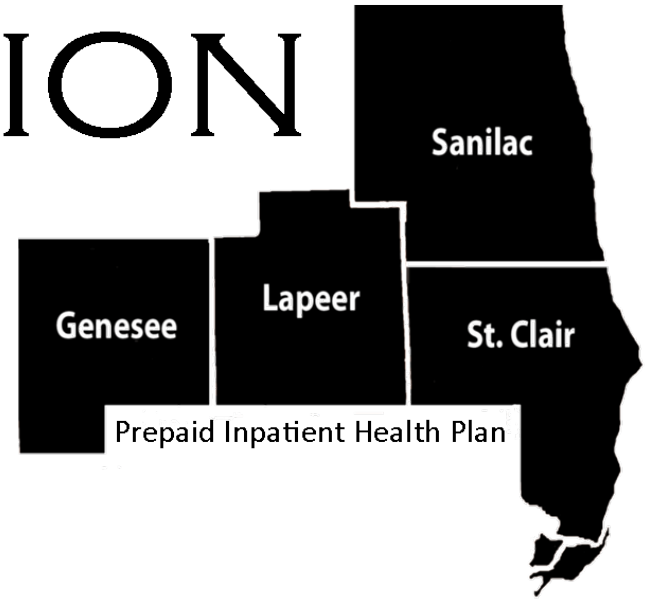
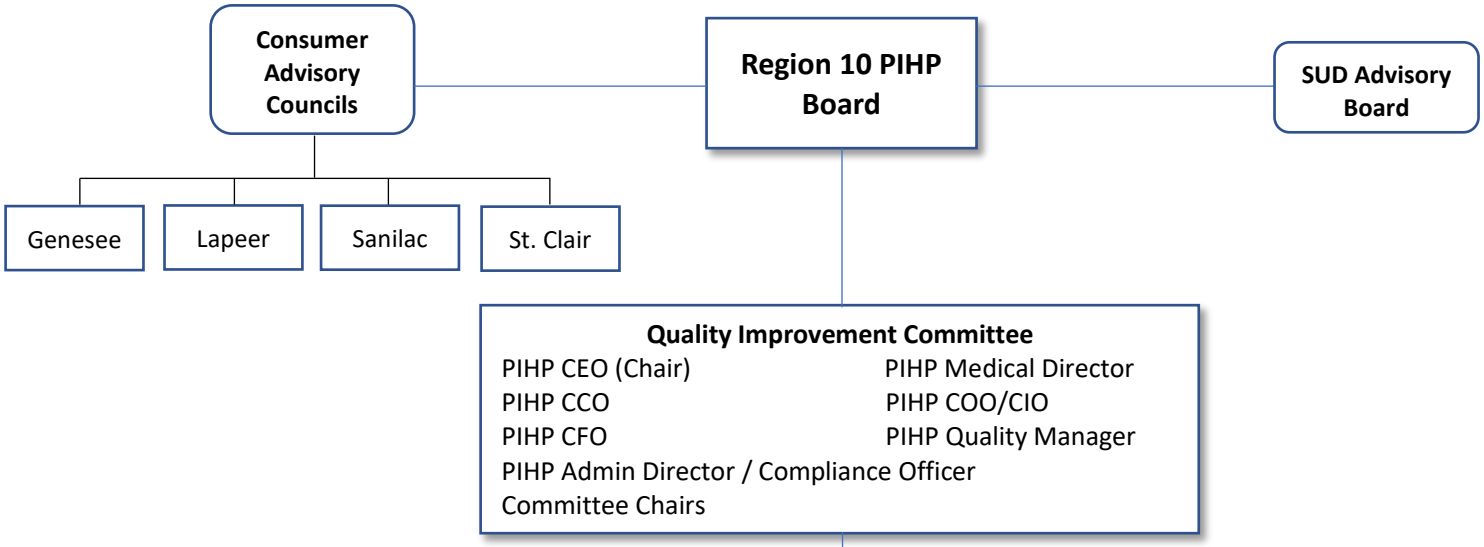
Region 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2021 – Annual Report

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



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

Quality Management Fiscal Year (FY) 2021 Work Plan (October 1, 2020 – September 30, 2021)

