTP not being compliant with the HCBS Final Rule. Follow-up dates were provided. Sanilac CMH and St. Clair CMH reported that all the cases their BTPRCs reviewed were compliant with the HCBS Final Rule. Quarterly HCBS Final Rule Case Management Trainings were completed in December, and certificates were completed and sent to the CMH HCBS leads. Region 10 Continues to hold bi-monthly round table discussions with HCBS leads as well as case managers from around the Region. Good discussion and collaboration

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			have taken place on how to write specific goals with restrictions. In the December HCBS Leads meeting with MDHHS, guidance was given around health and safety modifications based solely on chronic physical health conditions. This is not how the definition of health and safety needs has been previously interpreted. We have reached out to MDHHS for further guidance. **Q2 (Jan-Mar):** Region 10 received timely review documentation from 3 out of 4 CMHs on the BTPRC reviews that occurred, capturing FY26 Q1 data. GHS reported findings, with recommendations of HCBS elements, be added to either the Individual Plan of Service (IPOS) or the Behavior Treatment Plan (BTP). There was an increase in the number of cases with findings, however, overall cases reviewed by GHS' BTPRC also increased pretty significantly this quarter. Lapeer CMH reported also reported cases, with a decrease from last quarter. Follow-up dates were provided, and it was noted that both these cases were COFR arrangements. Sanilac CMH and St. Clair CMH reported that all the cases their BTPRCs reviewed were compliant with the HCBS Final Rule.

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			Quarterly HCBS Final Rule Case Management Trainings were completed in March, and certificates were completed and sent to the CMH HCBS leads. MDHHS has still not released the Case Management trainings and said that they want to adjust these, so the PIHP will be continuing these quarterly at this time. MDHHS and the PIHP HCBS Leads have started a HCBS workgroup that started this quarter. This group will work through some struggles in the field and collaborate over topics related to chronic health conditions, guidance from CMS, and better defining necessary consistent guidance. **Q3 (April-June):** Region 10 received timely review documentation from CMH BTPRC reviews that occurred, capturing FY26 Q2 data. GHS reported substantial findings – sixty (60) cases were found to not be compliant with the final rule requesting recommendations of HCBS elements be added to either the Individual Plan of Service (IPOS) or the Behavior Treatment Plan (BTP). Lapeer CMH, Sanilac CMH and St. Clair CMH reported that all the cases their BTPRCs reviewed were compliant with the HCBS Final Rule.

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			In Q3, HCBS survey remediation was completed for two providers based on 2025 Setting Survey responses and submitted to MDHHS, with no further follow-up or recommendations. Region 10 held HCBS Roundtable meetings this quarter to review HSW enrollment questions to help reduce enrollment barriers. Region 10 also completed Case Manager training for new hires in April and May. MDHHS has released the training modules for distribution for new hires, Region 10 is developing a plan and memo to meet the training requirements which will be distributed to CMH Leads. MDHHS continues monthly PIHP workgroups to improve statewide HCBS guidance; in May, the group reviewed feedback on the MDHHS standardized Annual Physical Assessment. MDHHS gave an update on respite services with HCBS guidance. Some information was shared, but further information and clarification are needed. **Q4 (July-Sept):** Region 10 received timely review documentation from 3 out of 4 CMHs on the

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			BTPRC reviews that occurred, capturing FY26 Q3 data. All CMHSPs reported data before the close of Q4. GHS reported findings, with recommendations of HCBS elements, be added to either the Individual Plan of Service (IPOS) or the Behavior Treatment Plan (BTP). There was a slight increase in the number of cases reviewed compared to Q2, but the number of cases found to be non-compliant has shown progressive decline across the FY. Lapeer CMH reported comparable cases to Q2; there continues to be no cases found non-compliant for Lapeer in Q3. Sanilac CMH and St. Clair CMH reported that all the cases their BTPRCs reviewed were compliant with the HCBS Final Rule. HCBS Final Rule Case Management Trainings were distributed in Q4 to the CMHSP HCBS Leads with a PIHP memo to explain the training requirements. CMH staff will be responsible for ensuring this training is completed annually. MDHHS and the PIHP HCBS Leads continue to collaborate through the HCBS workgroup. This group will work through some struggles in the field and collaborate over topics related to chronic health conditions, guidance from CMS, and better defining necessary consistent guidance. In Q4 Region 10 and the CMH HCBS Leads completed and submitted the new respite

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			requirement spreadsheet attesting that visits of respite camps were completed and reviewed for HCBS standards. **Evaluation:** In FY2026 this goal was marked as met and showed great progress. We could see more cases start to be reviewed by the BTPRC at the CMH level and as quarterly updates were provided, it was identified that the every quarter more cases were being brought into compliance with the final rule through this process. Including this review has proven to be an important step in bringing a plan of service and behavior treatment plan into HCBS compliance. In FY2026 there were productive and collaborative discussions about the HCBS Transition Plan and any Corrective Action progress at the IPLT monthly meetings. **Barrier Analysis:** There was a change to the Secure Setting Application process that was implemented in September of FY2025, this new process was rolled out in FY26, but collecting documents and waiting for MDHHS approval has slowed down some Provisional Approvals in FY2026. **Next Steps:** Continue with an HCBS IPLT goal in FY2027 to monitor changes, CAP work, and allow for collaboration.

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Integrated Health Care	• 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 Continue process for identifying members of the youth and foster care population who are appropriate for care coordination.	Laura Karig/ Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Q1 (Oct-Dec):** In Q1, Region 10 facilitated a total of one hundred forty-three (143) case discussions. Forty-six (46) care plans were opened, and forty-seven (47) were closed. Thirty-six (36) members were closed with all goals met, seven (7) members closed with some goals met, two (2) members closed with no goals met, three (3) members were well connected and did not need any additional resources and two (2) members closed out to CMH services and the MHP and PIHP continued collaboration. The next MHP PIHP Collaboration group has not been scheduled but is anticipated to be held in January. **Q2 (Jan-Mar):** At the end of second quarter, Region 10 facilitated a total of one hundred fifty-three (153) case discussions. Forty-seven (47) care plans were opened, and forty-three (43) were closed. Thirty-five (35) members were closed with all goals met, twelve (12) members closed with some goals met, nine (9) members were well connected and did not need any additional resources and three (3) members closed out to CMH services and the MHP and PIHP continued collaboration.

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			Optum has updated the CCBHC indicator tool in CC360 to allow CCBHC individuals to be factored into joint care measures. Optum will also be updating the Care Plan template to include CCBHC participation and allowing CCBHCs to access the Care Planning Section within CC360. Moving forward, if the individual is CCBHC, documentation will need to be documented in CC360 from all entities. The current measure of Implementation of Joint Care Management (Child and Adult) will be replaced with a new measure of Joint Care Planning (Child and Adult) (JCP30). This changes the measure from a 15-month numerator compliance window to an event-based measure following the calendar month of an ED event. The next MHP/PIHP Workgroup will be held on April 23. **Q3 (April-June):** In Q3, Region 10 facilitated a total of one hundred fifty-three (153) case discussions. Forty-two (42) care plans were opened, and forty-eight (48) were closed. Forty-two (42) members were closed with all goals met, seven (7) members closed with some goals met, two (2) members closed with no goals met, seven (7) members were well

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			connected and did not need any additional resources and three (3) members closed out to CMH services and the MHP and PIHP continued collaboration and (1) one member termed with the MHP. In the last MHP / PIHP Collaboration meeting, there was continued discussion around CCBHC Joint Care expectations. Questions were raised about when and how CCBHCs should be included in monthly care plan meetings, including whether meetings should be combined or held separately based on shared members. MDHHS indicated that the timeline for including CCBHCs in joint care meetings remains under discussion at the state level. MDHHS has compiled the workgroup's questions and concerns and brought them back for state-level discussion. The next meeting is being planned for July, when the group expects to receive feedback and next steps. **Q4 (July-Sept):** In Quarter 4, Region 10 facilitated a total of one hundred thirteen (116) cases in the Care Coordination meetings. A total of forty-one (41) cases were closed during the quarter. Of those forty-one (41), twenty-nine (29) were closed with all goals met and twelve (12) with partial goals met. Two (2) cases were not open during the quarter as they were

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			well connected and had adequate resources. There were ten (10) children from the foster care list brought to the Care Coordination meetings during the quarter as well as an additional ten (10) children identified on the Children's Risk Stratification list. **Evaluation:** For the year, a total of thirty-one (31) children within the foster care system and twenty-five (25) children were brought to the Integrated Care Coordination meetings for review. This goal is ongoing, and processes will be maintained to ensure coordination of care continues for the identified members. **Barrier Analysis:** No barriers **Next Steps:** Develop goals for upcoming FY27 QIC workplan to ensure Integrated Care Coordination continues to be effective.
Behavioral Health Home	• Implementation of the Behavioral Health Homes requirements for participating CMHs to enhance coordination of care for participating individuals with SMI/SED diagnosis o Support CMH implementation of the BHH through the program six core services. o Provide support and oversight to the CMH Providers through the onboarding and roll out of this program. o Increase and manage enrollment of BHH beneficiaries through the Waiver Support Application.	Shannon Jackson/ Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Q1 (Oct-Dec):** MDHHS has continued to meet with Region 10 throughout Q1 to provide guidance. Additionally, the PIHP Lead has started attending statewide meetings to learn more about this program. Region 10 continues to wait on CMS approval of the Amendment prior to program implementation and providing Behavioral Health Home services.

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	○ Development of continuous utilization and quality improvement of the program.		**Q2 (Jan-Mar):** In second quarter, CMS approved the State Plan Amendment, which included the expansion of Region 10 and three of our CMHSPs as Behavioral Health Home Providers. Region 10 participated in WSA trainings and a BHH Orientation, and Region 10 established monthly leads meetings to better support CMH staff through the implementation of this program. Region 10 has also updated to allow for BHH service authorizations through the centralized utilizations management process and made necessary changes to allow for encounter reporting for the BHH service code. In Q2, MDHHS updated and released the BHH Handbook to include several changes incorporated in the approved SPA. CMHSP are now working on identifying individuals in their services who would benefit most from Behavioral Health home services. **Q3 (April-June):** In the third quarter, Health Homes continue to make progress on hiring staffing for this program and identify eligible enrollees. No cases have been assigned through the Wavier Support Application yet, the PIHP

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			meets monthly with the CMH Leads to touch base on this programs progress. MDHHS sent out the save-the-date for the Health Home Summit which is scheduled for September 10th. This year's summit will include SUD Health Home and will provide CEUs for participants. **Q4 (July-Sept):** In the fourth quarter, Health Homes continue to make progress on hiring staffing for this program and identify eligible enrollees. Region 10had the first two enrollees start this program August 1st, with two more enrolled in September. All the region's first enrollees came through Sanilac CMH. The PIHP meets monthly with the CMH leads to touch base on this program and its progress. The Health Home Summit took place on September 10th and included the SUD Health Homes. This was a collaborative day full of providers sharing success stories. There was discussion of the BHH program changing the current billing structure to have two codes, one for initial planning and one for care coordination/planning and maintenance. It was ultimately decided that this change would be beneficial to the program and will be updated and implemented in April FY27.

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			Evaluation: This goal has made considerable progress in FY2026. There were initial delays in starting the program due to waiting on approval from CMS. In January that approval came through and training began in March. The CMHSPs have been responsive, and collaborative in the implementation of this program and have worked hard to get this off the ground. **Barrier Analysis:** Some of the CMHSPs continue to struggle with staffing. Without the guarantee for CMS approval the CMH leads decided to wait to hire staff for this program, so it has been a slow start due to these struggles. **Next Steps:** This goal will be carried into FY2027 as an IPLT goal through the continued implementation of the program.
Home & Community Based Services	• Monitor the CMH progress and assessment process of Provider settings and ensure homes and plans are in compliance with the HCBS Final Rule. o Monitor the Provisional Approval Process. o Ensure compliance with the HCBS Final Rule by facilitating internal review of applications for secure settings. o Monitor and Track CMHSP Annual Physical Assessment process.	Shannon Jackson	**Q1 (Oct-Dec):** The PIHP has implemented the new Provisional Approval process as of September 2nd, 2025. The PIHP finalized a list of settings in Region 10 that are considered Secure and is working with the CMH HCBS leads to submit Secure Setting Applications for individuals throughout the Region. In Q1, Region 10 had ten (10) provisional applications submitted, two (2) of which resulted in Secure Setting applications which were approved by MDHHS.

