REGION 10 PREPAID INPATIENT HEALTH PLAN



FY2027 Quality Improvement Program Description & Workplan
October 2026

This report describes Region 10 PIHP's Quality Assessment and Performance Improvement Program (QAPIP). Included are a written description of the Quality Improvement (QI) Program, the QAPIP organizational structure, and the QI Workplan including goals for FY2027.

I. Written Description of the PIHP Quality Improvement Program

A. Organizational Structure:

The Region 10 PIHP has responsibility for oversight and management of the regional PIHP. This responsibility includes approving and monitoring the region's QAPIP.

The Quality Assessment and Performance Improvement Program policy delineates the features of the Quality Improvement (QI) Program for both the PIHP and its provider network. The PIHP manages its provider network of SUD Providers and four Community Mental Health agencies. Each CMH has accountability to how it implements the PIHP's QI Program within its designated catchment area.

To implement the QI Program, the PIHP Board has established a Quality Improvement (QI) Committee. The QI Committee assures that its sub-structure is aligned with the mandates and improvement priorities of the PIHP Board. The PIHP Medical Director provides clinical input, feedback, direction, and oversight to the QI Program. The Chief Clinical Officer (CCO) provides operational direction and oversight leadership to the QI Program and the QI Committee. The QI Committee is composed of core members including PIHP Chief Executive Officer, PIHP Medical Director, PIHP Chief Financial Officer, PIHP Chief Operations Officer, PIHP Chief Information Officer, PIHP Chief Clinical Officer (Clinical PhD), PIHP Administrative Directors, PIHP Compliance Officer, and QAPIP Committee Chairs. The QAPIP Committees consist of the following designated areas: Compliance Committee, Finance Committee, Improving Practices Leadership Team, Information Technology Committee, Privileging & Credentialing Committee, Provider Network Committee, Quality Management Committee, Sentinel Events Review Committee, and Utilization Management Committee.

Functional areas of the QI Program are detailed through assigned QI Program Standing Committees. The Compliance Committee focuses on regulatory compliance as well as corporate compliance issues to ensure service provision in network as required. The Finance Committee focuses on budget and funding issues to provide good management of the PIHP network. The Improving Practices Leadership Team develops and monitors clinical service areas such as clinical practice guidelines, evidence-based practices, care integration processes, home and community-based services transition planning to ensure quality of clinical care, safety of clinical care, quality of service, and enhance members' experience. The Information Technology Committee focuses on addressing findings from the Annual Network Security Audits and Assessments, along with monitoring security risks and reviewing the annual IT budget. The Privileging & Credentialing Committee focuses on ensuring network practitioners and providers have the appropriate qualifications to provide services to ensure safety and quality of clinical care. The Provider Network

Committee focuses on contract compliance to ensure services are provided as required and that the network is adequate to ensure provision of services. The Quality Management Committee focuses on performance indicator data, conducting and analyzing satisfaction survey data, oversight of performance improvement projects, and monitoring QI plans to ensure quality of services, and evaluate members' experience. The Sentinel Events Review Committee focuses on reviewing and monitoring critical and sentinel events to ensure safety of clinical care, and quality of service. The Utilization Management Committee focuses on service utilization within the network to ensure quality and safety of clinical care and quality of service.

Many committees include representatives from the PIHP and each CMH Affiliate. These health care practitioners provide direct input on the QI Program through their assigned committee. The Committees meet on a designated frequency, with most meeting monthly. Each committee member participates fully in their committee(s), including developing goals to address in the annual work plan, working on assigned tasks to meet goal performance objectives, reporting to committee monthly on improvement activities, evaluating progress towards goals, determining actions to be taken to meet objectives, identifying potential barriers to achieving targets, providing feedback, and identifying additional opportunities for improvement efforts.

The QI Standing Committee members report directly to their specific Standing Committee. The Standing Committee Chair completes a monthly status update which is discussed at the monthly Quality Improvement Committee (QIC) meeting. Any recommendations from Standing Committees are reviewed and appropriate action is taken by the QIC. Written reports of the status of each goal within the QI Annual Workplan are presented to the Governing Body (PIHP Board of Directors) quarterly. The PIHP Board approves any modification to the QI Workplan. The quarterly and annual QI Program Plan performance reports are prepared by the Quality Management Department.

Resources and analytical support are provided to the QI Program from several sources. The Electronic Medical Record software (MIX) contains service data, encounter claims data, demographic data and standardized reports. CareConnect 360 is a web-based system containing service data (both Behavioral Health and Physical Health) for persons with Medicaid. The Michigan Department of Health and Human Services (MDHHS) provides downloads of encounter and demographic data regularly and upon request. The PIHP has contractual relationships with TBD Solutions to provide analytic support and training to the PIHP.

The organization delegates administration of the Consumer Satisfaction Survey to the CMHs/SUD Providers. The CMHs/SUD Providers report the data up to the PIHP for analysis and compilation into the annual report.

Many of the goals in the annual QI Workplan are collaborative in nature as the CMH practitioner standing committee members work to achieve goal objectives within their CMH systems. For example, the QMC provides oversight to the Performance Improvement Projects (PIPs), but the CMH systems develop and work on the goal areas to implement the PIPs. The practitioner CMH representatives on the QM Committee develop action plan goals, identify barriers to implementation, work to bring compliance to the set target within their individual CMHs, and report back to the Committee on the progress made towards achieving the target within their organizations. Communication and feedback mechanisms are both formal (Committee reporting) as well as informal (i.e., discussing the project via conference

calls or email). Then the results and actions taken are compiled into a region-wide report on the PIP.

To ensure direct customer involvement and participation in the PIHP's Quality Improvement Program, the PIHP Board has identified Consumer Advisory Councils within its county/catchment area. QI Plan and status reports are regularly communicated and discussed.

The QI Program includes objectives to serve a diverse membership by reducing health care disparities in clinical areas and by improving the network adequacy to meet the needs of underserved groups. The organization strives to improve quality and safety of clinical care, quality of services, and members' experiences for members with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions.

The PIHP evaluates the overall effectiveness of the QI program annually. The evaluation reviews all aspects of the QI program with emphasis on determining whether the program has demonstrated improvement in the quality of care and services provided to customers. The QI Department develops an annual written report on quality, including a report of completed QI activities, trending of clinical and service indicators and other performance data, and demonstrated improvements in quality. This report is presented to the QI Committee and the PIHP Board for review and approval.