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	• Submit FY2020 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020.	• Present the Annual Evaluation to the Quality Improvement Committee. The Quality Improvement Committee will be responsible for providing feedback on the qualitative analysis, proposed interventions and implementation plan. • After presentation to the Quality Improvement Committee the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1 (Oct-Dec):** **The FY2020 QI Program Annual Report was presented and approved by QIC and the PIHP Board at the October meetings. No further action needed.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No update** **Q 4 (July-Sept):** **No update** **Evaluation: Complete** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Program Description	• Submit FY2021 QI Program Description to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020.	• Review the previous year's QI Program and make revisions to meet current standards and requirements. • Include changes approved through committee action and analysis. • Include signature pages, Work Plan, Evaluation, Policies and Procedures and attachments.	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The FY2021 QI Program Description was reviewed and approved by QIC and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No update** **Q 4 (July-Sept):** **No update** **Evaluation: Completed** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Work Plan	• Submit FY2021 QI Program Description to the Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020. • Develop the FY2021 QI Program Work Plan standard by 12/1/2020. • Present the work plan to committee by 12/1/2020.	• Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year. • Prepare work plan including measurable goals and objectives. • Include a calendar of main project goal and due dates	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The FY2021 QI Workplan was reviewed and approved by QIC and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **Responsible staff revised for the QI Program Structure, Monitoring of Quality Areas, Autism Program, and External Quality Review Corrective Action goals.** **Q 3 (Apr-June):** **Responsible staff revised for QI Program Structure goals.** **Q 4 (July-Sept):** **No update** **Evaluation: Completed** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Aligned System of Care	The goals for FY2021 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service.	○ Monitor utilization of the PIHP Clinical Practice Guidelines. ○ Review Evidence-Based Practices and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., IDDT, LOCUS. ○ Monitor and advise on ESC activities to encourage CMHSP a) employment targets, b) standardized employment services data and report formats, and c) share and learn opportunities. ○ Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **EOY CPG Evaluation Report was completed and submitted to QIC.** **GHS LOCUS MIFAST Report was presented, with useful Q/A and discussion.** **St. Clair LOCUS MIFAST review is scheduled for February. EBP discussion also focused on LOCUS state workgroup meeting and regional call for updates and feedback on the FY 2021 R10 LOCUS implementation plan, including the BHDDA launch of the centralized LOCUS training system; November BTPRC Webinar was noted, and participation was encouraged. ESC meeting Minutes were reviewed, noting regional challenges with service provision in the COVID-19 environment; IHC meetings have been taking place as scheduled; HCBS activities are noted in the next section.** **Q 2 (Jan-Mar):** **Members have begun submitting their updated EBPs list, as these will be incorporated in the EOY annual CPG evaluation report.**

		aligned network practices in utilizing the CC360 system. o Monitor and advise on the CMHSP network's work on the continuation and remediation plans addressing Home and Community-Based Services transition.		**The LOCUS consultation meeting with the BHDDA LOCUS implementation coordinators has been scheduled for early June. ESC members have shared their COVID-19 work arounds regarding employment services provision. Members continue to meet as scheduled to support and expand ICPs, with all CMHSPs participating and entering timely case record documentation. Committee monitoring of HCBS services transition activities continues, as discussed in detail in the HCBS section, below, with no regional issues or further points of discussion noted.** **Q 3 (Apr-June): Biennial and Annual Evaluation reports will begin during 4Q. The updated CMH EBP reports have been received and the regional EBP report has been drafted. The June LOCUS / BHDDA consultation meeting was held to further inform and support the CMH LOCUS implementation annual plans. The ESC quarterly report was reviewed and approved, noting various local efforts to maintain viable services during the pandemic, along with sharing of best practices information.**

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<td>IHC activities are proceeding according to plan.
HCBS activities were reviewed, as noted in the separate entry, below.

Q 4 (July-Sept):
CPG annual and biennial evaluation reports are in-process. Affiliate EBP updates have been received. The ESC met in August. IHC activities are proceeding per plan, and HCBS activities noted below.

Evaluation: Progress
Barrier Analysis: None
Next Steps: Continue

Continue Objective(s)?
☒ Yes ☐ No</td>
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<tr>
<td>Home & Community Based Services</td>
<td>The goals for FY2021 Reporting are as follows:
o Monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service.
<table>
<tr><th>FY20 Re-Survey Group</th><th># of Out of Compliance Providers</th><th># of CAPs Required</th><th># of CAPs Approved</th><th># of Attestations Sent</th><th># of Attestations Received</th><th># of Compliance Letters Sent</th></tr>
<tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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</td>
<td>o Monitor network completion of the FY2020 HCBS re-survey cycle
o Monitor Heightened Scrutiny work
o Monitor the provisional approval process</td>
<td>Tom Seilheimer