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			Monthly updates on the Physical Annual assessments have been going well. MDHHS is working on finalizing a standard state-wide assessment that they will require we switch to and upload to the CRM for review. More guidance on this process will be coming in the new year. **Q2 (Jan-Mar):** In second quarter, Region 10 had eight (8) provisional applications submitted which followed the process and were approved. No Secure Settings were identified through Provisional process this quarter. Region 10 had two (2) Secure Setting Applications approved this quarter and two (2) additional applications pending with MDHHS in Q2. One approval was our first extension which went smoothly; extension submissions do require more documentation to allow the individual to continue to be placed in a secure setting. The PIHP continues to work closely with the CMH HCBS leads to review cases from the Secure Setting list and submit Secure Setting applications to MDHHS to bring these cases into compliance.

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			Monthly updates on the Physical Annual assessments continue to be going well. **Q3 (April-June):** In the third quarter, Region 10 had nineteen (19) provisional applications submitted which followed the process and were approved. Two (2) Secure Settings were identified through Provisional process this quarter. There were several homes who switched ownership and license this quarter which would explain the higher number of provisionals. Region 10 has had four (4) Secure setting Applications approved in the third quarter and continue to work with the CMH HCBS leads to bring these cases into compliance. Monthly updates on the Physical Annual assessments continue to be going well. MDHHS is in the final stages of finalizing the standardized assessment to utilize across the state. How these will be submitted and reviewed annually is still being finalized at the State level. **Q4 (July-Sept):** In the fourth quarter, Region 10 had eleven (11) provisional applications submitted which followed the process one however was dissolved so only 10 were approved. Four (4) Secure Settings were identified through the

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			Provisional process this quarter all followed process and were approved. Region 10 has had eight (8) Secure setting Applications approved in the fourth quarter and Region 10 continues to work with the CMH HCBS leads to bring these cases into compliance. Monthly submission updates on the Physical Annual assessments continue to be going well. MDHHS sent out the standardized assessment to utilize across the state in Q4. We are allowed to continue to use our current review process, as long as we incorporate all of the MDHHS assessment questions. How these will be submitted and reviewed annually is still being finalized at the State level, but they have asked follow-up questions to provide CMS with proof of our implementation plan. **Evaluation:** This goal is considered met with progress to this goal in FY2026. All Provisional Applications were submitted according to Region 10 Policy in FY2026 and if needed, received approval. The CMHSPs incorporated new standards for the Physical Annual Assessments in FY2026 and have reported no barriers to this new process. The reports have additionally identified multiple instances where these reviews have effectively identified non-

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			compliance and provided corrective action to address the issues. **Barrier Analysis:** Previously stated changes to the Secure Setting Application process has proven to slow down the Provisional Approval Process in some cases in FY2027, CMHSPs have been understanding of the new process. **Next Steps:** This goal has many overlapping discussion items that occur at the IPLT meeting In FY2027 the intention is to combine the focus in these two goals to be one HCBS goal discussed through the IPLT committee.
Credentialing / Privileging	• Complete Privileging and Credentialing reviews of Organizational Applications for CMH and SUD Providers. o Review and approve or deny all Organizational Applications: ▪ New Providers ▪ Existing Provider Re-credentialing / Updates ▪ Provider Terminations / Suspensions / Probationary / Provisional Status ▪ Provider Adverse Credentialing Determinations	Grace McGhee Privileging and Credentialing Committee	**Q1 (Oct-Dec):** No organizational applications were received in October, November, or December. **Q2 (Jan-Mar):** In February, the Privileging and Credentialing Committee reviewed and approved an application for Great Lakes Recovery Mission. **Q3 (April-June):** No organizational applications were received in this quarter. **Q4 (July-Sept):** The Privileging and Credentialing Committee reviewed and approved two Additional SUD location applications for an SUD Provider in

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			September. These applications were reviewed timely, and the Provider was notified within 30 days of the Privileging and Credentialing Committee's decision. **Evaluation:** During FY2026, The P&C Committee reviewed all Organizational applications in a timely manner. Applicants were notified of their decision in a timely manner. The P&C Committee is aware of the credentialing schedule for FY2027 and is prepared to review organizational credentialing applications as they are submitted. **Barrier Analysis:** No Barriers. **Next Steps:** This goal for FY2026 is met. For FY2027, this goal has been revised and will continue.
Credentialing / Privileging	• Complete Privileging and Credentialing reviews of all applicable Region 10 staff. o Review and approve or deny all PIHP Individual Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, Access Clinicians: ▪ New Practitioners ▪ Existing Practitioner Re-Credentialing / Updates ▪ Practitioner Terminations / Suspensions / Probationary / Provisional Status ▪ Practitioner Adverse Credentialing Determinations	Grace McGhee Privileging and Credentialing Committee	**Q1 (Oct-Dec):** Two (2) existing clinicians, Lead Access Clinician and a Utilization Management Clinician were re-credentialed in October. No Practitioner applications were received in November or December. **Q2 (Jan-Mar):** No practitioner applications were received in January, February, or March. **Q3 (April-June):** No Practitioner applications were received during this quarter.

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			Q4 (July-Sept): No Practitioner applications were received in July, August, and September. The next Region 10 Practitioner application review is scheduled to occur in January. **Evaluation:** During FY2026, The P&C Committee reviewed all Practitioner applications in a timely manner. Applicants were notified of their decision in a timely manner. The P&C Committee is aware of the credentialing schedule for FY2027 and is prepared to review practitioner credentialing applications as they are submitted. **Barrier Analysis:** No barriers. **Next Steps:** This goal for FY2026 is met. For FY2027, this goal has been revised and will continue.
Credentialing / Privileging	• Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. o Annually review and/or update the current PIHP Privileging and Credentialing policy content. ▪ Review for alignment between policy and Privileging & Credentialing applications. ▪ Revise and clarify language where needed.	Grace McGhee Privileging and Credentialing Committee	**Q1 (Oct-Dec):** The P&C team have started their revisions of the Region 10 P&C policy with consideration of the current MDHHS and Medicaid Standards along with the recommendations from HSAG. **Q2 (Jan-Mar):** The P&C Policy was approved by the Region 10 PIHP Board at their February Meeting. The P&C is in the process of planning an information session for providers.

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			Q3 (April-June): The P&C team is in the process of planning an information session for providers to review the changes to the Region 10 credentialing policy. During the information session, we will begin the implementation of monitoring of the credentialing functions that have been delegated to providers. **Q4 (July-Sept):** The P&C team continues to plan the Policy Update information session for providers. The P&C team will reach out to the Providers to schedule the information session. **Evaluation:** During FY2026, The Credentialing and Privileging Policy was revised to better align with MDHHS and Medicaid Standards. The Credentialing and Privileging policy was approved by the Region 10 PIHP Board in February. The P&C team notified CMHSPs and SUD Providers about the policy update and discussed the changes in more detail during Annual Contract Monitoring Site Visits. The P&C team is planning an information session to discuss policy change and changes in monitoring with providers. **Barrier Analysis:** No barriers. **Next Steps:** For FY2026, this goal is met as the policy was updated to better align with MDHH Credentialing policy, the CFR, and additional

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			standards. The P&C team will continue to update and revise the credentialing policy as needed. This goal will be discontinued in FY2027.
Credentialing / Privileging	• Participate in MDHHS' Universal Credentialing initiative. o Participate in MDHHS-hosted meetings regarding Universal Credentialing. o Develop necessary processes and / or guidance to support Universal Credentialing efforts.	Grace McGhee Privileging and Credentialing Committee	**Q1 (Oct-Dec):** The P&C team continues to work on completing subscriptions to the Universal Credentialing CRM profiles of Providers who were credentialed by Region 10. Three (3) Credentialing profiles were completed in December. The P&C team is continuing to outreach to SUD Providers and the RCC on the outstanding profiles. P&C team members continue to attend the Universal Credentialing Leads meetings to learn more about the CRM and the Universal credentialing process. **Q2 (Jan-Mar):** The P&C team continues to attend Universal Credentialing Leads meeting to learn more about the Universal Credentialing CRM and upcoming changes to the CRM program. The P&C team is still working with Providers to complete their CRM profiles. **Q3 (April-June):** The P&C team continues to attend the Universal Credentialing Leads meeting. MDHHS provided guidance that the PIHP will work with their CMHs to create and maintain a CRM credentialing profile. The MDHHS

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			credentialing lead also provided an preview of the proposed changes to the MDHHS credentialing policy. The policy will be sent out to the PIHP leads to review. **Q4 (July-Sept):** The P&C team continues to attend the Universal Credentialing Leads meeting. Updates to the Universal Credentialing CRM were discussed during the July Leads meeting, such as the new ability to manually enter the decision date. A new pilot program is being launched to allow approval and subscription completion while the profile is in the process of being edited. In the August meeting, The P&C leads were given a small update on the upcoming changes to the MDHHS Credentialing Policy. The changes are still in the process of being reviewed and approved. The MDHHS lead gave an estimate that the policy will be approved by October. The SUD Providers were informed about the Universal Credentialing CRM profile requirements for licensed Practitioners during the August SUD Provider Network Meeting. There was no September Universal Credentialing Leads meeting. **Evaluation:** The P&C team was an active participant in the Universal Credentialing Leads meetings throughout the year. The P&C team has also regularly shared updates

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			from these meetings with management and our provider network. The P&C provided updates to Universal Credentialing during Provider Network Meetings. The P&C team has also assisted the CMHSPs and SUD Providers with their CRM credentialing profiles. As of September 2026, Region 10 is the responsible credentialing coordinator (RCC) for four (4) CMHSPs and three (3) SUD Providers. Region 10 submitted a request to MDHHS credentialing lead to have the RCC position be transferred to us for one (1) SUD Provider. This request is still being processed. **Barrier Analysis:** No Barriers. **Next Steps:** For FY2026, this goal is met. This goal for FY2027 has been revised to include monitoring the status of credentialing profiles that Region 10 is the responsible credentialing coordinator.
Verification of Services	• The PIHP will verify whether services reimbursed by Medicaid were provided to members by affiliates (as applicable), providers, and/ or subcontractors. o Conduct quarterly claims verification reviews for each provider contracted during the quarter being reviewed. o Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. o Annually review and/ or update the PIHP Claims Verification Policy 04.03.02 to reflect current processes and changes in state/ federal guidelines.	Grace McGhee Quality Management Department	**Q1 (Oct-Dec):** The Findings Letters for the FY2024 Q4 and FY2025 Q1 Claims were sent out in December to the CMHSP and SUD Providers. The Providers will have an opportunity to appeal non-compliant findings. The Claims Verification team continues their work on revisions for the Claims Verification policy. **Q2 (Jan-Mar):** The Claims Verification Team is continuing their work on updating the Claims Verification policy along with the Denial of

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	○ Provide guidance and/ or training for CMHSPs and SUD providers as necessary to clarify PIHP expectations for documentation and standards. ○ Send Explanation of Benefits (EOB) letters biannually during the fiscal year. ○ Send EOB letters to more than 5% of consumers receiving services.		Claims Payment Appeals process to better align with the current process. The Claims Verification team is continuing to work with providers on their appeals for the FY2024 Q4 & FY2025 Q1 Claims Verification Audit cycle. The team is hosting discussions with providers to address the findings. An information session to review documentation standards and expectations for the next cycle was held. The supporting documentation request for the FY2025 Q2-FY2025 Q4 was sent out in the beginning of March. Providers will have until April 10th to submit their supporting documentation for review. **Q3 (April-June):** The Claims Verification audit (CVA) team has completed our initial review and re-examination of the supporting documentation for the FY2025 Q2-Q4 cycle. The CVA team will be sending out the Findings letters in July. The Final letters for the FY2024 Q4 – FY2025 Q1 is in the process of being finalized. **Q4 (July-Sept):** The Claims Verification Audit team is in the process of finalizing the Findings Letters for the FY2025 Q2-Q4 audit cycle. The CVA team is revising the Denial of Claims Payment Appeal Process Policy to provide additional clarification on what documentation should

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			be submitted with the appeal request. A new staff member joined the CVA team. **Evaluation:** During FY2026, the appeal FY2024Q4-FY2025Q1 audit cycle has been completed and the PIHP is in the process of following up with providers and providing oversight of the takeback/reconsideration process. POCs have been issued to all providers with non-compliant findings and been sent to the CMHSPs and SUD Providers via their contract manager. The FY2025Q2-FY2025Q4 audit documentation review period concluded, and the CVA team is in the process of revising the Findings Letters to better convey non-compliant findings and concerns to providers. Preparations for the FY2026Q1-FY2026Q3 audit has begun. **Barrier Analysis:** Scheduling conflicts which delay meetings and discussions. **Next Steps:** The CVA team continues to work on closing out the FY2025Q2-Q4 CVA cycle. Findings Letters are in the process of being finalized and will be sent out as soon as possible. The CVA team has started preparations for the next Claims Verification Audit cycle. The sample selection methodology is in the process of being revised. This goal is met. For FY2027, this goal has been revised and will continue.