An Organizational Chart of the organizational model for the PIHP and its QI Program structure is included in this plan.

B. Components and Activities:

Annually, the PIHP Board reviews and approves the Quality Improvement (QI) Program Plan for the network. The QI Program Plan includes the following two components: (1) a detailed narrative description of the overall Quality Improvement Program; and (2) an annual Quality Improvement Workplan (referred to as the QI Plan) that addresses ongoing QI activities and contains the PIHP Board's prioritized goals, improvement strategies and anticipated outcomes designed to improve the PIHP's overall systemic processes. The QI Workplan details the Standing Committees' goals which are designed to improve quality of clinical care, safety of clinical care, quality of service, and members' experience. The goals describe the timeframe for completion, responsible staff for each activity, monitoring of previously identified issues, and evaluation of the QI Program. The QI Workplan is a dynamic document and is updated annually or more frequently as needed. The PIHP Quality Management staff are responsible for overall evaluation of the QI Program's success and for providing mid-year status updates.

The PIHP's QI Program includes the following items:

- Design and planning, performance measurement, intervention strategies, and outcome evaluation are the primary components of the PIHP quality improvement process. Quality improvement activities are determined by the PIHP's mission, vision, contractual requirements, strategic plan, and historical data for the region. Along with standards of care and markers developed from external data sources (e.g., reports, accreditation standards, state and federal reports), improvement activities occur in response to customer needs, safety of

clinical care issues, ethical guidelines, cultural considerations, clinical standards, and good business practices.

- Indicators: the activities, events, occurrences, or outcomes for which data are collected which allows for the tracking of performance and improvement over time. The quality indicators employed are objective, measurable, and based on current knowledge and clinical experience to monitor and evaluate key aspects of care and service.

- Performance goals: the desired level of achievement of the standard of care and benchmarks for measuring the best performance for an indicator.

C. Roles for Recipients of Service:

Customer participation and involvement in the development and ongoing monitoring of the PIHP's QAPIP is critical and occurs through a three-tiered model.

First, at the policy-level, of the fifteen PIHP Board members, no less than one-third of the membership are recipients of service and/or their family member representatives. This framework provides for direct customer involvement in QI Program policy setting and goal prioritization. Second, the PIHP has designated Consumer Advisory Councils within all counties that provide direct input and feedback on critical program plan and development areas. Third, individuals directly participate on the PIHP's committees and monitoring activities.

In addition to the above direct involvement, input is also obtained through a variety of satisfaction surveys used to make system and service changes to respond to identified needs.

D. Mechanisms for Adopting and Communicating Process and Outcome Improvements:

Communication processes occur through four (4) primary mechanisms within the PIHP's organizational structure.

First, the PIHP Board ultimately establishes the PIHP's Quality Improvement (QI) Program and its annual program description and plan, which includes prioritization of each fiscal year's improvement activities. Semi-annual and annual reports are provided to the PIHP Board on the QI program status and outcomes. These reports are also communicated with the QI Committee, Consumer Advisory Councils, and key stakeholder and community advocacy groups.

Second, the QI Committee, through the standing committees, is an integral part of the QI Program communication process. Opportunities for quality improvement activities and outcome status reports are discussed at the monthly QI Committee meetings. Improvement activities can arise from the discussion of problem areas, or from the identification of new processes that need to be improved. Each committee has assigned annual performance goals/indicators that are a part of the overall QI plan, as approved by the PIHP Board. These goals become the primary committee goals for the upcoming fiscal year.

Third, customer input into the QI Plan, and on-going review of status reports (semi/annually), are an important communication mechanism within the PIHP's

quality improvement program. This occurs through the PIHP's designated Consumer Advisory Councils, SUD Advisory Boards, and the PIHP Board of Directors.

Fourth, MDHHS, as the principal payer, has direct input into the PIHP's QI Program. Annually, two State-mandated Performance Improvement Projects are prioritized and implemented through the PIHP provider network. These improvement projects are led by PIHP staff and assigned to the Quality Management Committee for design and implementation methodology. Progress reports on these projects are submitted to the PIHP Board and MDHHS on a semi-annual basis. Information on these project results is then communicated to the various CMH Boards, Consumer Advisory Councils, and community advocacy groups that work with the PIHP and its provider network.

II. Governing Body Responsibilities

A. Oversight of QI Program:

As stated earlier, the Region 10 PIHP Board has ultimate oversight for the PIHP's QI Plan. Annually, the PIHP Board is charged with the responsibility for the approval and monitoring of the PIHP's Quality Improvement Plan.

Management of the region's QI Program implementation is done by QI Committee. In this manner, it is the QI Committee that develops the committees, and then provides direct oversight of the network's staff to achieve the plan. The QI Committee also evaluates periodic status reports on plan progress. Status reports are provided to the PIHP Board on a semi-annual and annual basis.

B. QI Plan Progress Reports:

A plan is created annually that directs the activities that are the focus of Quality Improvement efforts for the coming year. Region 10 PIHP QI Committee monitors progress on planned quality improvement activities, through each committee's meeting minutes/report.

Quarterly, the PIHP's Quality Management staff prepare a QI Workplan Report. This report is shared with the PIHP Board, QI Committee, and various customer/interested parties and community stakeholders. The report is also posted on the PIHP website for public viewing.

C. Annual QAPIP Review Report:

At year-end, the PIHP's Quality Management staff prepare an annual report that summarizes the PIHP's QI Program efforts for the year, including QI Plan results. This report is shared with the PIHP Board, Consumer Advisory Councils, QI Committee, CMH Provider Network, SUD Provider Network, MDHHS, and various customer / interested party and community stakeholders. The report will be posted on the PIHP website for public viewing.

D. Submission to MDHHS:

Once reviewed / approved by the PIHP Board, the Annual QI Program Report is sent to MDHHS along with a list of the PIHP Board Members. The annual submission will also include materials to demonstrate the implementation of Performance Improvement Projects.

III. Designated Senior Officials:

The Region 10 PIHP Chief Executive Officer has the overall responsibility to the Region 10 PIHP Board for the QI Program. Additionally, the PIHP Medical Director provides direct clinical oversight and medical supervision of the QI Program Plan. The Chief Clinical Officer (CCO) provides day-to-day guidance on clinical initiative, clinical issues, and interventions implemented by the PIHP, accepting questions and reviewing progress of the clinical initiatives for direction in consultation with the Medical Director.