Improving Practices Leadership Team (IPLT)</td>
<td>Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
The Corrective Action Plan process for the July re-survey cycle has not yet begun. MDHHS has stated that this process is not a current priority, and they will be shifting to working on validating settings that were found to be compliant after completing the initial B and C survey cycles. Pre-validation work has started and the CMH's have begun verifying information needed to begin the validation process. Heightened Scrutiny work has begun at the CMH level with assistance from MDHHS</td>
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				and Michigan State University. IPOSs are being reviewed and attested to by supervisors and Michigan State University has begun finalizing the Heightened Scrutiny lists with the assistance of the CMH Heightened Scrutiny Leads. MSU will also begin interviewing individuals in the upcoming months. **For FY2021 1Q the PIHP received two provisional approval requests from GHS for new settings. These requests were completed timely and followed the Provisional Approval Process outlined by Region 10.** **Q 2 (Jan-Mar):** **The Corrective Action Plan process for the July re-survey cycle has not yet begun. Regarding the Provisional Survey Approval Process, four requests were submitted for approval in Q2. The PIHP HCBS Lead has been reviewing the provisional approval process with CMH HCBS Leads to ensure understanding of this process. DHHS has stated that they would like to improve and streamline the provisional process, no further action or communication has been taken at this time. All CMHs continue to work through the Heightened Scrutiny process with MSU. In February, Sanilac reported that they**

				were close to completing the HS process. GHS, LCMH and SCCMH stated that they continue to work towards completion and each CMH is in a different phase of the HS work. All CMHs report having a positive collaborative experience with the MSU consultation team. **Q 3 (Apr-June):** **The July Survey Corrective Action Plan Process did not begin during FY21 Q3. Other HCBS projects have taken priority per DHHS. Heightened Scrutiny work was completed at LCMH, SCMH and SC CMH during FY21 Q3. GHS continues to work with MSU to complete the Heightened Scrutiny process. During FY21 Q3 fourteen (14) provisional requests were submitted to the PIHP for approval. GHS submitted six (6) requests, LCMH submitted two (2) requests, SCMH submitted three (3) requests and SC CMH submitted three (3) requests. All requests were reviewed and provisionally approved by the PIHP.** **Q 4 (July-Sept):** **The July 2020 Survey CAP process has not started. It is presumed that this process will not begin during FY21. All CMHSPs have completed the Heightened Scrutiny work with MSU. Four (4)**

				provisional requests were submitted to the PIHP in FY21 Q4 for approval. Three (3) requests were submitted by GHS and one (1) request submitted by Sanilac CMH. All requests were reviewed and approved. **Evaluation: Progress** **Barrier Analysis: NA** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2021 Reporting are as follows: o To review and monitor the safety of clinical care.	o Review critical incidents, to ensure adherence to data and reporting standards and to monitor for trends, to improve systems of care. o Monitor sentinel event review processes and ensure follow-up as deemed necessary. o Monitor unexpected deaths review processes and ensure follow-up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **FY 2020 Annual CI Report along with the monthly CI reports were reviewed and no issues were identified.** **Sentinel Events were reviewed noted compliance to reporting processes and completion of RCA and applicable systems improvement action.** **EOY Mortality Reports were reviewed, noting no systems issues along with areas of potential systems improvement or heightened monitoring.** **Q 2 (Jan-Mar):** **Monthly CI reports were reviewed, and no issues were identified. First Quarter CI Report was approved and submitted to QIC for review/approval of recommendations. Discussion**

				continues regarding whether to monitor for potential COVID-19 factors. **Three Sentinel Events were received, all from St. Clair. All were noted in compliance to reporting processes and appropriate follow up. The SERC Chair will outreach the other CMHSPs to recheck their SE reporting processes. EOY Mortality Reports are reviewed on a semi-annual basis.** **Q 3 (Apr-June):** **Monthly CI report was reviewed, and the 2Q CI report was reviewed, with no systems issues identified. Sentinel Event reports have been received from network affiliates/providers. Committee review identified adherence to policy and procedure, and no systems issues. Committee continues to monitor for potential pandemic factors. Discussion with CMH affiliates clarifying how to apply SE criteria also was completed.** **The CMH semi-annual mortality report reviews were completed, noting adherence to standards and appropriate response to affiliate system trends. Committee continues to monitor for potential pandemic factors.** **Q 4 (July-Sept):**

				CI 3Q report was reviewed with no significant services systems issues identified. Annual workplan goals were developed and submitted. **CI monthly reports and sentinel events were reviewed with no significant systems issues noted. An SUD SE Review Form is in-draft.** **Evaluation: Progress** **Barrier Analysis: NA** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No
Employment Services	The goals for FY2021 Reporting are as follows: • To monitor and advise on Employment Services activities as the CMHSPs	• Encourage and support CMHSP progressive employment services practices. • Support to CMHSP pursuit of local employment targets pertaining to competitive employment (community-based) and compensation (minimum wage or higher). • Explore additional opportunities to utilize standardized employment	Tom Seilheimer Employment Services Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **ESC meeting Minutes reviewed, noting regional challenges with service provision in the COVID-19 environment; local employment targets are being evaluated accordingly, and active efforts at partnering with MRS and local businesses are taking place.** **Q 2 (Jan-Mar):** **ESC members have shared their COVID-19 work arounds regarding employment services provision.** **Q 3 (Apr-June):** **ESC quarterly report was reviewed and approved, noting various local efforts to**

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<td>services data and report formats.
• Provide share and learn opportunities as such may pertain to employment targets and collaborative practices, e.g., MRS.</td>
<td></td>
<td>maintain viable services during the pandemic, along with sharing of best practices information.