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Utilization Management	• Provide oversight on CMHSP affiliate crisis services utilization. o Monitor and advise on CMHSP affiliate crisis service utilization reports per committee for discussion of findings, trends, potential systems improvement opportunities, and adherence to standards (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Q1 (Oct-Dec):** Quarterly reports were reviewed, and no service utilization issues were identified. **Q2 (Jan-Mar):** This quarterly monitoring was completed at the January meeting. Quarterly review of crisis services utilization reports identifies no significant issues. **Q3 (April-June):** Quarterly review of reports identified no concerning trends. **Q4 (July-Sept):** In Q4 The Utilization Management Committee (UMC) reviewed and discussed any notable trends and crisis service utilization reports for all four Community Mental Health Service Providers (CMHSPs) within the Region 10 Network. No major concerns were noted during Q4 of FY26. **Evaluation:** Overall, progress was achieved toward this goal and it was met. CMHSPs provided reports and the committee analyzed the data quarterly. No concerning trends were observed. Inpatient psychiatric unit (IPU) admissions and continuing stay reviews trended similarly across CMHSPs given the use of the Indicia system and crisis services revealed minor variation.

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			Committee discussion overall identified adherence to standards and no systems improvement opportunities were identified. **Barrier Analysis:** None Identified **Next Steps:** This goal will be revised and continued into FY2027
Utilization Management	• 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	**Q1 (Oct-Dec):** Quarterly reports were reviewed at the December meeting, and no service utilization issues were identified. **Q2 (Jan-Mar):** Monitoring activities and findings were shared at UMC, with no concerning issues noted. **Q3 (April-June):** Quarterly review of reports identified no concerning trends. **Q4 (July-Sept):** The Utilization Management Committee (UMC) reviewed and discussed any notable trends with BTPRC management activities related to new plans, plan reviews, physical management, and 911 contacts for all four Community Mental Health Service Providers (CMHSPs) within the Region 10 Network. No major concerns were noted during Q4 of FY26.

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			Evaluation: Overall, progress was achieved toward this goal and it was considered met. Quarterly BTPRC data spreadsheet reports were submitted and committee discussion of findings noted adherence to standards as well as no concerning trends or potential system improvement opportunities. BTPRC activities continue to adhere to and provide service based, high-quality standards, and indicate that practitioners are more aware of adherence to person-centered planning principles and comprehensive diagnostics documentation. **Barrier Analysis:** None Identified **Next Steps:** The committee has identified two activities pertaining to the BTPRC and the development of a mechanism to longitudinally track and analyze quality of life improvement and trends in service delivery and health outcomes over time. This goal will be revised and continue into FY2027.
Utilization Management	• Oversight of regional Utilization Review (UR). o PIHP UM Department conduct UR ▪ SUD network provider programs (quarterly). ▪ CMHSP OASIS-user affiliates (quarterly). ▪ Monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Q1 (Oct-Dec):** Quarterly UR reports were reviewed, and corrective action items were discussed along with service systems improvement opportunities, such as ensuring timely documentation, complete and updated diagnostic summaries, and closing or more assertively attending to inactive or low activity cases.

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			Q2 (Jan-Mar): Quarterly CMH UR activities are underway as scheduled. SUD UR will take place beginning in May as per aligned with the PNM monitoring system, and two subsequent URs have been scheduled for later in the FY. **Q3 (April-June):** SUD quarterly activities are underway as scheduled, but the UM team has encountered intermittent challenges in obtaining case record documentation. The UM team is working closely with PNM to help ensure timely access to case record documentation. Regarding CMH UR, GHS reported on its 3Q and identified no significant issues. OASIS UR has been delayed by issues in generating the case finding reports as well as by the delays linked to SUD UR with PNM. **Q4 (July-Sept)** July: SUD PNM UR is completed, and OASIS CMH UR is underway. August: The SUD UR report is pending completion and will be reviewed at the September meeting. The OASIS CMH UR report was completed and reviewed, with areas of compliance and POCs discussed.

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			Q4 (July-Sept): The SUD Utilization Review (UR) and report were completed. GHS staff conducted and presented about their Q3 outlier UR and report. The Q2 outlier UR was conducted and reported on by Region 10 PIHP staff in relation to Lapeer, Sanilac, and St. Clair counties. The Q3 outlier UR was initiated for Lapeer, Sanilac, and St. Clair counties. **Evaluation:** Overall, progress was achieved toward this goal with one program exception, which was resolved through Utilization Review feedback on data submissions. Regional Utilization Review (UR) activities for quarterly OASIS-user affiliates revealed broad person-centered planning requirements and diagnostic narratives. SUD UR was found to be aligned with the SUD PNM monitoring system. UMC monitoring of delegated CMHSP (GHS) activity reports revealed similar findings and recommendations as those generated by the OASIS-user UR. **Barrier Analysis:** There was marginal system issues identified with two of the CMHSPs which were addressed. **Next Steps:** Revise goals and continue in FY2027.
Utilization Management	• Promote aligned care management activities across key areas of provider network operations.	Tom Seilheimer	**Q1 (Oct-Dec):** Per progress with UM Redesign implementation, the MIX User Group has

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	○ Complete Implementation of the Centralized Utilization Management (UM) System (UM Redesign Project) ▪ Oversight of the Mi.X Users Workgroup. ▪ Scheduled UM monitoring/ management reports and analysis. ▪ Monitoring of the GHS UM/UR Delegation to ensure alignment of operations ▪ Monitoring/ management of the ABD system in the Service Exception Request (SER) system. ○ Monitor and advise on the MDHHS/Region 10 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.	Utilization Management (UM) Committee	shifted to quarterly meetings. UM monitoring reports are pending the onboarding of 1Q service utilization data. The ABD component of the SER system is operational. The annual IRR evaluation is completed as scheduled. In conjunction with decentralized Access, Lapeer and Sanilac have been added to the MGC/Indicia quarterly support meetings. The UM Directors Group has been discussing Access issues in connection to the CCBHC Handbook 3.0 Standards to help facilitate shared understanding and response. **Q2 (Jan-Mar):** The recent UR reports on Auto-approvals and Service Exception Requests were completed and shared at the January MiX Users Group. The next round of UR reports on Auto-approvals and Service Exception Requests, and Access UR, are in-process. During second quarter, discussions at the UM Directors Group meetings were shared regarding Mental Health Framework, MDHHS reporting schedules, Decentralized Access Systems oversight, UM/UR monitoring and management activities ABD terminology clarifications, Plan of Safe Care, the ICSS and ICCW certification process.

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			Q3 (April-June): The recent UR report on Service Exception Requests were completed and shared at the April MiX Users Group. Also, the service authorization grids were updated per quarterly input. The next round of UR reports on Auto-approvals and Service Exception Requests, Access UR, and IPU UR were completed and shared at UMC. Discussions at the April UM Directors Group meeting were shared regarding Mental Health Framework, LTSS UM/UR, COFR issues, CFAP, and MDHHS ABD reporting. **Q4 (July-Sept):** Region 10 PIHP and GHS staff worked on starting the process of ensuring UR activities are aligned for the entirety of the regional service area related to changes being made in FY27. R10 started a conversation with St. Clair County CMHSP regarding all Indicia operations/activities being conducted by St. Clair County CMHSP staff in an effort to have a fully delegated process. The IRR Annual Assessment Process began for all CMHSP staff. **Evaluation:** PowerBI SER analysis report was activated, with the remaining UM reports coming online as service utilization data are available. Monitoring of the GHS UM/UR delegation has revealed adherence to

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			requirements. Quarterly monitoring of the ABD system revealed no concerning trends or improvement opportunities. The Milliman Care Guidelines Indicia System was completed with the remaining CMHSP coming online in July, and, Indicia Inter-Rater Reliability System evaluation process was initiated in August. Overall, progress was achieved toward this goal and it was met. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue in FY2027.
Utilization Management	• Oversight of decentralized Access operations across the region while maintaining adherence to Access Management System (AMS) Standards. o Scheduled UM monitoring/management reports and analysis. o Scheduled retrospective utilization review o CMHSP mid-year and end-of-year Access operations accountability reporting. o AMS- mid-year and end-of-year aggregate reporting with system improvement recommendations and remediation.	Tom Seilheimer Utilization Management (UM) Committee	**Q1 (Oct-Dec):** This report was completed, reviewed, and forwarded to the EOFY2025 UM Program Plan Evaluation Report, which will be presented at a later date to QIC. **Q2 (Jan-Mar):** Access Management System (AMS) Utilization Review (UR) activities were conducted, and CMH AMS quarterly reports were requested. The CHIP CMH quarterly UR report was received, with no major concerns noted. OASIS CMH quarterly reporting and feedback processes are underway and scheduled for the April UMC meeting.

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			Q3 (April-June): The AMS M-Y Report was completed and presented at UMC. Key findings are as follows: • Regional demand for services overall is fairly consistent month to month. • The number of *Abandoned Calls* generally decreased throughout the time period. • Less than half of the Walk-In Requests for Services were seen within 30 minutes, and approximately 13 percent of the total made other arrangements for the RFS but did so outside the 30-minute standard. • In terms of *Access Screening Dispositions*, the number of *CMHSP Specialty Services Eligible* comprised 38 percent of the total. • AMS UR indicates overall timely Access to a Screening along with CMHSP variance across the other categories and an overall improvement opportunity with regard to ensuring appropriate transfers to higher levels of care. • IPU UR indicates some isolated issues with timely Access and utilization of Indicia, although Genesee CMHSP demonstrates high level of compliance overall.

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			• Centralized SUD AMS demonstrates minor monthly variation in requests for services, and as expected, most *Screening Dispositions* are in the *SUD Eligible: Referred to SUD Provider* category. • Overall, CMHSPs within Region 10 PIHP's network are monitoring service access albeit slightly differently based on their EHR platforms and the learning curves that occur when service and accountability systems are redesigned. In conjunction, with the expansion of CCBHC funding, there has been a regional shift related to how Access data are obtained as well as interpreted. • Systems recommendations are as follows: o Continue to provide supportive and informative oversight of the decentralized Access operations, with attention to aligned data gathering and reporting practices. o Continue current UR activities and assess for their essential and added value for FY2027.