IV. Active Participation of Providers and Customers

Both providers and customers are encouraged to contribute suggestions relating to potential areas for investigation and/or improvement. Individuals receiving services have membership on Consumer Advisory Groups which provide formal opportunities for participation.

The PIHP utilizes a variety of mechanisms to identify important areas for improvement and to set meaningful priorities. The voices of its customers are legitimate sources of information in formulating quality improvement efforts, and customer satisfaction is indicative of quality services. The monitoring and evaluation of important aspects of care includes services provided to high-volume and high-risk customers.

In addition to seeking input from its customers, the PIHP solicits input from providers and stakeholders. Information gathering is used to determine satisfaction among these groups and identify methods of addressing concerns and fostering increased satisfaction.

V. Performance Measurement

A. State Performance Measures

The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. As required by MDHHS, the PIHP and Affiliates participate in the Michigan Mission-Based Performance Indicator System (MMBPIS) and the Michigan Behavioral Health Quality Program. All four CMHs submit their performance indicator reports independently to the PIHP. For the SUD system, performance indicators are reviewed ongoing and prepared by PIHP staff. The PIHP reviews data and aggregates all data to report to MDHHS as required.

A crucial part of the member satisfaction / data collection piece involves striving to surpass the benchmarks set for indicators established by the MDHHS in the area of access. Indicator data is submitted to MDHHS on a quarterly basis.

B. Other Performance Indicators

Other key performance indicators are evaluated and monitored through the QI Program, including items such as utilization management and Evidenced Based Practices. Each CMHSP has tools for promoting compliance with performance indicators which is monitored by the PIHP.

C. Clinical and Safety Initiatives

Region 10 PIHP focuses on clinical initiative to improve the safety of clinical care and service provided to the member. Region 10 PIHP conducts robust Coordination of Care initiatives, and annually conducts needs assessment studies for individuals with Serious and Persistent Mental Illness (SPMI) who have multiple medical issues, identifying participants, enrolling them in the Complex Case Management program, and assessing for specific care the member needs.

VI. QI Program Utilization to Assure Achievement of Performance Levels

The system for assuring QI Program implementation is two-fold: (1) Utilization of the PIHP's QI Committee and its designated committees charged with QI Program implementation; and (2) The PIHP's sub-contract compliance monitoring process of the PIHP's provider network to ensure quality improvement efforts have been implemented.

The QI Committee ensures that the QI Program remains in the forefront of the PIHP's improvement efforts, by meeting monthly and receiving reports from each Committee on goal status. Key issues and action items are addressed at each QI Committee meeting.

Secondly, each PIHP contract with providers includes specific performance and outcome requirements that are reviewed in the contract monitoring process. Monitoring is a collaborative effort between PIHP staff and the provider staff to monitor and assure quality of care on a regular basis. Policies and audit tools have been developed by staff to guide the monitoring and evaluation process.

The PIHP reports on performance via a quarterly Performance Indicators Report. This series of tables provides performance data on several indicators related to access, efficiency, and outcome measures. The QI Committee assures that quality measurements are in place to continuously monitor performance and to identify problems as they arise. This information is shared with management at the PIHP and the provider agencies on a regular basis.

Specific problem analysis is conducted as requested or as problems are identified in the monitoring process. Also, if a set performance benchmark is not achieved for the region, the indicator is investigated further by various committees within the QAPIP structure such as Quality Improvement Committee, Quality Management Committee, and Improving Practices Leadership Team to increase input from CMH partners, identify contributing factors and systemic issues for the outliers, and review opportunities for improvement across the region. These processes allow the PIHP to assure minimum performance levels on performance indicators are met and that causes of negative statistical outliers are analyzed when they occur.

Lastly, quarterly and annual reports are made available to the PIHP Board, QI Committee, Consumer Advisory Councils and key community interest groups, and they are posted on the PIHP web site for public viewing.

VII. Performance Improvement Projects

Performance improvement projects will be included in the QI Program that focus on achieving demonstrable and sustained improvement in both clinical and non-clinical

services which are likely to have beneficial effects on health outcomes and customer satisfaction.

A. Clinical and Non-Clinical Projects

Clinical areas to be targeted include integration of physical health care information for treatment. Non-clinical areas include administrative data collection methodology related to the integration of physical health care information.

B. Project Topics

Selection of project topics will be based on requirements from MDHHS with a focus on the integration of physical health care data. The prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed will also be part of the selection criteria. The Quality Management Committee (QMC) provides oversight to the Performance Improvement Projects. Project topic selection includes consultation with QMC members.

C. State- and PIHP-Established Aspects of Care

Aspects of care established by the State and PIHP will be used to identify performance improvement projects.

D. Number of Projects Undertaken During the Waiver Renewal Period

The PIHP will engage in a minimum of two projects during the waiver renewal period.

Improvement Project #1
This PIP topic is on racial/ethnic disparities in access-to-service-engagement with Substance Use Disorder (SUD) services. Improvement activities are aimed at reducing the rate of disrupted access-to-service-engagement for persons (Medicaid members and non-Medicaid persons) served within Region 10.

Improvement Project #2
The goal of this PIP is to increase the rate of screening for depression across Adult and Child populations such that it becomes a systematic, routine clinical task. If screening results are clinically significant, these will be addressed within the person-centered planning process.

E. Methodology

Improvement Project #1
The root cause analysis process included the completion of the Five Whys method, a Fishbone Diagram, and a flowchart/process map of the current referral and intake process. In conjunction, a barrier analysis was completed (Kittle, Bonnie. 2017. A Practical Guide to Conducting a Barrier Analysis (2nd ed.). New York, NY: Helen Keller International). The barrier analysis was initiated by a representative group of SUD program leaders and PIHP Access staff via brainstorming and round robin techniques, followed by cluster analysis. Cluster analysis findings were further discussed by PIHP staff, and an SUD program network survey was developed to further explore potential key service access barriers.

The SUD program network survey was distributed to a representative group of SUD subject matter experts (persons-served and SUD program service staff). Survey

analyses generated a comprehensive range of barriers, both in terms of identified Individual (persons-served) Factors and Program (staff/program service delivery) Factors. A follow up barrier analysis survey was developed, and, per point-in-time methodology, this survey was administered to all available subject matter experts. Quantitative data obtained from the barrier analysis survey were analyzed across both barrier analysis Factors and racial/ethnic groups. The barrier analysis identified four significant barriers. Findings from the root cause analysis / barrier analysis activities described above informed the development of service systems improvement action plans.