Q 4 (July-Sept):
Annual workplan goals were developed and submitted.

Programs report being busy near pre-COVID-19 level, but safety concerns continue, and the community settings remain vulnerable to pandemic influences. Lapeer has just launched its IPS program. Information on MIN training for employee specialists was shared.

Evaluation: Progress
Barrier Analysis: No barriers
Next Steps: Continue per plan

Continue Objective(s)?
☒ Yes ☐ No</td>
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<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2021 Reporting are as follows:
• The goal is to attain and maintain performance standards as set by the MDHHS contract.

<table>
<tr><th></th><th>FY20 Q4</th><th>FY21 Q1</th><th>FY21 Q2</th><th>FY21 Q3</th></tr>
<tr><td colspan="5">Ind. 1 - Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>1.2 Adults</td><td>99.91%</td><td>99.81%</td><td>99.71%</td><td>99.91%</td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. No standard</td></tr>
<tr><td>2a PIHP Total</td><td>73.41%</td><td>74.79%</td><td>72.43%</td><td>67.50%</td></tr>
<tr><td>2a.1 MI-Children</td><td>77.70%</td><td>79.71%</td><td>72.68%</td><td>72.13%</td></tr>
<tr><td>2a.2 MI-Adults</td><td>69.28%</td><td>71.07%</td><td>71.54%</td><td>64.66%</td></tr>
<tr><td>2a.3 DD-Children</td><td>82.63%</td><td>81.90%</td><td>73.78%</td><td>69.70%</td></tr>
</table>
</td>
<td>○ Report indicator results to MDHHS quarterly per contract
○ Provide status updates to relevant committees such as QMC, PIHP CEO, PIHP Board
○ Review quarterly MMBPIS data</td>
<td>Lauren Bondy

QI Department

Quality Management Committee (QMC)</td>
<td>Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Performance Indicators for FY2020 Q4 were submitted to MDHHS on 12/29/2020. The PIHP did not meet the set performance standard for PI 4a – Children and 4b. Lapeer CMH did not meet the standard for PI 4a – Adults. Sanilac CMH did not meet the standard for PI 10 – Children. St. Clair CMH did not meet the standard for PI 4a – Children, PI 10 – Children, and PI 10 – Adults.</td>
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2a.4 DD-Adults	81.36%	83.02%	78.26%	71.43%
Ind. 2b - Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. No standard				
2b SUD	70.42%	67.49%	68.76%	69.09%
Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. No standard				
3 PIHP Total	88.63%	88.92%	90.45%	88.98%
3.1 MI-Children	90.83%	89.71%	89.18%	89.89%
3.2 MI-Adults	86.06%	87.61%	89.53%	87.90%
3.3 DD-Children	93.65%	94.12%	95.35%	90.38%
3.4 DD-Adults	95.56%	87.50%	94.92%	91.49%
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	93.65%	98.88%	100%	98.70%
4a.2 Adults	95.90%	98.33%	97.29%	95.75%
4b SUD	86.96%	95.12%	87.76%	74.16%
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	11.96%	11.67%	8.08%	8.79%
10.2 Adults	14.87%	10.94%	12.94%	12.44%

Corrective action plans have been received.

Q 2 (Jan-Mar):
Performance Indicators for FY2021 Q1 were submitted to MDHHS on 3/31/2021. The PIHP met the set standard for every PI with a performance standard. Lapeer CMH did not meet the standard for PI 4a – Adults. Sanilac CMH also did not meet the standard for PI 4a – Adults. Corrective action plans have been received.
During second quarter, the PIHP developed contract standards for the new PIs without performance standards. The intent of the standards is to promote quality improvement for access to care and align documentation expectations with the MDHHS PI Codebook.

Q 3 (Apr-June):
Performance Indicators for FY2021 Q2 were submitted to MDHHS on 6/30/2021. The PIHP did not meet the set performance standard for PI 4b. Sanilac CMH and St. Clair CMH did not meet the set performance standard for PI 10 – Children. Corrective action plans have been received.