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			Q4 (July-Sept): The AMS EOY Report was discussed related to the completion process and the due date. The delegated function of Access to services was identified as an area which will be reviewed in October of 2026. **Evaluation:** Overall, progress was achieved toward this goal and it was met. Oversight of the decentralized Access operations has taken place so far in terms of completing the CMHSP mid-year Access operations accountability reports. The EOY report is in process. Findings indicate broad adherence to AMS Standards, and improvement opportunities and corrective feedback have been directed back to the CMHSPs regarding accurate data definition, tracking, and reporting. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue in FY2027.
Utilization Management	• Provide oversight of the CMHSP affiliate community access / care management activities. o Conduct quarterly monitoring of and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**Q1 (Oct-Dec):** The quarterly report was reviewed, and a wide range of community outreach and support activities are in place. It was decided to move this report to the AMS semi-annual report format.

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			Q2 (Jan-Mar): Quarterly updates were shared with the group, highlighting local success in informing about services and addressing stigma. **Q3 (April-June):** CMHSP activities were reviewed noting a wide range of outreach, engagement, and community information. **Q4 (July-Sept):** CMHSP activities were reviewed, noting a wide range of outreach, engagement, and community information. **Evaluation:** Oversight of the CMHSP affiliate community access / care management activities, as evidenced by conducting quarterly monitoring of and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly), have revealed a broad range of progressive and comprehensive outreach and education activities across the region. This goal is identified as met. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue in FY2027.

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Utilization Management	• Provide oversight of the regional Adverse Benefit Determination (ABD) operations and reporting processes. o Monitor and advise on provider ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Q1 (Oct-Dec):** This quarterly report was presented with no concerning trends noted. **Q2 (Jan-Mar):** Quarterly reporting was reviewed with no significant concerns noted. **Q3 (April-June):** Quarterly review of reports identified no concerning trends. **Q4 (July-Sept):** Quarterly review of reports identified no concerning trends. **Evaluation:** Oversight of the regional Adverse Benefit Determination (ABD) operations and reporting processes, as evidenced by monitoring and advising on provider ABD reports have revealed adherence to standards as well as no concerning trends or potential system improvement opportunities. This goal is identified as met. **Barrier Analysis:** None Identified **Next Steps:** Revise goal and continue in FY2027.

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Long-Term Services and Supports	• The PIHP will define long-term services and supports (LTSS). • The PIHP will assess the quality and appropriateness of care furnished to beneficiaries receiving LTSS, including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. Mechanisms to assess include: o Periodic reviews of plans of service o Utilization reviews o Claims verification reviews o Clinical case record reviews o Customer satisfaction surveys • The PIHP will assess each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. Mechanisms to assess include: o Biopsychosocial assessments o Ancillary assessments o At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.	Rosalie Monfette Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** The PIHP has not formally defined long-term services and supports (LTSS). Periodic reviews of plans of service, utilization reviews, and claims verification reviews continued. The PIHP will conduct 1915(c) Waiver, 1915(i)State Plan Amendment (SPA), and Autism clinical case record reviews at the time of annual contract monitoring. The FY2025 Customer Satisfaction Survey results were aggregated for the final report. **Q2 (Jan-Mar):** The PIHP has not formally defined long-term services and supports (LTSS). Periodic reviews of plans of service, utilization reviews, and claims verification reviews continued. The PIHP will conduct 1915(c) Waiver, 1915(i)State Plan Amendment (SPA), and Autism clinical case record reviews at the time of annual contract monitoring. The FY2025 Customer Satisfaction Survey Report was completed.

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			PIHP Staff are in the process of reviewing the MDHHS LTSS Guidance Document to determine how best to monitor LTSS in Case Record Review (CRR) process. Pending updates to the CRR process, during March the PIHP Utilization Management (UM) Staff conducted Case Record Reviews related to 23 Behavioral Health Treatment (BHT) Services, which includes review of LTSS defined consumers. **Q3 (April-June):** In June of 2026, UM Staff were informed that it appears the Comprehensive Quality Strategy being prepared by MDHHS' Federal Compliance Team is going to address LTSS. Throughout the quarter, UM Staff reviewed the MDHHS LTSS guidance document, met with Quality staff, reviewed the CMHSP audit tool, approved service exception requests which include some LTSS services, drafted a definition of LTSS, and started the process of scheduling a meeting with GHS staff to discuss how to monitor LTSS across the region. **Q4 (July-Sept):** In September of 2026, Region 10 UM Staff reviewed the draft Comprehensive Quality Strategy prepared by MDHHS' Federal Compliance Team which outlines information

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			related to LTSS. Region 10 UM Staff also reviewed a QAPIP Document from NorthCare (Region 1) which identifies some information related to how that PIHP is addressing LTSS. On 09/15/2026, Region 10 UM Staff met with Genesee Health System (GHS) UM Staff related to planning changes for Case Record Reviews in FY27 which will include a Utilization Review (UR) of H2015 Services which are categorized under the umbrella of LTSS. **Evaluation:** Region 10 Staff are making progress toward addressing concerns outlined by a HSAG Recommendation related to monitoring LTSS. **Barrier Analysis:** Region 10 UM Staff will need to collaborate with Region 10 Data Management Staff to add a Case Record Review Audit Module in PCE which will take some time to complete; however, the first Utilization Review (UR) related to H2015/LTSS is not slated to occur until February of 2027. **Next Steps:** Region 10 UM Staff and GHS Staff have a follow-up meeting scheduled on 10/06/2026 to develop the Case Record Review questions specific to H2015/LTSS.
Provider Network	• Address service capacity concerns and support resolution of identified gaps in the network. o Review and address CMH Network gaps and capacity concerns.	Adrienne Candela Provider Network Committee	**Q1 (Oct-Dec):** During the first quarter, the PIHP still continues to note issues with Autism services. St. Clair and GHS note discussions continuing to happen around staffing issues and lack of

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	○ Review and address SUD Network gaps and capacity concerns.		workers with contracted providers. GHS reported during the Provider Network Committee meeting that several ABA providers were approved in their November meeting for in-home services and a center-based group is up for approval in December. Sanilac and Lapeer did not report any issues during the December meeting. However, in previous updates from received from the Autism Lead Coordinator include Sanilac CMH not reporting issues or gaps. Lapeer CMH did report staffing issues in November. **Q2 (Jan-Mar):** Discussions continued through the quarter regarding service capacity. Provider Network Committee meeting was held in March. GHS shared that they continue to have discussions regarding staffing issues and evening hours for ABA providers. Lapeer CMH shared that they are planning to move their ABA department due to limited space in their current building for ABA. Sanilac CMH shared no barriers to services at this time. St. Clair shared that they are in contact with the ABA Liaison Lead and team, having been able to hire new staff for daytime and after hour kids.

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			St. Clair: St. Clair's Contract Management department recently reported Center for TLC is requesting to contract services with St. Clair CMH. They provide OT, ST, PT, and ABA services and are located in Macomb County. The Contract Management department is currently vetting this provider to see if they will be a suitable provider. No new update from Contract Management. Two of our providers are looking at hiring a new BCBA. One of our providers is losing a BCBA and has begun the process to hire a replacement. **Q3 (April-June):** Provider Network Committee was rescheduled for this quarter due to Contract Monitoring visits and to allow for an in-person meeting in July. However, the PIHP has collected the following updates: *GHS:* Discussions regarding staffing issues and lack of workers with contracted providers Continued discussions with current ABA provider network regarding the large demand of evening availability as most waiting for services are school aged and in school during the day

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			GHS onboarded two new providers, training in process, estimated start date within 30 days. *Lapeer:* • Currently there are 13 in-services at LCCMH, and 12 in-services with contract providers. • Contract providers currently are Pathways, PBP, & Journey • Program moved to a new location on May 18th and began providing services in new location in the afternoon on May 19th. The new address for ABA services is 1505 Suncrest Dr., Lapeer MI 48446. • New staff have been hired and are currently in training. ABA supervisors continue to interview for open positions. Additional staff for evening services will allow more individuals to come into services. These families have chosen to stay at LCCMH for services instead of going to contract providers. • In May two ADOS assessments were completed and 4 are scheduled for June currently. • ABA supervisor continues to interview for open positions.

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			Sanilac: No autism service concerns *St. Clair:* St. Clair's Contract Management department recently reported Center for TLC is requesting to contract services with St. Clair CMH. They provide OT, ST, PT, and ABA services and are located in Macomb County. The Contract Management department has been vetting this provider to see if they will be a suitable provider. ABA supervisor did reach out to the contract management department for an update and is waiting to hear back. Some providers reported adding a BCBA to their agency. **Q4 (July-Sept):** The PIHP and CMHSPs continue to actively expand its network capacity and address localized service gaps. While overall network capacity remains stable in some areas, providers are actively onboarding new staff, pursuing new contracts and navigating a high demand for even appointments for school-aged children. **Evaluation:** This goal continues to be ongoing. While some of the CMHSPs have onboarded new providers throughout the year and expanded in this area, it continues to be a concern. Overall, the Provider

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			Network Committee continues to center around service capacity. **Barrier Analysis:** No new barriers. Lack of providers aligning with the needs of individuals needing services and staffing has been a continuous issue. **Next Steps:** Continue to monitor ABA capacity and concerns.
Provider Network	• 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.	Adrienne Candela Provider Network Committee	**Q1 (Oct-Dec):** Email from MDHHS was received on December 12, 2025, requesting feedback on the Network Adequacy Report changes for this year's report. The Provider Network Committee met on December 9th. It was shared that there were no drastic changes to the Network Adequacy report; however, there were a few items added. **Q2 (Jan-Mar):** In March, the CMHSPs returned their completed draft reports, and the PIHP aggregated the data and worked internally on Narratives. Evaluation: Progress has been made. Requirements have been reviewed this quarter. **Q3 (April-June):** The PIHP worked to calculate information for the Network Adequacy Reporting Template. Region 10 submitted the report timely in relation to the April 30 deadline. The PIHP has

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			a meeting with HSAG in July regarding Network Adequacy Validation. **Q4 (July-Sept):** The PIHP participated in the Network Adequacy Validation (NAV) review in July. During the Provider Network Committee meeting, the CMHSPs discussed how the monitor internal network adequacy and geographic needs. The PIHP received the FY25 Network Adequacy Data Summary from MDHHS in August. The Summary Report noted the Network meeting Standards in the areas of Assertive Community Treatment (ACT), Crisis Residential Programs, Opioid Treatment and Inpatient Psychiatric Services. Unmet areas were identified as Psychosocial Rehabilitation, Home-Based Services, and Wraparound. **Evaluation:** The PIHP and CMHSPs are actively engaged in monitoring internal network adequacy and mapping regional geographic needs. According to the FY25 Network Adequacy Data Summary issued by MDHHS, the network demonstrates a mixture of met standards and targeted regional gaps **Barrier Analysis:** No barriers were noted.

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			Next Steps: The PIHP will continue to work to improve the process for reporting and utilize the information to identify deficiencies in the network.
Provider Network	• Assess annual contract monitoring practices and outcomes. o Collaborate on monitoring process improvement. o Review most recent FY PIHP Contract Monitoring results. o Review FY Contract Monitoring Aggregate Report. o Address identified trends and improvement opportunities.	Kim Wahl Provider Network Committee	**Q1 (Oct-Dec):** Throughout December 2025, Provider Network Management (PNM) Contract Monitoring staff held departmental meetings to refine and update the CMHSP Tool in preparation for FY 2026 monitoring. Tools are expected to be updated and returned to departments for final approval in early January before being sent to Management Team for review. PNM staff met in November with Statewide Reciprocity Workgroup led to relay feedback from both Region 10 and various providers regarding FY2025 Tool performance. An updated version of the Reciprocity Tool was issued in December with changes to the Clinical Case Review section, as well as minor adjustments throughout. The workgroup lead shared the Tool via Teams for workgroup members to make their own changes as needed. PNM Contract Monitoring staff will meet with internal PIHP departments in January to review the SUD Reciprocity Tool and the Companion Tool. FY2025 Plans of Correction (POC) have been submitted by providers and reviewed by

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			Subject Matter Experts (SMEs). Targeted meetings were conducted for Substance Use Disorder (SUD) providers requiring additional assistance to meet compliance standards. CMHSP providers are on track to have most POCs resolved before the next cycle of Contract Monitoring begins. PNM Staff continue to work with SUD providers to resolve outstanding POCs. During the Quarterly SUD Provider Network Meeting, a roundtable discussion was held regarding Contract monitoring. Feedback, concerns, and requests regarding the contract monitoring process were discussed and noted in detail. **Q2 (Jan-Mar):** Provider Network Management (PNM) Contract Monitoring Staff finalized and completed the customization of Contract Monitoring Tools. The Contract Monitoring process transitioned to the secure ShareFile platform for sending and receiving Contract Monitoring Documents. Providers were notified of this in the quarterly Provider Network Committee (PNC) and the SUD Provider Network meetings. All providers have been granted access to their respective agency's folder, and a test run was conducted.