Objectives of the developed interventions include create/strengthen caller engagement and commitment during the Access screening, expand transportation resources, improve SUD program appointments scheduling capacity and processes, and support SUD program intake and service provision innovations.

Improvement Project #2
This PIP topic was approved by MDHHS toward the end of FY2026. During FY2027, the PIP Design (steps one through six of the PIP Validation Tool) will be completed for this PIP.

VIII. Review and Follow Up of Sentinel Events

A. Ensuring Appropriate Action

The Region 10 PIHP Sentinel Events, Critical Incidents, and Risk Events Policy 07.01.03 establishes the guidelines for reporting and reviewing possible Sentinel Events, Critical Incidents, and/or Risk Events. The policy states that the PIHP will conduct administrative reviews and follow-up of Sentinel Events per the following:

1. The PIHP Chief Executive Officer will provide PIHP oversight to local Provider Network review processes and reporting.
2. Recipient Sentinel Events will be reviewed locally by each CMHSP or SUD Provider, through its Medical Director's Office and / or Sentinel Events Review Committee.
3. The PIHP or its delegate has three (3) business days after a Critical Incident occurs to determine if it is a Sentinel Event.
4. Once classified as a sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event.

The local CMHSP / SUD Provider develops an "appropriate response" to a sentinel event that "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring the effectiveness of those improvements" to ensure safety of clinical care and services. This should be completed by the assigned CMHSP / SUD Provider staff and forwarded to the CMHSP/SUD Sentinel Event Review Committee. Following completion of a root cause analysis or investigation, the CMHSP / SUD Provider develops and implements either a) a plan of action or intervention to prevent further occurrence of the Sentinel Event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement, and when and how implementation will be monitored or evaluated.

The local Sentinel Events Review Committee will report Sentinel Event findings to the PIHP for review and analysis, and to document follow-up and system improvement efforts, as required by MDHHS practice guidelines.

The PIHP Sentinel Event Review Committee will conduct review and analysis of sentinel events report, submitted by CMHSP/SUD Providers. The Sentinel Event Review Committee submits periodic summaries and recommendations to the PIHP QI Committee for action response / disposition. The PIHP may require follow-up action on the part of the provider in the form of a Corrective Action Plan / Improvement Plan.

B. Credentials of Reviewers

Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. Sentinel event findings and recommendations are reviewed by the CMH Medical Director, the CMH Office of Recipient Rights, CMH Quality Improvement Committee and the PIHP Medical Director. The CMH and PIHP Medical Directors are physicians.

C. Review of Unexpected Deaths

All unexpected deaths of Medicaid beneficiaries who at the time of their death were receiving specialty supports and services will be reviewed by the Provider. CMHs and SUD Providers have processes for reviewing and analyzing all unexpected deaths. Unexpected deaths are included in mortality reports. Reports are monitored by the PIHP, and the PIHP ensures regional tracking and trending of aggregate mortality data over time. Refer to the PIHP Sentinel Events, Critical Incidents, and Risk Events Policy (07.01.03) for specific review procedures.

D. Immediate Event Notification

Following immediate event notification to MDHHS, the PIHP will submit information on relevant events through the Critical Incident Reporting System.

Following immediate event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

E. Critical Incidents Reporting System

The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of consumer. Critical incidents are submitted to the PIHP by CMHs and SUD Treatment Providers. Critical incidents from residential treatment providers are included. The populations on which these events must be reported differ slightly by type of event. All critical incidents are submitted monthly by the Office of Recipient Rights. Quarterly reports generated via the Critical Incident Reporting System provide initial analyses on critical incident data per critical incident categorical findings. Further analyses are prepared by the PIHP staff regarding relevant clinical and demographic factors, thus, to identify systemic improvement opportunities within the provider programs and provider network. These findings are submitted as systems analysis and improvement recommendations to the CMH Quality Improvement Council (QIC) on a quarterly basis for CMH review, analysis and recommendations. These CMH QIC review dispositions are then submitted to the PIHP QI Committee for quarterly review and final disposition.

F. Risk Events Management

The PIHP has a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. This documentation will be available to MDHHS at site visits. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period; police calls by staff of specialized residential settings, or general (adult foster care) residential homes/settings or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan; and emergency use of physical management by staff in response to a behavioral crisis.

IX. Review of Behavior Treatment Plan Review Committee Data

The PIHP quarterly reviews analyses of data from the Behavior Treatment Plan Review Committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 contact with law enforcement has been used in an emergency. Only techniques that have been approved during person-centered planning by the beneficiary or his/her guardian and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person. CMHs submit quarterly reports to the PIHP. The reports are reviewed and analyzed by the PIHP and discussed during Utilization Management Committee meetings.

X. Periodic Quantitative and Qualitative Assessments of Member Experiences with Services

A. Issues Addressed in Assessments

The purpose of a QI program is to improve the quality of care and service provided to customers. An effective QI program demonstrates that its activities have resulted in significant improvements in the care or service delivered to customers. Improvements of the QI process are demonstrated by improvements in either the processes through which care and service are delivered or in the outcomes of care.

Issues of quality, availability, and accessibility of care are evaluated through periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of customer (beneficiary) experiences with services. The assessments are representative of persons served and supports offered. The PIHP coordinates one quantitative assessment throughout the fiscal year, the Customer Satisfaction Survey. The PIHP delegates qualitative assessments to CMHs/SUD Providers.

B. Actions Resulting from Assessments

The PIHP and Providers will use the assessment results to improve services for customers. Processes found to be effective and positive will be continued, while those with questionable efficacy or low customer satisfaction will be revised using the following:

- Takes specific action on individual cases as appropriate,
- Identifies and investigates sources of dissatisfaction,
- Outlines systemic action steps to follow-up on the finding, and
- Informs practitioners, providers, recipient of service and the governing body of assessment results.

C. Evaluation of the Effects of Actions

Just as the original processes must be evaluated, so do the interventions used to increase quality, availability, and accessibility of care. Therefore, all actions taken because of assessments will be evaluated periodically. Quality Improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

D. Incorporation of Customers in the Evaluation Process

Customers, including those receiving long-term supports or services (LTSS), are included in the Quality Improvement process, as survey participants, as members of Consumer Advisory Councils, and as members of the PIHP Board. In this way customers are incorporated into the review and analysis of information obtained from quantitative and qualitative methods. In the instructions for administering the Annual Customer Satisfaction Survey, CMHSPs are instructed to report survey responses for Medicaid beneficiaries receiving PIHP services. Further, CMHs are asked to include and identify individuals receiving Home and Community Based Services (HCBS).