Q 4 (July-Sept):
Performance Indicators for FY2021 Q3 were submitted to

				MDHHS on 9/30/2021. The PIHP did not meet the set performance standard for PI 4b. Lapeer CMH did not meet the set performance standard for PI #4a – Adults and PI #10 – Adults. Sanilac CMH did not meet the set performance standard for PI #10 – Children. St. Clair CMH did not meet the set performance standard for PI #10 – Adults. **The PIHP PI Leads reviewed materials for PI #4b to take steps to improve the PIHP's performance and increase the number of individuals receiving follow-up care after discharging from an SUD Detox unit. The Quality Manager met with PIHP Clinical, Provider Network, and Data staff to discuss and learn more about the SUD Detox discharge process. The PIHP Quality Manager is preparing for next steps.** **Evaluation: Regionally, there was not consistent improvement with performance and timely access to care and services. Barrier Analysis: Barriers include SUD engagement and follow-up care after discharge from an SUD Detox unit. Other barriers were identified by CMHs for recidivism to inpatient psychiatric facilities, such as staff capacity, individuals not**

				at baseline at time of discharge, and unsuccessful outreach to individuals following discharge from an inpatient psychiatric facility. Next Steps: The PIHP will continue to monitor performance and will discuss with CMHs and SUD Providers to improve performance and access to care. The PIHP will also uphold contract standards in place to analyze and improve performance with indicators without a set performance standard. Continue Objective(s)? ☒ Yes ☐ No
Members' Experience	The goals for FY2021 Reporting are as follows: • Conduct assessments of members' experience with services o Complete the member satisfaction survey by August 2021. o Conduct the Recovery Self-Assessment survey. o Conduct other assessments of members' experience as needed.	o Conduct annual regional consumer satisfaction survey o Participate in MDHHS annual customer satisfaction survey as specified by MDHHS o Conduct the Recovery Self-Assessment survey o Conduct other assessments of members' experiences as needed o Develop interventions to	Lauren Bondy QI Department Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The FY2020 customer satisfaction surveys for individuals served by SUD Providers were mailed out and received. The PIHP Survey Team will continue work to develop and finalize the FY2020 regional report. The FY2021 Recovery Self-Assessment survey has not yet been conducted.** **Q 2 (Jan-Mar):** **The FY2020 Customer Satisfaction Survey Report was presented to the Quality Management Committee to gather feedback and move forward with finalizing the report. The report is now**

		address areas for improvement based on member satisfaction survey		**final and will be presented for approval at the April QIC and PIHP Board meetings. Planning for the FY2021 RSA Survey continues.** **Q 3 (Apr-June):** **The FY2020 Customer Satisfaction Survey was approved during the April QIC and PIHP Board meetings. The FY2021 RSA Survey was administered. The PIHP is aggregating data to prepare a regional report.** **Q 4 (July-Sept):** **The PIHP prepared and presented the FY2021 RSA Survey Report during QMC, QIC, and SUD Provider Network meetings.** **The PIHP administered the FY2021 Customer Satisfaction Survey. During the monthly QMC meeting, members provided feedback regarding the administration process and materials. The PIHP will be developing a survey schedule and clarifying instructions. The PIHP will also continue discussion with QMC members to address concerns.** **Evaluation: The PIHP conducted assessments of members' experience. Overall, the RSA survey revealed a recovery-oriented system of care is in place throughout the region, with**

				scores and responses in the positive range. **Barrier Analysis: The FY2020 and FY2021 surveys were not conducted timely. Barriers also included methodology and administration methods to maintain and comply with safe COVID-19 procedures.** **Next Steps: The PIHP encourages CMHs to use RSA survey findings to guide discussion during Consumer Advisory Council meetings. The PIHP will also share survey results with CMHs and SUD Providers to make results available to persons served. The PIHP will continue to uphold standards to follow up on survey results as well. The PIHP will finalize a survey schedule and will continue working with QMC members to bring improvements to the survey administration process.** Continue Objective(s)? ☒ Yes ☐ No

State Mandated Performance Improvement Projects	The goals for FY2021 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 Tobacco Cessation: the proportion of SMI adult Medicaid consumers identified as tobacco users who had at least one reported encounter during the CY for prescribed medications to assist in reducing or eliminating tobacco use. 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 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	Tom Seilheimer Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **PIP 1: Final HSAG validation report received, noting 100% compliance.** **PIP 2: Steps I – VI are completed; BA and RCA tasks have been drafted and assigned to the CMHSPs.** **Q 2 (Jan-Mar):** **PIP 1: EOY evaluation activities are in-process with the CMHSP QM Leaders. Preliminary findings and analysis indicate regional progress.** **PIP 2: Steps I – VI are completed; BA and RCA tasks are in process of being completed and submitted by the CMHSPs.** **Q 3 (Apr-June):** **PIP 1: EOY report findings and analysis indicate regional progress. HSAG Validation report is complete and ready to submit to HSAG as scheduled in June.** **PIP 2: Steps I – VI are completed; BA and RCA tasks are in process of being completed and submitted by the CMHSPs.** **Q 4 (July-Sept):** **PIP 1: EOCY 2020 report findings and analysis indicate regional progress. CY 2021**