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			Q3 (April-June): Between April and June, Provider Network Management (PNM) conducted Annual Contract Monitoring Desk Audits and completed 39 on-site visits to providers and subcontractors **Q4 (July-Sept):** All Provider Final Summary reports and Plans of Correction (POC) reports were completed and issued to providers. Feedback on the contract monitoring process was gathered during the Quarterly Provider Network Committee (PNC) meeting. The FY26 Annual Contract Monitoring scores were tabulated into an Aggregate Report, which received formal review from the PIHP Management Team and official approval from the PIHP Board. Providers are submitting their required POC reports for review by Subject Matter Experts (SMEs). A significant portion of these reports have already been finalized and closed, while the remaining reviews are on track for resolution in the near future. **Evaluation:** The FY26 Contract Monitoring cycle concluded efficiently and on schedule, though annual audits revealed distinct regional deficiencies. Specifically, Community Mental Health Service Providers (CMHSPs) maintained "Not Met" compliance scores within the Autism and ABA services, SUD providers indicated uncertainty

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			regarding personnel training requirement. To address these gaps, the PNM team will collaborate with the Quality to align CMHSPs with active clinical standards, while simultaneously reevaluating and clarifying SUD training mandates ahead of the FY27 monitoring cycle. **Barrier Analysis:** Providers staggered responses lengthen the resolution process. **Next Steps:** Work with Providers as necessary to resolve POCs as quickly as possible.
Provider Network	• Review and Address SUD Network Adequacy gaps and capacity concerns. o Create standing Agenda Item for discussion at SUD provider Network Meetings. o Evaluate and update PIHP Policies and processes for Requests for Information (RFIs) and Requests for Proposal (RFPs). o Issue RFIs and RFPs as necessary to fill identified gaps.	Kim Wahl Provider Network Committee	**Q1 (Oct-Dec):** The Provider Network Management (PNM) team is addressing transportation gaps for Substance Use Disorder (SUD) treatment enrollees in St. Clair County. PNM, in collaboration with PIHP Management, reviewed RFI and RFP processes and drafted a Non-Emergency Transportation RFP to address network gaps identified in the current SUD Strategic Plan. The RFP, aimed at providing transport for SUD treatment appointments in St. Clair County, was submitted to and approved by the Region 10 Board in November, and subsequently publicized on the Region 10 website. There were no responses to the publicized RFP. **Q2 (Jan-Mar):** Network Adequacy gaps and capacity concerns were discussed at the quarterly SUD Provider Network Meeting. Medication-

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			Assisted Treatment (MAT) providers reported that Medicaid eligibility shifts are leading to coverage loss, preventing beneficiaries from receiving vital medications that support recovery. The PIHP is currently investigating potential solutions to ensure continuity of care and support recovery outcomes during this period. The Non-Emergency Transportation RFP continues to be on hold as the PIHP continues to monitor network needs. **Q3 (April-June):** Provider Network Management (PNM) visited an interested faith-based treatment provider in Flint. If contracted, this agency will offer Region 10 (R10) consumers a second faith-based program option within the area. Additionally, the PIHP is moving forward with securing a contract for adolescent services with Great Lakes Recovery Centers (GLRC) in the Upper Peninsula. Meanwhile, the Non-Emergency Transportation RFP remains on hold while the PIHP evaluates ongoing network demands. **Q4 (July-Sept):** PNM is finalizing the PIHP's Pre-Delegation and Assessment Tool for onboarding new SUD Treatment providers. Upon finalization,

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			the Tool will immediately be issued to a potential SUD Treatment Provider for the onboarding process to be completed by the end of the year. **Evaluation:** Although PNM missed its initial goal to issue the Pre-Delegation and Assessment Tool before the new fiscal year, the revised timeline strategically positions the team to successfully complete provider onboarding by January 1, 2027. This adjusted schedule balances administrative accountability with the rigorous evaluation required for new SUD Treatment partners. **Barrier Analysis:** Completion of the new Tool delayed the process. **Next Steps:** Finalize and send to a potential provider.
Provider Network	• Ensure individuals served apply for Medicaid. o Facilitate ongoing share-and-learn discussions of best practices with Network Providers o Evaluate the use of MDHHS integrated staff at CMHSPs. o Evaluate and update contract language. o Develop mechanism for monitoring contract compliance.	Kim Wahl Provider Network Committee	**Q1 (Oct-Dec):** Provider Network Management (PNM) is evaluating provider-level processes regarding assisting individuals with Medicaid applications. During the December PNC meeting, Community Mental Health Service Programs (CMHSPs) outlined their specific workflows for maximizing client enrollment. At the Quarterly Substance Use Disorder (SUD) Provider Network Meeting, all providers confirmed they have active protocols to verify Medicaid eligibility for every individual

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			seeking services, including those referred through central access points. **Q2 (Jan-Mar):** Providers proactively address capacity concerns by helping consumers secure and maintain Medicaid coverage. This includes hands-on support for enrollment and advocacy to resolve coverage denials, ensuring fewer barriers to treatment access. **Q3 (April-June):** Medicaid eligibility was an agenda item on each Treatment Provider's site visit. Each Provider clearly explained their process to check for coverage for each client prior to admission and how they assist clients in obtaining Medicaid or a Health Plan, and a system for monthly checks of current clients for changes in status. **Q4 (July-Sept):** The quarterly Substance Use Disorder (SUD) Network Meeting agenda featured a presentation and discussion on the upcoming implementation of H.R. 1 Medicaid legislation, which included a presentation by a treatment provider detailing their specific Medicaid verification and enrollment processes. To ensure continuous alignment across the network, comprehensive details regarding the H.R. 1

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			legislative updates were distributed to all providers immediately following the meeting. **Evaluation:** Region 10's paneled SUD provider network is fully informed of upcoming regulatory changes and best practices for ensuring uninterrupted consumer coverage. **Barrier Analysis:** None **Next Steps:** Continue to distribute state-issued updates and regulatory information to providers.
Substance Use Disorder (SUD) Health Home	• Provide oversight of the Substance Use Disorder Health Home (SUDHH) model within Region 10. o Identify, enroll, and onboard potential Health Home Partner(s) (HHP). o Increase and manage enrollment of SUDHH beneficiaries. o Development of continuous utilization and quality improvement program.	Stephanie Rebenock Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** During the first quarter of the FY, enrollments increased from 442 beneficiaries to 479 beneficiaries. Current enrollees for Region 10 are 479 (BioMed 76, Flint Odyssey House 86, New Paths 155, Sacred Heart Flint 87, Sacred Heart Port Huron 32 & Sacred Heart Richmond 43). Monthly LE MDHHS meetings were held and attended each month of the quarter. MDHHS advised that we are still waiting for CMS approval for the SUDHH SPA. MDHHS is hosting two WSA trainings in Q2 of FY26 - these are not mandatory. In an effort to optimize our HHP meetings, I sent an email poll to Providers to get their opinion on our current monthly meetings. The poll asked about meeting cadence, best time and day to have the meeting and

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			topics they'd like to discuss. This poll was sent at the end of December, with the poll closing Friday, January 9th. **Q2 (Jan-Mar):** During the second quarter of the FY, enrollments decreased from 479 beneficiaries to 475 beneficiaries. Current enrollees for Region 10 are 475 (BioMed 71, Flint Odyssey House 86, New Paths 155, Sacred Heart Flint 79, Sacred Heart Port Huron 37 & Sacred Heart Richmond 47). Monthly LE MDHHS meetings were held and attended. MDHHS advised in our March meeting, we are still waiting for CMS approval for the SUDHH SPA. MDHHS hosted two WSA trainings in Q2 - these are not mandatory but provide an overview of WSA for new users. One Provider attended the first session. There have been some SUDHH staff turnover this quarter - with 3 of the 4 Providers losing a staff member. With that, I will make sure the Providers have access to SUDHH resources, trainings and TA for the new staff members. **Q3 (April-June):** During the third quarter of the FY, enrollments stayed about the same, ending with 474 beneficiaries enrolled. Current enrollees for Region 10 are 474 beneficiaries (BioMed 66,

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			Flint Odyssey House 88, New Paths 152, Sacred Heart Flint 82, Sacred Heart Port Huron 36 & Sacred Heart Richmond 50). MDHHS advised that the SUDHH State Plan Amendment (SPA) was approved on 5/19. MDHHS advised that the updated case rate will start in late June. I have been in contact with our Finance Team to make this a smooth transition. MDHHS stated that they are still waiting for an update regarding retro-funding. Pay for Performance (P4P) funds were sent to Providers on 6/12. Monthly LE meetings were attended. April and June's HHP Meetings were attended by all Providers. Decreasing enrollment numbers were discussed in June's meeting and will continue to be talked about (if needed). **Q4 (July-Sept):** During the fourth quarter of the FY, we have increased our enrollment to 517 beneficiaries. Current enrollees for Region 10 are 515 beneficiaries (BioMed 55, Flint Odyssey House 99, New Paths 196, Sacred Heart Flint 85, Sacred Heart Port Huron 39 & Sacred Heart Richmond 43). Conversations have been continuing to take place regarding the addition of another S Code for FY27. Currently, we are waiting for MDHHS to add this code to the code chart.

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			Once they do that, we can add it internally (max rate grid, MiX, etc.). Providers have been made aware of this change for FY27. MDHHS conducted a SUDHH Desk Review on 9/02. Results should be sent within the next couple of weeks. MDHHS hosted a Health Home Summit (SUDHH & BHH) on 9/10. FY27 SUDHH Handbook to be sent by MDHHS in the next couple of weeks. This will have the new SPA updates, Z Code additions, and an overview of changes. **Evaluation:** This goal is considered met and will be ending in FY27. **Barrier Analysis:** No new barriers have been identified. **Next Steps:** Continue to provide program oversight.
Autism Program	• Reduce and monitor the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services. as reported monthly on the Autism Monthly Reporting Form. o Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form. o Monitor timely submission of the Autism Monthly Reporting Form and timely communication from the CMHSP Autism Leads.	Shannon Jackson Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** At the close of Q1, Genesee Health System (GHS) reported having 221 individuals eligible and not authorized for services. St. Clair CMH reported having 99 individuals eligible and not authorized for services. Lapeer CMH reported having 10 individuals eligible and not authorized for services. Sanilac CMH has reported zero cases of individuals eligible and not authorized for ABA services. GHS reported being able to serve 49 eligible individuals this quarter, thus reducing the number of individuals eligible but not

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			receiving services. In Q1, GHS reported six (6) new ABA providers were being explored, which helped alleviate the number of individuals eligible but not receiving services. St. Clair CMH's list increased by 17 individuals this quarter, but they report they are continuing to explore an additional ABA provider which may help with these increased numbers. There were no significant changes reported by Lapeer CMH for Q1. Tracking sheet timely submission continues to be a barrier for this program. **Q2 (Jan-Mar):** At the close of second quarter, Genesee Health System (GHS) reported having 254 individuals eligible and not authorized for services. St. Clair CMH reported having 97 individuals eligible and not authorized for services. Lapeer CMH reported having 8 individuals eligible and not authorized for services. Sanilac CMH has reported zero cases of individuals eligible and not authorized for ABA services. GHS reported a significant increase in eligible individuals not receiving services this quarter. They have contributed this to provider staffing issues and family provider movement.