XI. Monitoring of Clinical Protocols & Practice Guidelines

The PIHP monitors quality of care on a regular basis. All PIHP contracts with providers require that contractors adhere to accrediting bodies, state and federal agency requirements and all relevant regulatory documents.

Clinical protocols and practice guidelines are utilized as a tool to determine eligibility for services and assist in making determinations regarding continued necessity of care. In other words, the PIHP refers to these protocols and guidelines to determine medically necessary supports, services, or treatment for those that they serve.

Adoption Process:

The Region 10 PIHP, via its QI Committee, is the lead entity to develop and maintain up to date clinical Practice Guidelines for the PIHP provider network. The PIHP Medical Director, with the support of the Chair and membership of the Improving Practices Leadership Team, assumes lead for this process. The following criteria are considered when establishing priorities for adopting Clinical Practice Guidelines relevant to the membership: the incidence or prevalence of the diagnosis or condition, the degree of variability in treatment approaches or outcomes for the diagnosis or condition, the availability of scientific and medical literature related to the effectiveness of various treatment approaches, input from Region 10 staff and Physician Reviewers, requests from Practitioners or Members, and evidence-based guidelines that have been developed by recognized sources involving exhaustive review of the literature supplemented by expert consensus when the body of available research literature is not conclusive. The Quality Improvement Committee is responsible for adopting Clinical Practice Guidelines and processes for measuring

adherence with Clinical Practice Guideline recommendations on behalf of Region 10. The final step occurs when the guidelines are posted on the PIHP website for provider use and access.

Development Process:
With the support of the Improving Practices Leadership Team and the direction of the PIHP Medical Director, the Region 10 PIHP staff develops a comprehensive package of practice guidelines that are well researched and well documented in the literature. Prior to adopting a Clinical Practice Guideline from a recognized source with modification, input is gathered from appropriate board-certified Practitioners by presenting the Clinical Practice Guideline and any proposed modifications to network Practitioners for review and comment. To further develop the most effective behavioral health care services and methodologies for those that are served, the PIHP has developed both clinical service protocols, which focus on the type of service to be delivered, as well as diagnostic treatment protocols, which focus on specific evidenced based treatment delivery methodologies for key diagnostic classifications. Additionally, key stakeholders such as providers and users of services are invited to participate. Public review and comment are also an integral piece of the developmental process.

Implementation:
Following a series of clinical trainings and postings on the PIHP website of the most updated clinical protocols and practice guidelines, implementation takes place via the Utilization Management Process. Those staff completing the utilization management reviews are expected to routinely utilize the practice guidelines to assist in determining eligibility, as well as the most effective clinical standards of care. Additionally, all providers should utilize the practice guidelines to assist in ongoing treatment decisions and methods of behavioral health care.

Continuous Monitoring:
PIHP staff under direction of the PIHP Medical Director assume responsibility for continuous monitoring and updating of all practice guidelines and clinical protocols, regarding the latest literature, state/federal rules and regulations, and most effective standards of care. Updates are completed at a minimum of every two (2) years.

Evaluation:
Typically, a 30-day public review, comment, and feedback period takes place for any updates and/or changes to the practice guidelines. Evaluation of adherence to guideline recommendations and effective implementation of the practice guidelines are determined by a structured evaluation process, in part informed by Utilization Management and its case record review process.

XII. Assurance of Practitioner Licensure, Credentialing, Staff Qualification, and Staff Training

The qualifications of Physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed by following the various PIHP guidelines on credentialing as in the PIHP Credentialing and Privileging Policy (01.06.05).

Within this framework, the PIHP credentials all organizational providers under direct contract to the PIHP and its own PIHP behavioral healthcare practitioners.

Conversely, the PIHP has delegated to each CMH the responsibility of credentialing of all organizational providers under direct contract to the CMH; and all behavioral health practitioners employed directly or under contract to the CMH as part of its panel network. The PIHP has delegated to each SUD Treatment Provider the responsibility of credentialing all behavioral health practitioners employed by the provider.

Regarding recredentialing of practitioners, the procedures detailed in the PIHP Credentialing and Privileging Policy (01.06.05) include the review of monitoring and intervention of provider sanctions, complaints, and quality issues pertaining to the provider. The review should include Medicare/Medicaid sanctions, State sanctions or limitations on licensure, registration, or certification, member concerns which include appeals and grievance (complaints) information, and PIHP quality issues. The PIHP Credentialing and Privileging Policy (01.06.05) also includes expectations for recredentialing of organizational providers. During recredentialing of organizational providers, quality of care and contract compliance will be considered. This includes contract monitoring findings, grievance and appeal and recipient rights complaints. Additionally, for organization providers, MMBPIS and other performance indicators, if applicable, shall meet standards or have an accepted Root Cause Analysis and/or Plan of Correction approved by the Provider Network Management Department on file.

All CMHs and SUD Treatment Providers will have Credentialing policies in place that are approved by the PIHP and that cover all behavioral health care practitioners. Providers are also bound by PIHP contract requirements and MDHHS standards to provide training for all new staff and periodic training and staff development activities for all staff. This requirement includes Recipient Rights training. Other specific trainings are designated for non-licensed staff to ensure competency skills.

The PIHP and its Provider Network's Staff Training program will ensure, regardless of funding mechanism (e.g., voucher), that staff possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: educational background; relevant work experience; cultural competence; and certification, registration, and licensure as required by law. A program shall train new personnel regarding their responsibilities, program policy, and operating procedures. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

All PIHP CMHs and SUD Treatment Providers (other than peer recovery and recovery support services when these are provided through a prevention license) are required by contract to be accredited by one of the major healthcare or rehabilitation accreditation bodies and are responsible for ensuring that staff are qualified and trained. Under the established accreditation standards, practitioner licensure, credentialing, staff qualification, and staff training are required. The requirement that organizational providers be accredited (or demonstrate how they meet accreditation standards) as specified in the PIHP Credentialing and Privileging Policy, affords the PIHP with the capacity to provide assurances that all provider staff (including those not specifically privileged via the credentialing process) meet minimum qualifications for providing specific services and have access to adequate training related to services provided within the PIHP network. Assurances that these criteria are met are documented via the Organizational Credentialing and Enrollment process, as well as via the PIHP Contract Monitoring process. Policies, credentials, and documentation concerning these requirements are reviewed during

PIHP contract monitoring audits and during the MDHHS annual site review. This provider requirement is also discussed and reviewed through periodic examination of provider QI Plans and policies that are reviewed and maintained by the PIHP.