				activities are proceeding according to plan. HSAG Validation report was submitted as scheduled. **PIP 2: Steps I – VI are completed; BA and RCA tasks are completed for CY2021.** **Evaluation: Progress** **Barrier Analysis: NA** **Next Steps: Continue into the next remeasurement year.** Continue Objective(s)? ☒ Yes ☐ No
External Monitoring Reviews	The goals for FY2021 Reporting are as follows: • To monitor and address activities pertaining to the PIHP Waiver Programs (HSW, CWP, SEDW): a) Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements b) Ensure both Professional and Aide staff meet required qualifications c) Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations	○ QMC members will follow up and report monthly on each CMHSPs follow up activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements	Lauren Bondy Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **CMHs reporting that ongoing monitoring in these areas continues. CMHs report conducting quarterly audits. The 2020 MDHHS Site Review concluded in October and the PIHP received the final report. The SUD and Administrative processes components of the review were in full compliance. There were citations identified for the clinical record review and provider qualifications review. CMH and PIHP corrective action plans for the 2020 MDHHS Site Review were submitted to MDHHS on November 20 and December 23, 2020.** **Q 2 (Jan-Mar):**

				CMHs report that ongoing monitoring in these areas continues. CMHs report conducting quarterly audits. CMH and PIHP corrective action plans for the 2020 MDHHS Site Review were approved by MDHHS. Follow up will be done to ensure corrective action plans are implemented. Work continues for corrective action plan activities from the 2020 MDHHS Site Review. The PIHP is moving forward with annual clinical and credentialing case record reviews for the Waivers. During second quarter, the QMC approved updated committee goals which included changes to the goal related to PIHP Waiver Programs. **Q 3 (Apr-June):** **CMHs report adjustments to their auditing processes based on the 2020 MDHHS Site Review tools or findings/citations. During April, MDHHS conducted the 90-day follow-up review of corrective action plan supporting documentation from the 2020 MDHHS Site Review. During May, the 2020 MDHHS Site Review concluded. MDHHS found that the corrective action plans in place were effective in remediating deficiencies identified during the review.**

				CMHs also report continuing their auditing processes. **Q 4 (July-Sept):** **The PIHP concluded HSW, CWP, and SEDW clinical case record reviews. The QMC will discuss CMH, PIHP, and MDHHS review findings in more detail during meetings. The PIHP HSW/CWP/SEDW Lead joined QMC.** **Evaluation: The PIHP monitored and addressed activities pertaining to the Waiver programs, but improvements can still be made to Waiver enrollee case records and Waiver processes across the region.** **Barrier Analysis: No specific barriers identified** **Next Steps: The PIHP will continue monitoring CMH plans of correction to address Site Review findings. The PIHP will continue analyzing and addressing Site Review findings with CMHs.** Continue Objective(s)? ☒ Yes ☐ No

Monitoring of Quality Areas	The goals for FY2021 Reporting are as follows: ○ To explore and promote quality and data practices within the region.	○ Monitor critical incidents ○ Monitor emerging quality and data initiative / issues and requirements ○ Monitor and address Performance Bonus Incentive Pool activities and indicators ○ Monitor and address changes to service codes ○ Review / analysis of various regional data reports ○ Review / analysis of BH TEDS reports	Lauren Bondy and Laurie Story-Walker Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Monthly critical incident reports were reviewed; each CMH confirmed its data. The following quality / data issues were discussed: BH-TEDS, service code changes, LOCUS, encounter reporting, CAFAS/PECFAS software access, expectations for Assertive Community Treatment (ACT), Evaluation and Management code changes, and transportation services reporting.** **Q 2 (Jan-Mar):** **Monthly critical incident reports were reviewed; LCMH, SCMH, and SC CMH confirmed their data. Additional follow up was needed with GHS to correct data. The PIHP also continues discussions with Medicaid Health Plans on racial disparities related to the Performance Bonus Incentive.** **The FY21 BH TEDS completion rates were provided as a handout and reviewed. Review of code chart updates sent by MDHHS. Discussed status of FY2020 year-end data validation/reconciliation and final pull date 2/1/2021. Briefly discussed potential change to transportation in FY2022. Informed the**

				workgroup of the decision that the I/DD disability designation field will remain as one field and the FY22 coding instructions will be updated to contain additional language from the Mental Health Code. Reminder of the upcoming Technical Assistance for the H2015 transition and challenges some are experiencing. The CMHSP's reported several staff will be participating. EQI templates were due to Mr. Carpenter 2/12/2021. DHIP annual reporting lists were sent to the CMHSPs and reports are due to MDHHS by 3/8/2021. EDIT subgroup meeting minutes was provided as a handout regarding potential changes to modifiers for FY2022. Autism Fee Schedule was provided as a handout. Discussed the proposal to unbundle transportation effective 10/1/2021. MDHHS will discuss the request to change the implementation date to 10/1/2022. This topic will be on the next EDIT agenda scheduled for April 15, 2021. CMHs did not report any changes to ongoing improvements to LOCUS reporting. **Q 3 (Apr-June):** **Monthly critical incident reports were reviewed. Performance Bonus Incentive reports were also discussed.**