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			Tracking sheet timely submission continues to be a barrier for this program through Q2 but has shown improvements with prompting though Provider Network staff. **Q3 (April-June):** At the close of the third quarter, Genesee Health System (GHS) reported having 264 individuals eligible and not authorized for services. St. Clair CMH reported having 97 individuals eligible and not authorized for services. Lapeer CMH reported having 9 individuals eligible and not authorized for services. Sanilac CMH has reported zero cases of individuals eligible and not authorized for ABA services. In the third quarter, Lapeer CMH moved to their new location and began providing services. They are also in the process of hiring and training new staff, so they are hopeful this new space and capacity will eliminate their individuals waiting for services. Genesee and St. Clair CMH are also working through onboarding new providers in their counties. No barriers in Q3 with timely submission of tracking sheets. **Q4 (July-Sept):** At the close of second quarter, Genesee Health System (GHS) reported having 240 individuals eligible and not authorized for

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			services. St. Clair CMH reported having 91 individuals eligible and not authorized for services. Lapeer CMH reported having 0 individuals eligible and not authorized for services. Sanilac CMH has reported zero cases of individuals eligible and not authorized for ABA services. GHS and St. Clair reported a decrease in eligible individuals not receiving services this quarter they have both reported onboarding new providers which has helped with these numbers. Lapeer CMH has reported that they have eliminated their list of eligible individuals not receiving services this quarter. This is due to the opening of their new Children's Building and the expansion of their program which took place this FY. Tracking sheet timely submission continues to be a barrier for this program through Q4 but has shown improvements with prompting though Provider Network staff. **Evaluation:** This goal has shown great progress this FY, however this is not considered met. Lapeer has eliminated their individuals eligible and not receiving services, and St. Clair CMH and Genesee Health System took on new providers this year and worked on progress towards this goal. **Barrier Analysis:** The number of individuals presenting with Autism needs continues to

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			increase across the state and Region 10 continues to have provider network capacity struggles. **Next Steps:** Continue to have this goal into FY2027 and track the progress.
External Monitoring – 1915(c) Waivers & 1915(i) State Plan Amendment	• Increase efficiencies and enrollment activities related to the PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW], and the 1915(i)State Plan Amendment [iSPA]). o Encourage and education CMH's to increase enrollment in HSW program throughout FY2026 o Identify potential iSPA participants quarterly and collaborate with CMH's to encourage enrollment throughout FY2026. o Monitor enrollment and disenrollment Medicaid issues occurring within the WSA and provide timely remediation or notification within 5 business days.	Laurie Karig Quality Management Department	**Q1 (Oct-Dec):** At the end of the first quarter, there were 521 individuals enrolled in the Habilitation Supports Waiver (HSW) program, falling to 89% utilization rate. There were 3 disenrollment in December and 2 new enrollees with January active start dates once approved. During the PIHP Leads meeting in January, identifying potential HSW enrollees will be added to the agenda and will be ongoing to improve the number of enrollees to reach 95% utilization. During the quarter, MDHHS identified several individuals throughout the state receiving iSPA services but were not enrolled in the iSPA. Region 10 has 65 individuals identified and these will be decimated to the CMH's for follow-up and possible enrollment. At the end of quarter 1 the iSPA had 2461 open cases, with a possible 3590 individuals identified as potential enrollees. Enrollments and disenrollments with Medicaid Spenddown issues continue to be handled in a timely fashion.

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			The Children's Waiver Program (CWP) has one new enrollee to the program for Sanilac County, bringing the total number of enrollees to 21. The Serious Emotional Disturbances Waiver (SEDW) program has 60 enrollees at the end of December 2025. **Q2 (Jan-Mar):** At the end of Quarter 2 the HSW program has 512 enrollees which is 88% utilization of available slots. Due to falling below the 95% standard MDHHS issued an email on March 11, 2026. Contained in the email was an ask from MDHHS to Region 10 to increase HSW slot utilization from its current level to 95% by June 1, 2026. A response was sent to MDHHS outlining a plan and steps to be taken by Region 10 to meet this standard. One of the first steps was to analyze current data to identify if we could meet this expectation. Currently we will need 45 new enrollees for the HSW program to reach 95%. We ran a report which identified 1,595 individuals currently receiving an HSW service code encounter which could possibly be enrolled; however, limiting factors could reduce this number as they may not reach all eligibility requirements for the HSW program. The enrollment work for the 1915(i)SPA program wrapped up the first of March with identified individuals needing enrollment

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			being enrolled. Monitoring continues for those individuals receiving iSPA service through the CCBHC, but the CCBHC currently does not hold a contract Designated Collaborating Organization (DCO) service provider. On average for the quarter, potential iSPA enrollees identified was 944. The Children's Waiver Program and Severe Emotional Disturbance Waiver remain consistent. **Q3 (April-June):** As of the writing of this report, 55 new HSW cases have been approved during the third quarter. Four of those have a start date of July 1, 2026. Bringing the total number of enrollees to 557. This is a 95.3% slot utilization rate. There are 11 new potential enrollees waiting in the MDHHS queue for approval and 20 others in various stages of the review process. The 1915(i)SPA currently has an enrollment of 2,346 individuals. Additionally, 1,256 individuals have been identified as potential enrollees currently receiving at least one 1915 (i)SPA service.

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			The Children's Waiver program currently has 22 open cases with 2 additional children invited to the program. The SEDW program currently has 55 children enrolled with one pending. **Q4 (July-Sept):** At the end of the fourth quarter, the Habilitation Supports Waiver (HSW) program remained on a new enrollee pause until 10/1/2026. Enrollment for this program remained steady at 569 through the end of September. At the MDHHS/PIHP leads meeting on September 21st, 2026, the state team announced that enrollment can continue as usual starting 10/1/2026. The 1915(i)SPA program has 2,387 current enrollees during the last week of quarter 4, with an identified 3,391 potential enrollees for September. Enrollments for the Children's Waiver program had 3 new cases pending enrollment during the fourth quarter, bringing the total number of cases to 28 once approved. At the end of quarter 4 the Serious Emotions Disturbance Waiver program enrollment was 53. During the quarter there were 3 new cases approved.

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			Evaluation: Progress was noted in the HSW enrollment and slot utilization. During the upcoming fiscal year, we will monitor the 95% utilization standard to ensure we maintain this standard. The 1915(i)SPA program, the CMHSP's completed past due case work effectively, bringing cases 3 years past due up to date. They continue to work on past due cases and are reducing those numbers. The 1915(i)SPA program completed work on enrolling individuals when the Code Chart had a change, and individuals were identified as receiving 1915(i)SPA services but were not enrolled in the program. **Barrier Analysis:** None noted **Next Steps:** Re-evaluate and update goals for FY2027.
External Monitoring – 1915(c) Waivers & 1915(i) State Plan Amendment	• Prepare, report, and monitor processes to ensure compliance standards are met for MDHHS annual site review which include the Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW], and the 1915(i)State Plan Amendment [iSPA]. o Continue to facilitate quarterly meetings with CMHs to gather updates on previous CAP work o Education on the HCBS final rule requirements for future Site Review.	Shannon Jackson Quality Management Department	**Q1 (Oct-Dec):** Communication continues with CMHSPs regarding the State Site Review of 2024 and continued corrective action plan (CAP) monitoring and support. The next scheduled meetings are occurring in January and February. Additional planning meetings for the upcoming Site Review will be scheduled. The HCBS team continues to hold Round Table meetings each month, with December's meeting being held on the 8th. During the meeting it was suggested this move to a quarterly schedule.

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			The PIHP HCBS team continues to hold quarterly training courses for CMH staff; these trainings cover volume 2 and 3 of the MDHHS created training curriculum. Upcoming training is to be determined. **Q2 (Jan-Mar):** In Q2 Quarterly CMH meetings concluded. These meetings looked at previous CAP follow up from the FY2024 review process. These meetings will begin again after the FY26 review to look at the progress on CAPs in this cycle. Feedback has been positive on these meetings from the CMHs. The PIHP hosted a Site Review Preparation meeting in the month of March and went over the changes to the Site Review tool and the new Performance Measures to help the CMHs prepare for the coming review. **Q3 (April-June):** In the third quarter, Region 10 received the Site Review time frame of August 3rd-September 30th and confirmation of the use of the CRM as a platform for this review. Region 10 received the Initial Memo in May and the Draft Agenda in June with which dates were shared with the CMH leads. Region 10 has not received any training

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			materials on the CRM or selected cases at this time. **Q4 (July-Sept):** In Q4 MDHHS initiated and completed the FY2026 State Site Review. Region 10 acted as a liaison between MDHHS and the CMH to provide documents, questions, and aid in accessing the CMH EMR systems. MDHHS started their review process in August of St. Clair CMH, and Sanilac CMH and concluded Genesee Health System and Lapeer CMH in the month of September. MDHHS sent the CMHs comment sheets after their review and provided an opportunity for the CMH Leads to provide documentation to disprove the findings. GHS and Lapeer comment sheets are due at the end of September and Region 10 has our Exit Conference that same day. **Evaluation:** Region 10 met this goal in FY2026. There was collaboration and good communication between the CMH Leads and the PIHP toward this goal throughout the year. The State Site review results will be determined in the next FY where this goal will continue with a focus on CAP action and support for the CMHs **Barrier Analysis:** The training for the CRM was established later than it should have been which has thrown off the review schedule in

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			this years review. The CRM has had some user struggles and the trainings were not as valuable as expected. **Next Steps:** To continue this goal into FY27 with further support and monitoring toward the CAP work
External Quality Review Corrective Actions	• Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. o Standard Leads will report Compliance Review CAP updates monthly to the External Quality Review Team. o Recommendations resulting from the Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review will be addressed by the designated lead staff. o Any recommendations resulting from the Encounter Data Validation (EDV) activity will be addressed by the designated lead staff.	Standard Leads & External Quality Review Team / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** The SFY2024 External Quality Review (EQR) Technical Report Follow Up on Recommendations Template was completed and submitted to the Health Services Advisory Group (HSAG). Recommendations from SFY2024 EQR activities were addressed. SFY2025 Encounter Data Validation findings were received from HSAG. The PIHP was tasked with submitting a response to each finding. Technical assistance with HSAG was requested but not scheduled. Further information related to the findings is necessary before corrective action can be developed. The 2025 Performance Measure Validation Review Final Report was received from the Health Services Advisory Group (HSAG). Recommendations from the review were reviewed. The SFY2025 Compliance Review Final Report and Corrective Action Plan (CAP) Template

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			were received from HSAG. CAPs were prepared by Standard Leads and their teams. The completed CAP Template was submitted to HSAG. Standard Leads also addressed recommendations using PIHP-developed templates. Some CAPs needed to be resubmitted to HSAG with updated completion dates. CAP and Recommendation Tracking Templates will be used to track follow-up on findings and recommendations from SFY2025 EQR activities. **Q2 (Jan-Mar):** At the January Quality Improvement Committee (QIC) meeting, there was discussion about how MDHHS will monitor PIHP performance in lieu of a SFY2026 Compliance Corrective Action Plan (CAP) Review. MDHHS indicated that PIHP-submitted reports will be reviewed. Standard Leads will provide updates on CAP and Recommendations Tracking Templates for both the SFY2024 Compliance Review and SFY2025 Compliance Review findings. Standard Leads were asked to provide updates on both SFY2024 and SFY2025 Compliance Review Corrective Action Plan (CAP) and Recommendation Tracking Templates.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			The PIHP sought clarification about the 2026 Performance Measure Validation (PMV) Review. The 2026 PMV Review will be a review of the FY2026 Michigan Mission-Based Performance Indicator System (MMBPIS). HSAG scheduled a 2026 PMV and Network Adequacy Validation (NAV) Review Technical Assistance Webinar for April. The SFY2025 Encounter Data Validation (EDV) Aggregate Report was received from HSAG. PIHP Lead staff conducted a review of the report and began follow-up. **Q3 (April-June):** Region 10 prepared for the 2026 Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review. The PMV & NAV Review was scheduled for July 15, 2026. All requested responses and materials were submitted to HSAG, including the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents, primary source verification supporting documents, and source code review responses. Standard Leads were asked to provide updates on both SFY2024 and SFY2025 Compliance Review Corrective Action Plan