XIII. Verification of Medicaid Services

All program and clinical case records will comply with existing standards, rules or interpretative guidelines as defined by the PIHP, MDHHS, and CMS/Medicaid. The PIHP verifies whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors. To conduct these reviews, the PIHP first identifies a sample of individuals (and their services) during the specified quarter. PIHP staff then notify the Providers of the review and include the sample selection along with instructions for document collection and submission. Following the PIHP's review of the submitted supporting documentation, results of the verification process are communicated to the provider in writing.

A. The PIHP has a policy regarding claims verification. An annual plan is developed that outlines the methodology for verification.

B. Annually the PIHP submits a report to MDHHS which contains its methodology for verification and its findings from the process, as well as providing any follow up actions that were taken because of the findings.

In addition to the PIHP's process to conduct claims verification, the PIHP has a process to provide Explanation of Benefits (EOBs) to consumers receiving services.

XIV. Utilization Management Program

The PIHP's Utilization Management (UM) program is an integral part of the PIHP's quality improvement plan. The PIHP's UM program core goals are as follows:

- Prompt and easy access to services and supports for all service recipients.
- Services and supports provided are appropriate for recipients' needs and are neither insufficient nor excessive.
- Services and supports provided are high quality, clinically appropriate, and are the most cost- effective available.
- Coordination among all providers of supports and services.

To ensure the above goals are achieved, the PIHP has developed a comprehensive Utilization Management program for its provider network in the management of its plan benefits.

Oversight of the PIHP's Utilization Management program is provided through two components: (i) The PIHP Medical Director provides clinical oversight and direction of the PIHP's overall UM program and staff; and (ii) The PIHP Chief Clinical Officer operates a Utilization Management Committee to ensure both the PIHP staff and its provider network are following the PIHP's clinical policies and practices.

To achieve its Utilization Management goals, the PIHP engages in several specific UM functions with some items being delegated to an affiliate.

- Eligibility Screening, including Psychiatric Hospitalization pre-evaluation

- Service Authorization
- Utilization Review
- UM Committee: Retrospective Review & Outlier Management
- Development and Maintenance of Standards and Guidelines

These utilization management activities and operating processes are detailed in the PIHP UM Plan which will be approved by the PIHP Board. The UM Plan details the above UM functions performed by the PIHP and any delegated items. The UM Plan includes mechanisms to detect under-utilization and over-utilization. For detected under-utilization and over-utilization, utilization reviews are completed on a sample of cases for specific CMH and SUD Treatment services. Findings and reports are reviewed with the UM Committee.

In addition, for specific procedures on UM processes, please refer to the PIHP Policy Manual.

XV. Provider Network Monitoring

The PIHP annually monitors its provider network, including any affiliates or subcontractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any action items regarding provider network monitoring of its subcontractors. The PIHP conducts formal Annual Contract Monitoring, which consists of desk audit activities and site visits. Performance standards on Contract Monitoring Tools are assessed as either Met, Not Met, or Not Applicable. Plans of correction are required from providers for assessment scores of Not Met.

XVI. Special Targeted Monitoring Activities

The PIHP continually evaluates its oversight of vulnerable people to determine opportunities for improving oversight of their care and outcomes. MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable people and those with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