				Unbundling of the transportation code has been delayed to FY23, however, MDHHS is looking for volunteers to pilot in FY22. Reviewed the 4/15/2021 Memo from Belinda Hawks regarding the "Flourish" database that is available for Clubhouse data. The BH TEDS file specs and FY22 changes were reviewed. The FY BH TEDS Completion Rates were provided. CMHSPs continue work on improving completion of LOCUS. The EDIT handout from the Improving Outcomes conference was shared that overviews the Code Chart and Modifier changes. It is proposed that Supports Coordination (T1016) will be removed, and Case Management will be used in its place. CMHSPs have concerns regarding the code/modifier changes and the impact it will have on authorizations that extend beyond 9/30/2021. The CMHSPs will submit concerns, barriers or challenges regarding the purposed removal of Supports Coordination by 7/12/2021 prior to the 7/15/2021 EDIT meeting. **Q 4 (July-Sept):** **EDIT Workgroup updates were shared. BH TEDS Completion rates were**

				shared. The group discussed the encounter reporting changes. CMH staff working with their PCE Project Manager regarding the upcoming code and modifier changes and system logic to support the changes. **MDHHS updated the following documents to the website Monday, September 13th:** • **The SFY22 Behavioral Health Code Charts and Provider Qualification document.** • **The Technical Assistance Question and Answer guide.** **Staff should review for changes, such as the addition of the U modifier to service codes 90846, 90847 and 90849.** **The FY22 BH TEDS Edits and PIHP FY22 Encounter Reporting Schedule were provided to the workgroup.** **Monthly critical incident reports were reviewed. Performance Bonus Incentive reports were also discussed.** **Evaluation: The PIHP explored and promoted quality and data practices.** **Barrier Analysis: No specific barriers identified**

				Next Steps: Continue discussion and monitoring of implementation of changes with QMC members Continue Objective(s)? ☒ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: • Evaluate funding allocation methodology.	○ Determine appropriate risk factors to drive payment methodology. ○ Create funding report in MIX based on appropriate risk factors. ○ Present side-by-side comparison of funding under old and new methodology.	Richard Carpenter Finance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Analysis tool has been developed and implemented in MIX. FY2020 Data has been downloaded for comparison purposes and will be presented to the CFOs for consideration.** **Q 2 (Jan-Mar):** **No Update.** **Q 3 (Apr-June):** **Analysis/Evaluation Completed and reviewed by CFOs. Consensus that alternative funding allocation method more accurately anticipates expected cost as compared to the straight pass-through model currently used.** **Q 4 (July-Sept):** **Analysis was presented to and accepted by the CEOs at the July CEO meeting. Goal met.** **Evaluation: Complete** **Barrier Analysis: No barriers** **Next Steps: Continue to monitor** Continue Objective(s)?

				☒ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: • Implement risk-based payment methodology.	○ Identify any barriers to the new risk-based funding model ○ Modify funding model to eliminate barriers or reduce them to an acceptable level. ○ Implement new risk-based funding as primary funding mechanism	Richard Carpenter Finance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec): This goal requires goal #1 to be completed first.** **Q 2 (Jan-Mar):** **No update.** **Q 3 (Apr-June):** **Drafted and recommended a new payment methodology to be implemented starting October 1, 2021. Will present at July CEO meeting and Board.** **Q 4 (July-Sept):** **Revised payment methodology procedure was presented to and accepted by the CEOs at the July CEO meeting as well as the Region 10 Board at the July Board meeting. Goal met.** **Evaluation: Complete** **Barrier Analysis: No barriers** **Next Steps: Continue to monitor** Continue Objective(s)? ☒ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: ○ Implementation of MDHHS Standardized Cost Allocation Model.	○ Receive further direction from MDHHS regarding new process for standardized cost allocation model	Richard Carpenter Finance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **State Workgroup is finalizing templates to be distributed in February. CFOs will review the template to identify barriers and next steps for**