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			(CAP) and Recommendation Tracking Templates. The SFY2025 External Quality Review Report was received and reviewed. **Q4 (July-Sept):** The 2026 Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review was July 15th. The PIHP Team involved addressed follow-up items before and after the review timely. In August, the Final Information Systems (IS) Tracking Grid was received from the Health Services Advisory Group (HSAG) for the 2026 PMV Review. Additionally, all items were marked as resolved. Source code for the 2026 PMV Review was also approved by HSAG. In September, the PIHP received the draft 2026 PMV Review (PMV) Report. The PIHP provided feedback to HSAG. In August, HSAG sent a request to PIHPs to complete Follow Up on External Quality Review (EQR) Recommendations templates. Content experts were assigned to complete their parts of the EQR Recommendations template. Responses were submitted to HSAG by the due date. Additionally, Standard Leads were asked to provide updates on the Compliance Review

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Corrective Action Plan (CAP) and Recommendation Tracking Templates. **Evaluation:** For all EQR activities, there were efforts to analyze results. Recommendations and findings from EQR activities were addressed when possible. Work will need to continue. **Barrier Analysis:** Barriers were noted for the EDV Review and the PMV Review. For the EDV Review, per the SFY 2025 EDV Report, there were "confirmed errors in the MDHHS extract or differences in interpretation of the data extract requirements between MDHHS and the PIHPs," which negatively impacted Region 10's reported results. This included differences in exclusion criteria based on Medicaid coverage, and data elements that HSAG identified as being affected by variations in reporting methodology, derivation logic, or extract specifications. These differences limited Region 10's ability to fully reconcile certain review findings. For the PMV Review, First, significant updates to the Michigan Mission-Based Performance Indicator System (MMBPIS) methodology in FY2026 required the PIHP and CMHSPs to adapt existing reporting, validation, and review processes to align with the revised requirements. Next, multiple additional updates to the FY2026 MMBPIS Codebook during the review period required repeated

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			recalibration and reduced the time available for the PIHP and CMHSPs to adjust workflows and update underlying coding logic used to identify reportable events, resulting in increased reliance on manual staff review. Further, the updated FY2026 MMBPIS methodology restricts the PIHP's ability to independently validate the identification of reportable events, as CMHSPs interpret and apply exclusion criteria prior to submitting data to the PIHP. As a result, events may be excluded upstream and are therefore never visible to the PIHP. This results in limited ability of the PIHP to confirm dataset completeness and consistent interpretation/application of the updated FY2026 methodology across the region. Last, the exclusion of individuals receiving only CCBHC-funded services reduced the number of reportable events in FY2026 Q1 by more than 50% compared to FY2025 Q1. This substantially smaller reporting population increased the impact of individual noncompliant events on overall performance rates. Additionally, established benchmarks continue to be based on historical data collected under the previous methodology which may not be directly comparable to performance under the FY2026 methodology. **Next Steps:** For FY2027, Region 10 PIHP will continue the goal to implement CAPs and

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			address recommendations from EQR activities. Efforts in FY2027 will address any outstanding remediation tasks from SFY2025 EQR activities, as well as any new findings from SFY2026 EQR activities.
Corporate Compliance	• 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).	Lauren Campbell Corporate Compliance Committee	**Q1 (Oct-Dec):** The Regulatory Compliance Committee met in October and approved the FY2026 Corporate Compliance Plan. The Corporate Compliance Committee reviewed the FY2026 Corporate Compliance Plan in November. The PIHP Board approved the plan in November. The plan was shared with all staff and providers. The FY2025 Q4 Program Integrity Report, Monthly Overpayment Reports, and Annual Subcontracted Entities Report were submitted to the OIG. A corrective action plan (CAP) was required for the FY2025 Q4 Program Integrity Report. All CAP items were addressed, and the report was resubmitted to the OIG. The CAP was accepted. The PIHP Compliance Team continued working on the Annual Program Integrity Report. The MDHHS OIG hosted an MDHHS OIG PIHP Bi-Annual Meeting.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q2 (Jan-Mar): The PIHP Board approved the FY2025 Annual Compliance Report in January. The PIHP Compliance Team worked on finalizing the FY2026 Q1 Complaint Report. Monthly Overpayment Reports were submitted to the OIG. The 6.10 Annual Program Integrity Report was submitted to the OIG. The PIHP Compliance Team received questions from the OIG. Revised report materials were submitted to the OIG for review. The FY2026 Q1 Program Integrity Report was completed and submitted to the OIG. The 6.9 Annual Compliance Program Report was prepared and submitted to the OIG. In March, the PIHP Compliance Team worked on a request for additional documentation received from the OIG. A follow-up item from the February CIO Forum meeting is to convene a subgroup to discuss OIG reports and join IT/Data and Compliance.

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			Additionally, the PIHP Compliance Team began policy reviews, which will include revisiting program integrity requirements. **Q3 (April-June):** Monthly Overpayment Reports were submitted to the OIG. The FY2026 Q2 Program Integrity Report was completed and submitted to the OIG. An OIG Reporting Workgroup of PIHP Compliance Officers and Chief Information Officers was created. The group will meet monthly, with a primary focus on methodology for pre-payment cost avoidance figures. This is part of the 6.10 Annual Program Integrity Report. Policy reviews continued. Feedback from the OIG from the 6.9 Annual Compliance Program Report is being addressed. **Q4 (July-Sept):** Monthly Overpayment Reports were submitted to the OIG. The FY2026 Q3 Program Integrity Report was submitted to the OIG, and Region 10 received a corrective action plan (CAP) from the OIG. The CAP was approved by the OIG.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			On July 8th, the OIG sent FY2027 report templates and guidance documents to the PIHPs. The PIHP Compliance Officers met on July 27th. The group discussed the FY2027 OIG report templates. During the quarter, the OIG Reporting Workgroup met monthly to discuss OIG report templates and methods for acquiring necessary data to complete OIG reports. Concerns were raised about the new reporting elements, including duplicative items and elements which may require special report development or intensive manual work. Reports and due dates were discussed with the Compliance Committee at the September meeting. **Evaluation:** The PIHP Compliance Committee representatives regularly provided information regarding upcoming reports and report due dates to ensure timely submissions. The PIHP committee representatives also provided information about OIG report template updates. For FY2027, the Corporate Compliance Committee approved a goal to submit OIG-required reports to the OIG in accordance with guidance documents and be defined due dates.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Barrier Analysis: It is anticipated that additional data reports or processes will need to be developed to ensure accurate and complete reporting on the new FY2027 OIG Report templates. **Next Steps:** Convene a meeting with internal representatives from Compliance, Data Management, and Finance to discuss how to report on certain elements within the OIG Reports. Continue participating in any statewide workgroups discussing OIG Reports, including the PIHP Compliance Officers Workgroup, OIG Reporting Workgroup, and/or CIO Forum.
Corporate Compliance	• 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.	Lauren Campbell Corporate Compliance Committee	**Q1 (Oct-Dec):** Following the SFY2025 Compliance Review with the Health Services Advisory Group (HSAG), a corrective action plan (CAP) was prepared to address findings and recommendations related to Notice of Privacy Practices. The CAP was submitted to HSAG. In November, the PIHP Compliance Team met with the Compliance Committee and discussed Privacy Notices. The PIHP's Privacy Notice content will need to be updated and the PIHP will also need to conduct review of providers' Privacy Notice content and websites. Performance standards on Contract Monitoring Tools will be updated accordingly.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q2 (Jan-Mar): Revised language for the performance standard addressing Privacy Notices on the CMH and SUD Companion Annual Contract Monitoring Tools was prepared. The PIHP Compliance Officer requested Privacy Notices from other PIHP Compliance Officers from PIHPs who scored "Met" in this area in the SFY2025 Compliance Review, to assist with the task of updating the PIHP's Privacy Notice. Materials related to Privacy Notices are being reviewed to inform updates to the PIHP's Privacy Notice. The PIHP's Privacy Notice has been revised but is still in draft form and has not been finalized. **Q3 (April-June):** The Privacy Notice was revised, and a draft copy was sent to the Health Services Advisory Group (HSGA) with questions and a request for review and feedback. Feedback was received from HSAG and the Privacy Notice was updated accordingly. Work was done to prepare a timeline and finalize logistics for printing and preparing the Privacy Notice for mailing.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q4 (July-Sept): On July 30th, the revised Privacy Notice was finalized and approved. The revised Privacy Notice was printed and prepared for mailing. Providers were notified of Region 10's new Privacy Notice. The revised Privacy Notice was mailed to Medicaid beneficiaries and guardians of Medicaid beneficiaries who received PIHP-covered services. The mailings concluded in September. **Evaluation:** During FY2026, Region 10 PIHP updated its Privacy Notice and distributed the revised Privacy Notice to Medicaid beneficiaries (and guardians of Medicaid beneficiaries) who received PIHP-covered services. All mailings were completed before the conclusion of the fiscal year. In FY2027, the PIHP Compliance Team will complete a review of PIHP Privacy Policies to ensure policies align with all federal requirements. **Barrier Analysis:** No barriers identified. **Next Steps:** The Compliance Team will complete a review of PIHP Privacy Policies to ensure policies align with all federal requirements.
Corporate Compliance	• 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.	Lauren Campbell Corporate Compliance Committee	**Q1 (Oct-Dec):** The Compliance Team reviewed plan of correction (POC) submissions and some additional supporting documents as part of the FY2025 Annual Contract Monitoring

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			process. Not all POCs were accepted and resolved. The PIHP Compliance Team reviewed performance standards for FY2026 Annual Contract Monitoring to ensure all Corrective Action Plan (CAP) items from the SFY2025 Compliance Review are addressed. The PIHP Compliance Team will meet with the PIHP Provider Network Management Team in December to work on updating CMH Contract Monitoring Tool performance standards. Performance standards were modified to address findings from the SFY2025 Compliance Review. **Q2 (Jan-Mar):** Revised language for performance standards on the CMH and SUD Companion Annual Contract Monitoring Tools was prepared. **Q3 (April-June):** Subject Matter Experts reviewed documentation and performance standards for CMHs and SUD Providers. **Q4 (July-Sept):** Work continued on reviewing and scoring Provider plans of correction from the FY2026 Contract Monitoring cycle.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Evaluation: Annual Contract Monitoring was completed during FY2026 with CMHSPs and SUD Providers. Some of the compliance-related standards reviewed for both CMHSPs and SUD Treatment Providers were related to timely and accurate report submissions, breach tracking and reporting, and Privacy Notice requirements. Plans of correction were issued to providers for any "not met" performance standards. Throughout the fiscal year, the Compliance Committee was apprised of the status of FY2026 Annual Contract Monitoring. **Barrier Analysis:** No barriers identified. **Next Steps:** For FY2027, this will not be a goal of the Compliance Committee, but monitoring w remain a committee responsibility. The Compliance Department will review and update, if necessary, the Compliance performance standards for FY2027 Contract Monitoring Review Tools.
Information Technology (IT) & Security	• Continue collaborating with the Information Technology (IT) Managed Service Provider (MSP) as part of the special project created to address findings from the 2025 Security Audit and Assessment. o Develop and maintain a workplan to address findings from the 2025 Security Audit and Assessment. o Meet with the IT MSP biweekly to discuss the workplan activities and identify progress,	Lauren Campbell & Mike Klemmer Monitored by Quality Improvement Committee (QIC)	**Q1 (Oct-Dec):** The Chief Information Officer and Operations Manager / Security Officer met with Endeavor IT to discuss IT projects and activities related to the 2025 Security Audit and Assessment. The group discussed how to track this information and priority action items. A workplan was prepared and presented to the Endeavor IT Team.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
	measure risk reduction, and remain engaged in the organization's technology strategy.		Focused discussions were held to continue addressing audit findings and specific projects. The developed workplan was used to document status updates. Additionally, the 2026 Security Audit and Assessment was scheduled for April 2026. **Q2 (Jan-Mar):** The Chief Information Officer and Operations Manager / Security Officer continued discussions with Endeavor IT to address items on the workplan to address audit follow up items and other IT projects. The CIO completed another review of the workplan to identify other projects or action items that can be addressed. Tickets were created to address more of the follow up items from the 2025 Security Audit and Assessment. The 2026 Security Audit and Assessment was rescheduled for May 2026. Two significant remediation items from the 2025 Security Audit and Assessment were completed – Disaster Recovery testing and the installation of a new firewall.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q3 (April-June) The 2026 Network Security Audit and Assessment was conducted. Preliminary findings were shared at the conclusion of the on-site portion of the review. Formal draft reports were received, and an exit conference was conducted. There have been internal discussions and discussions with the Managed Service Provider regarding audit follow-up items. **Q4 (July-Sept):** At the July 17th PIHP Board meeting, an executive summary of the 2026 Network Security Audit and Assessment was presented. A new workplan was created to better track Network Security Audit and Assessment remediation items. Weekly project status meetings were scheduled. The team of staff from Region 10 and Endeavor IT discussed status of projects and prioritizing tasks. **Evaluation:** While there was progress on remediating some audit findings, not all repeat findings were addressed prior to the end of FY2026. However, the team of staff from Region 10 PIHP and the IT MSP will continue weekly project status meetings for the remainder of Calendar Year (CY) 2026 to ensure completion of remediation activities and related projects.