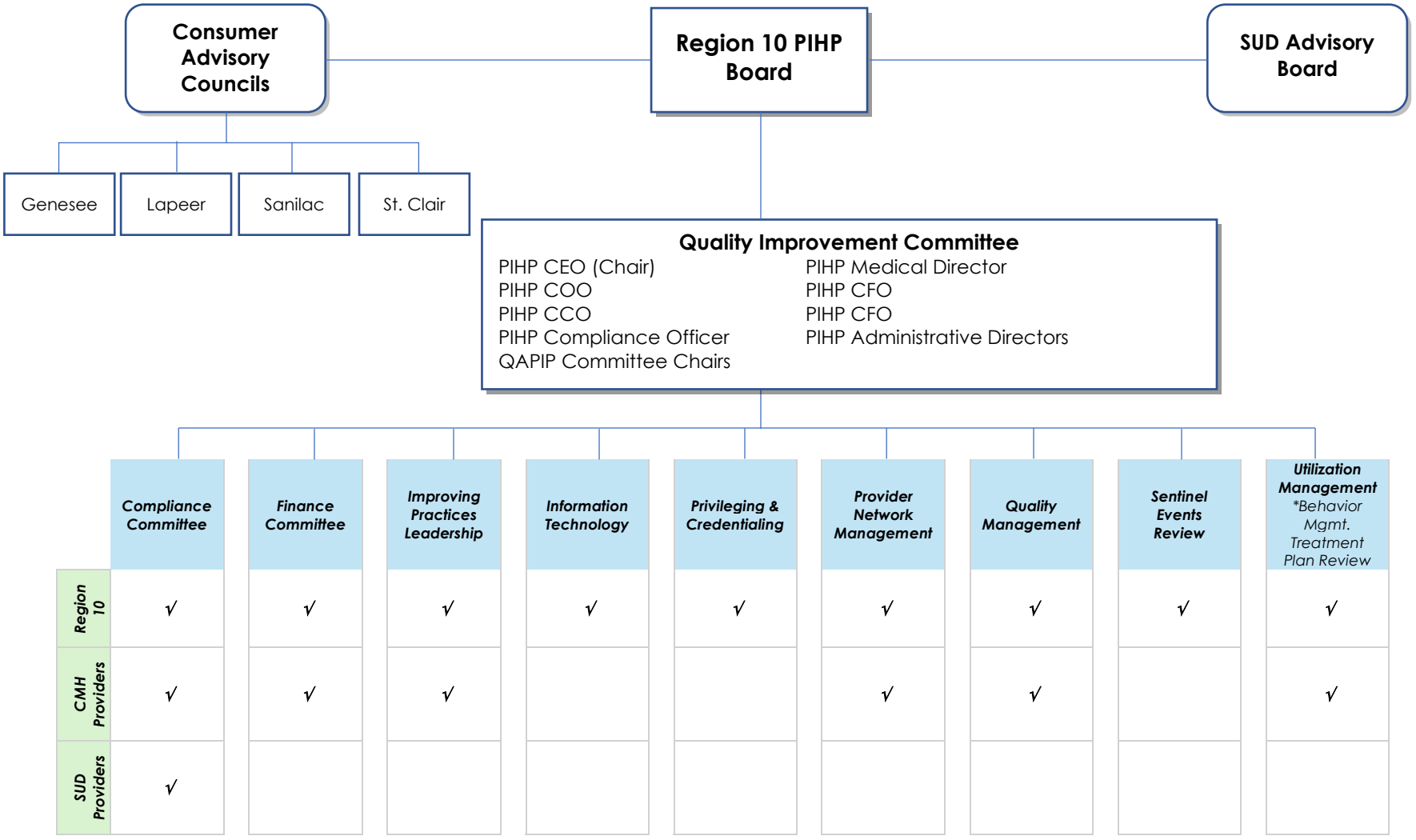
XVII. Long-Term Services and Supports

The PIHP has mechanisms to assess the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS), including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. These mechanisms include periodic reviews of plans of service, utilization reviews, claims verification reviews, clinical case record reviews, and customer satisfaction surveys. These mechanisms are represented within the QI Workplan in the areas of Members' Experience, External Monitoring Reviews, Utilization Management, Autism Program, and Verification of Services.

Additionally, the PIHP has mechanisms to comprehensively 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. These mechanisms include biopsychosocial assessments and ancillary assessments.

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Region 10 QAPIP Organizational Structure



	Compliance Committee	Finance Committee	Improving Practices Leadership	Information Technology	Privileging & Credentialing	Provider Network Management	Quality Management	Sentinel Events Review	Utilization Management *Behavior Mgmt. Treatment Plan Review
Region 10	√	√	√	√	√	√	√	√	√
CMH Providers	√	√	√			√	√		√
SUD Providers	√								

FY2027 Quality Improvement Workplan (October 1, 2026 – September 30, 2027)

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Performance Measures (MMBPIS)	Meet and exceed Michigan's Mission-Based Performance Indicator System (MMBPIS) 50th percentile (57.0%) and 75th percentile (62.0%) performance benchmarks for Indicator #2: Access – Timeliness/First Request.	Brooke Ryan / Divine May Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Performance Measures (BHQT)	Meet and exceed the performance benchmarks for the Behavioral Health Quality Transformation (BHQT) measures established by MDHHS.	Brooke Ryan / Divine May Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Performance Improvement Project 1	Eliminate racial/ethnic disparities in access to SUD services.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Performance Improvement Project 2	Complete the Health Services Advisory Group (HSAG) Validation Report steps 1 – 6 for the new PIP so it is ready for a submission to MDHHS/HSAG.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Members' Experience	Improve satisfaction of members' experiences with services as measured by increased percent scores on the Annual Customer Satisfaction Survey	Divine May Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Members' Experience	Increase the number of responses for the Annual Customer Satisfaction Survey from FY2026 to FY2027.	Divine May Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Electronic Visit Verification	Achieve and maintain the 85% threshold for Electronic Visit Verification (EVV) records for verified visits without manual edits.	Laurie Story-Walker Quality Management Committee (QMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	Complete quarterly monitoring and evaluation reports (CI, RE) and EOY summary reports (CI,RE,SE), including evaluation findings and systems improvement recommendations.	Tom Seilheimer Sentinel Event Review Committee (SERC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Annual Longitudinal Mortality Report	Conduct annual/longitudinal mortality assessment and analysis activities pertaining to causes of death for members, and to identify service system trends and prospective improvement opportunities.	Tom Seilheimer Sentinel Event Review Committee (SERC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Clinical Practice Guidelines Annual Evaluation Report	Complete the Clinical Practice Guidelines Annual Evaluation Report, including evaluation findings and improvement recommendations.	Tom Seilheimer Improving Practice Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Supported Employment Practices	Discuss on a quarterly basis progressive (IPS-related) supported employment practices based on each CMHSP representative sharing information and didactic materials on program activities, concerns, and service improvement opportunities.	Tom Seilheimer Improving Practice Leadership Team (IPLT)/ Employment Services Committee (ESC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Tracking Quality of Life Improvements	Develop a mechanism to longitudinally track and analyze a) quality of life improvement and b) trends in service delivery and health outcomes over time.	Tom Seilheimer Improving Practice Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Integrated Healthcare	Expand CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. Identify eligible members and develop complete monthly Care Coordination meeting agendas for each of the four Community Mental Health and Medical Health Plan partners, using at least 95% of allotted meeting time slots to support timely integrated health care coordination.	Sammy Abdelazim/ Laura Karig Improving Practice Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Home and Community Based Services Assessment Reviews and Monitoring	Complete the implementation of the Home and Community Based Services (HCBS) Transition Plan. Complete timely assessment reviews and monitor documentation and providers for HCBS standards.	Shannon Jackson Improving Practice Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Behavioral Health Home Enrollment	Increase numbers of enrollments in the Behavioral Health Home for participating CMHs.	Shannon Jackson Improving Practice Leadership Team (IPLT)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Committee Review of Credentialing Applications	Complete Privileging and Credentialing reviews of all Organizational (SUD and CMH) and Region 10 staff Practitioner applications.	Grace McGhee Privileging and Credentialing (P&C) Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Monitoring of Delegated Responsibilities	Complete on-going monitoring of the delegated credentialing responsibilities to the CMH and SUD Providers. The P&C team will review organizational credentialing applications and practitioner applications completed by CMH and SUD Providers semi-annually and during Annual Contract Monitoring.	Grace McGhee Privileging and Credentialing (P&C) Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Universal Credentialing	Create and maintain Universal Credentialing CRM profiles for CMH and SUD Providers within our region. Maintain an active subscription to the credentialing profile for all contracted providers.	Grace McGhee Privileging and Credentialing (P&C) Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Verification of services	Complete a Claims Verification Audit to verify if services billed to the PIHP were completed and documented in compliance with PIHP, MDHHS, and other applicable standards.	Sammy Abdelazim/ Grace McGhee Quality Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management Reporting	Complete quarterly monitoring and evaluation reports, including evaluation findings and systems improvement recommendations. • PCE-based Crisis Service Utilization Reports • Behavior Treatment Plan Review Committee Reports • Utilization Reviews of SUD Network Provider Programs and CMHSP OASIS-user affiliates • Monitoring and Advising on delegated Utilization Review Reports from CHIP-user (GHS)	Tom Seilheimer Utilization Management Committee (UMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management Redesign Project	Finalize implementation of the UM Redesign Project.	Tom Seilheimer Utilization Management Committee (UMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Utilization Management Program Plan Evaluation Report	Complete the annual UM Program Plan Evaluation Report, including evaluation findings and systems improvement recommendations.	Tom Seilheimer Utilization Management Committee (UMC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Long-Term Services and Supports	To develop and implement a Long-Term Services and Supports (LTSS) case record review system, 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.	Rosalie Monfette Utilization Management Committee (UMC	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Service Capacity	Address service capacity concerns and support resolution of identified gaps in the CMHSP network on a quarterly basis. • Add a standing Agenda item to follow up on interested providers quarterly	Nancy Scott Provider Network Committee (PNC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Network Adequacy	Develop a uniform regional framework for calculating Network Adequacy Standards as defined by MDHHS to ensure consistent compliance • Establish a collaborative workgroup comprised of PIHP and CMHSP representatives. • Apply methodology to previous FY MDHHS Network Adequacy Results Report to compare workgroup findings to the MDHHS report Follow up with MDHHS regarding any differences in results by end of Q2. • Upon receipt of the annual Network Adequacy Reporting Template, conduct a meeting with CMHSPs to review prior to reporting.	Nancy Scott Provider Network Committee (PNC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Communicate Contract and Policy Updates	Review and discuss Contract and Policy updates. • Add a standing Agenda item to quarterly PNC meetings to discuss any contractual or policy changes.	Nancy Scott Provider Network Committee (PNC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Contract Monitoring	Conduct annual, formal reviews of network providers to ensure ongoing contract compliance. • Collaborate with all PIHP Departments on monitoring process improvement by having at least two (2) meetings with each team. • Visit each network provider on-site to discuss monitoring findings and support resolution of any areas of non-compliance. • Issue plans of correction (POCs) for all areas of non-	Kim Wahl Provider Network Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
	compliance following completion of formal review. • Discuss Aggregate Report findings with the Quality Improvement Committee. • Address identified trends and improvement opportunities.		
SUD Network Adequacy	Review and Address SUD Network Adequacy gaps and capacity concerns. • Continue standing Agenda Item for discussion at all FY27 SUD Treatment Provider Network Meetings. • Issue at least one (1) Request for Proposal (RFP) to address identified gap(s).	Kim Wahl Provider Network Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Strategic Plan	Evaluate ongoing adherence to current SUD Strategic Plan goals and timelines. Update Strategic Plan Workbook quarterly. Conduct quarterly SUD Strategic Plan meetings to discuss findings. • Share findings with QIC and Provider Network.	Kim Wahl Provider Network Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Prevention Fidelity	Monitor and evaluate prevention programs to check fidelity to respective program components. • Visit each contracted Prevention provider at least once in FY27 to conduct a fidelity check.	Peyton Frazer Provider Network Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Autism Services	Monitor and reduce the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services as reported monthly by the CMHSPs.	Grace McGhee Quality Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
MDHHS Annual Site Reviews	Monitor and review performance and corrective action through the MDHHS annual site review which includes the 1915(c) and 1915(i)State Plan Amendment (iSPA). Improve outcomes for the state site review by improving process and through corrective action.	Sammy Abdelazim/ Shannon Jackson Quality Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
HSW Waiver Slot Utilization	Maintain HSW Waiver slot utilization at 95% or higher by monitoring utilization monthly, identifying underutilized slots, monitoring disenrollments, and implementing timely follow-up actions to support full and appropriate use of available waiver capacity.	Laura Karig Quality Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
1915(c) Waivers and 1915(i)SPA Recertification submissions	Submit all required 1915(c) Waiver and 1915(i) SPA recertification materials in accordance with contract policy requirements by tracking recertification due dates, completing required documentation, and submitting materials on or before each established deadline.	Laura Karig Quality Management Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
External Quality Review Corrective Actions	Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. • Standard Leads will report Compliance Review CAP and recommendations updates monthly to the Quality Management Department using specially developed templates. • Recommendations resulting from the Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review will be addressed by the designated lead staff. • Any recommendations resulting from the Encounter Data Validation (EDV) activity will be addressed by the designated lead staff.	Designated Lead Staff for EQR Activities Quality Management Department Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Reports to the Office of Inspector General	Submit Office of Inspector General (OIG)-required reports to the OIG in accordance with guidance documents and by defined due dates.	Lauren Campbell Corporate Compliance Committee (CCC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Compliance Training	Develop and disseminate an updated Compliance Training PowerPoint to the Region 10 PIHP Provider Network.	Lauren Campbell Corporate Compliance Committee (CCC)	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Network Security Audits and Assessments	Complete remediation activities to address priority, repeat citations from the 2026 Network Security Audit and Assessment.	Mike Klemmer Information Technology (IT) Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Business Continuity	Complete a business impact analysis, risk assessment, incident response plan, and business continuity plan.	Mike Klemmer Information Technology (IT) Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Customer Service Inquiries	Collect and analyze baseline customer service inquiry data for the region to identify consistent patterns related to customer service inquiries and develop interventions to address critical issues identified within the network monthly.	Erin Goodman/ Tom Seilheimer PIHP Customer Service Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Appeals	Collect and analyze baseline appeals data for the region to identify consistent patterns related to appeals and develop interventions to address critical issues identified within the network monthly.	Erin Goodman/ Tom Seilheimer PIHP Customer Service Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Grievances	Collect and analyze baseline grievance data for the region to identify consistent patterns related to grievances and develop interventions to address critical issues identified within the network monthly.	Erin Goodman/ Tom Seilheimer PIHP Customer Service Department	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/ Department/ Committee	Status Update & Analysis
Finance	Improve financial knowledge, reporting, and communication between Region10 and the CMHSPs by implementing the following: • Quarterly one-on-one meetings with members of management from both Region10 and the CMHSP, including the CEO, CFO, and operational management. • A documented comparison between budget amounts and actual trends, including written responses • Requests for further CMHSP information, such as internal financial statements that include budget to actual that is sent to their respective boards.	Finance Committee	**Quarterly Update:** **Q1 (Oct-Dec):** **Q2 (Jan-Mar):** **Q3 (Apr-Jun):** **Q4 (Jul-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Region 10 PIHP Board Officers

CHAIRPERSON
Lori Curtiss

VICE CHAIRPERSON
Robert Kozfkay

SECRETARY
Ellen Ellenburg

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Region 10 PIHP Board General Membership

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John Groustra

Ted Hammon

Joyce Johnson

Chad Polmanteer

Nathan Russell

Nancy Thomson

Rev. Dr. Rabon Turner

Jerry Webb

As of 09.30.2026