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/ Department/ Committee</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td>Barrier Analysis: There was not consistent traction on remediating all audit findings.
Next Steps: For FY2027, a new IT Committee will be established under Region 10 PIHP's QAPIP structure. The IT Committee had its first meeting in September 2026 and approved goals and responsibilities for FY2027. The first goal of the IT Committee will be to complete remediation activities to address priority, repeat citations from the 2026 Network Security Audit and Assessment by December 31, 2026. The second goal of the IT Committee will be to complete a business impact analysis, risk assessment, incident response plan, and business continuity plan by September 30, 2027.</td></tr>
<tr><td>Customer Service Inquiries</td><td>• To review and analyze baseline customer service inquiry data for the region for FY2026.
o To track and trend internally the customer service inquiries on a monthly basis.
o Identify consistent patterns related to customer service inquiries.
o Develop interventions to address critical issues within the Network.

Reporting Period: FY2026<table><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr><tr><th></th><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr><tr><td>GHS</td><td>9</td><td>2</td><td>7</td><td>4</td><td>0</td><td></td><td>22</td></tr><tr><td>Lapeer</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td><td></td><td>2</td></tr><tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr><tr><td>Sanilac</td><td>3</td><td>0</td><td>0</td><td>1</td><td>0</td><td></td><td>4</td></tr></table></td><td>Erin Goodman/ Tom Seilheimer

PIHP Customer Service Department</td><td>Q1 (Oct-Dec):
There was a total of eighteen (19) customer service inquiries in Q1, this is a decrease from FY25 Q1, which was twenty-eight (28).

Q2 (Jan-Mar):
There was a total of eight (8) customer service inquiries in Q2, this is a decrease from FY25 Q2, which was twenty-eight (28).

Q3 (April-June):
There were a total of twelve (12) customer service inquiries for FY26 Q3. One (1) customer service inquiry resulted in two (2) inquiry resolution (appeal & grievance). This is a decrease from FY25 Q3 which had eighteen (18).</td></tr>
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<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/ Department/ Committee</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td>St. Clair</td><td>1</td><td>1</td><td>0</td><td>2</td><td>0</td><td></td><td>4</td></tr>
<tr><td>SUD</td><td>6</td><td>4</td><td>5</td><td>0</td><td>2</td><td></td><td>17</td></tr>
<tr><td>TOTAL</td><td>19</td><td>8</td><td>12</td><td>7</td><td>3</td><td></td><td>49</td></tr>
<tr><th colspan="7">Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>11</td></tr>
<tr><td colspan="7">Grievance</td><td>8</td></tr>
<tr><td colspan="7">Referral to Access</td><td>1</td></tr>
<tr><td colspan="7">Rights Complaint</td><td>0</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>19</td></tr>
<tr><td colspan="7">Other</td><td>4</td></tr>
<tr><td colspan="7">Pending</td><td>1</td></tr>
<tr><td colspan="7">Unable to Reach</td><td>6</td></tr>
</table>
</td><td></td><td>Q4 (July-Sept):
There were a total of twenty (20) customer service inquiries for FY26 Q4. This is an increase from FY25 Q4 which had nineteen (19).

Evaluation: The goal has been met. The Customer Service Department has tracked and reviewed trends related to customer service inquiries monthly. No critical issues were identified; therefore, no interventions were developed.
Barrier Analysis: None identified.
Next Steps: Develop FY27 goals.</td></tr>
<tr><td>Appeals</td><td>

To review and analyze baseline appeals data for the region for FY2026.

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

<table>
<tr><th colspan="8">Reporting Period: FY2026</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>3</td><td>0</td><td>2</td><td>2</td><td>0</td><td></td><td>7</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td></td><td>2</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td></td><td>2</td></tr>
</table>
</td><td>Erin Goodman/
Tom Seilheimer

PIHP Customer Service Department</td><td>Q1 (Oct-Dec):
There were two (2) appeals in Q1, this is a decrease from FY25 Q1, which had four (4) appeals.

Q2 (Jan-Mar):
There was one (1) appeal in Q2, this is the same from FY25 Q2, which had one (1).

Q3 (April-June): There were a total of five (5) appeals in FY26 Q3. This is an increase from FY25 Q3 which had three (3).

Q4 (July-Sept): There were a total of six (6) appeals for Q4. This is an increase from FY25 Q4 which had three (3).</td></tr>
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<tr><td></td><td>
<table>
<tr><td>SUD</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td>TOTAL</td><td>3</td><td>1</td><td>5</td><td>2</td><td>2</td><td></td><td>13</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Service Denial</td><td>11</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>1</td></tr>
<tr><td colspan="7">Service Suspension</td><td>0</td></tr>
<tr><td colspan="7">Service Termination</td><td>1</td></tr>
</table>
</td><td></td><td>Evaluation: This goal has been met. The Customer Service Department has tracked and reviewed trends related to appeals monthly. No critical issues were identified and therefore, no interventions were developed.
Barrier Analysis: None identified
Next Steps: Develop FY27 goals.</td></tr>
<tr><td>Grievances</td><td>

To review and analyze baseline grievance data for the region for FY2026.

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: FY2026</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th></th><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>2</td><td>1</td><td>1</td><td>n/r</td><td>n/r</td><td>n/r</td><td>4</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td>n/r</td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>n/r</td><td>n/r</td><td>n/r</td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>1</td><td>n/r</td><td>n/r</td><td>n/r</td><td>1</td></tr>
<tr><td>St. Clair</td><td>0</td><td>3</td><td>0</td><td>n/r</td><td>n/r</td><td>n/r</td><td>3</td></tr>
<tr><td>SUD</td><td>5</td><td>1</td><td>2</td><td>0</td><td>0</td><td>n/r</td><td>8</td></tr>
<tr><td>TOTAL</td><td>7</td><td>5</td><td>4</td><td>0</td><td>0</td><td>n/r</td><td>16</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
</table>
</td><td>Erin Goodman/
Tom Seilheimer

PIHP Customer Service Department</td><td>Q1 (Oct-Dec):
Thus far in Q1 the PIHP has received four (4) grievances. The PIHP will not receive Q1 grievance data from the CMH Network until January 15th. This data will be provided in the February Quality Improvement Committee (QIC) meeting with all data received.

Q2 (Jan-Mar):
Thus far in the second quarter, the PIHP has received one (1) grievance. The PIHP will not receive Q2 grievance data from the CMH Network until April 15th.

Q3 (April-June):
In FY26 Q3, the PIHP received two (2) grievances. The PIHP will not receive Q3's grievance data from the CMH Network until July 15th. This data will be provided in July's Quality Improvement Committee (QIC) meeting with all data received.

Q4 (July-Sept): There has been zero (0) grievances in FY2026 September. The CMH</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
	Quality of Care: 4 Service Concerns / Availability: 8 Service Environment: 1 Suggestions / Recommendations: 0 Interaction with a Provider or Plan: 3		Network Q4 data will not be received until October. This grievance data will be reported in November's Quality Improvement Committee (QIC) meeting with all data received. **Evaluation:** This goal has been met. The Customer Service Department has tracked and reviewed trends related to grievances monthly. No critical issues were identified and therefore, no interventions were developed. Unable to compare grievance volumes due to not having Q4 data from CMH Network at the time of evaluation. **Barrier Analysis:** None identified. **Next Steps:** Develop FY27 goals.
Financial Management	• Modify processes and procedures to align with MDHHS changes with CCBHC reporting and oversight. Activities include: o Updating financial reports. o Educating CFOs on costing practices. o Tracking results.	Chief Financial Officer Finance Committee	**Q1 (Oct-Dec):** Deputy CFO and Finance Director continue to work with CMHSPs during December on reporting for FY26. Two of the four CMHs are waiting for PCE updates in order to provide the PIHP with accurate information. **Q2 (Jan-Mar):** Region 10 received the financial statements from each CMH for YTD through January. We have noted some variances from budget and have reallocated additional funds to Sanilac CMH and St. Clair CMH based on additional requests. This may need to be done again if CCBHC reporting challenges result in changes.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q3 (April-June): Discussion at June CFO and QAPIP meeting. **Q4 (July-Sept):** Discussions continue. CMHS still monitoring CCBHC services to ensure they are reported correctly. **Evaluation:** Ongoing analysis is needed. **Barrier Analysis:** No barriers were identified. **Next Steps:** Continue data review throughout year end reporting.
Financial Management	• Update CMHSP monthly reporting to implement the following: o A narrative component. o A comparison between budget amounts and actual trends.	Chief Financial Officer Finance Committee	**Q1 (Oct-Dec):** November reports were delayed as the CMHSPs are working through PCE changes. **Q2 (Jan-Mar):** Region 10 received financial statements from each CMH for YTD through March. We have noted some variances from budget and have reallocated additional funds to Sanilac CMH and St. Clair CMH based on additional requests. This may need to be done again if CCBHC reporting challenges result in changes. **Q3 (April-June):** Discussion at June CFO and QAPIP meeting.

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			Q4 (July-Sept): Discussions continue at the monthly Finance meetings with the CMHs. We noted additional fluctuations in budget to actual results in August financials. We will continue to monitor the results throughout the year-end close process. **Evaluation:** Ongoing analysis is needed. **Barrier Analysis:** No barriers were identified. **Next Steps:** Continue data review throughout year end reporting.
Financial Management	• Enhance financial reporting mechanisms for substance use disorder (SUD) programs. Activities include: o Budget to actual reporting by grant for management o Budget development and reporting based on strategic goals and available funding o Update and implement SUD block grant waitlist, as needed o Standardize SUD Oversight Policy Board Reporting	Chief Financial Officer Finance Committee	**Q1 (Oct-Dec):** We continue to work on Block Grant management and SUD reporting. The CFO or Deputy CFO have been reporting monthly grant expenses to the SUD oversight Board, with the November report being presented at the January 6th meeting. **Q2 (Jan-Mar):** In January, the Deputy CFO reported additional SUD reports to management team and met with SUD oversight board to provide further analysis on budget to actual spending. Throughout the quarter, maintained reporting requirements for SUD Oversight Policy Board. Finance will review budget to actual reporting for both Grants and Operations to address differences and

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
			discuss with Management at the April 13th meeting. **Q3 (April-June):** Review Financials with management, but the oversight policy board did not meet. **Q4 (July-Sept):** The Deputy CFO presented the Financials monthly, and the SUD Director, presented FY26 PA2 requests related to retention payments for providers, as well as the FY27 PA2 requests at the 9/1/26 SUD Oversight Board Meeting. **Evaluation:** Significant improvement in understanding of SUD overall financial topics. **Barrier Analysis:** None noted. **Next Steps:** Ongoing monthly reporting.



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As of 09.30.2026