		○ Participate in relevant MDHHS training webinars ○ Identify barriers to the new model ○ Review process and implement strategies		**consistent implementation.** **Q 2 (Jan-Mar):** **State workgroup is receiving questions and modifying the template for distribution. Once received the Region 10 CFO group will evaluate and start to plan an implementation process. MDHHS/ Milliman have not released revised template or instructions yet.** **Q 3 (Apr-June):** **Began a review of the standard cost allocation methodology as presented by MDHHS. Each CMH will be bringing questions and concerns to the group to discuss as we move toward a consistent implementation.** **Q 4 (July-Sept):** **CFOs and guests discussed the Standard Cost Allocation methodology and how to implement consistently. CFOs reported no additional discussion needed and that all were on track for go-live on October 1. Goal has been met.** **Evaluation: Complete** **Barrier Analysis: No barriers** **Next Steps: Continue to monitor.** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Ensure that monthly regional service utilization reports are generated (10/1/2020 – 9/30/2021).	• Monitor and advise on regional Crisis service	Tom Seilheimer	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:**

		utilization reports (monthly PCE-based reports), including new services implementation.	Utilization Management (UM) Committee	**Q 1: (Oct-Dec):** **Not all reports were available during the quarter due to COVID-19 imposed administrative capacity issues. Monthly reports received were reviewed, with no systems or service issues identified, and pending reports are being forwarded to the January meeting.** **Q 2 (Jan-Mar):** **Monthly reports have received and reviewed, with no systems or service issues identified.** **Q 3 (Apr-June):** **Monthly reports have received and reviewed, with no systems or service issues identified.** **Q 4 (July-Sept):** **Monthly reports have been received and reviewed, with no systems or service issues identified** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Provide periodic oversight on the use of restrictive and intrusive behavioral techniques, physical management or 911 contact with law enforcement use on an emergency basis.	• Monitor and advise on BTPRC data on use of Restrictive and Intrusive techniques, physical	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Not all reports were available during the quarter due to COVID-19 imposed administrative capacity**

		management or contact with law enforcement use on an emergency behavior basis; evaluate reports per committee review / discussion of findings, trends, potential systems improvement opportunities, adherence to standards.		**issues. Quarterly reports received were reviewed, with no systems or service issues identified, and pending reports are being forwarded to the January meeting.** **Q 2 (Jan-Mar):** **Three reports were received and reviewed, with no service or systems issues noted. The fourth report will be reviewed at the April meeting.** **Q 3 (Apr-June):** **Quarterly reports were received at varied points along the quarter, but all reports received indicated no outstanding systems or service issues.** **Q 4 (July-Sept):** **Quarterly reports were received and reviewed, with no service or systems issues noted.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Conduct Utilization Review (UR)	• Conduct UR of SUD Provider Network • Conduct UR of CMHSP Provider Network per CMHSP Delegation	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **SUD UR will begin 2Q.** **Centralized R10 UM/UR has been phased in for the OASIS CMHSPs according to UM Redesign, as noted in the FY 2021 UM Program Plan.**

		• Conduct UR of CMHSP per Centralized UM Operations • Explore feasible opportunities for additional outlier-based UR linked to high-cost, high-risk, or tele-med formats.		**Other outlier-based UR activities have been identified are planned for phase-in later in the FY.** **A UR protocol for Community Living Supports has been developed and will be phased in following implementation of the centralized automated UM/UR system.** **Q 2 (Jan-Mar):** **SUD UR case record selection process has begun for FY 2021.** **Centralized R10 UM/UR is now fully operational in OASIS.** **Q 3 (Apr-June):** **The SUD UR Annual Report was reviewed, and the report identified provider program adherence to standards, with isolated issues identified and addressed through the CAP process. The report is submitted to QIC for review.** **The centralized CMH UR / reporting system is now fully implemented. The 3Q report was reviewed, which identified provider program adherence to standards, with isolated issues identified and addressed through the UR consultative process.** **Expanded R10 UR has been completed in other key areas, such as CLS and Respite, and are provisionally scheduled for implementation in conjunction with the other**

				UM/UR Redesign activities, implementation date pending. **Q 4 (July-Sept):** **The 4Q CMH UR report was reviewed, which identified provider program adherence to standards, with isolated issues identified and addressed through the UR consultative process.** **Expanded R10 UR has been completed in other key areas, such as CLS and Respite, and are provisionally scheduled for implementation in conjunction with the other UM/UR Redesign activities, implementation date pending.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Promote aligned care management activities across key areas of network operations.	• Implement Centralized UM System • Promote aligned care management activities across Access Management System Access sites • Monitor and advise on community access care management activities: Quarterly	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **AMS Report is completed and submitted to QIC. Quarterly Customer Involvement, Wellness/Healthy Communities reports were reviewed, with CMHSPs identifying ongoing / effective efforts to engage and inform the community despite the challenges with the pandemic.** **Q 2 (Jan-Mar):** **Local implementation challenges have been**

		Customer Involvement, Wellness/Healthy Communities reports		**expressed by the OASIS users and R10 is currently in discussions with the OASIS users.** **The next AMS Report is scheduled at mid-year. Quarterly reports were reviewed, with no systems or service issues identified.** **Q 3 (Apr-June):** **Monthly OASIS User Group meetings are addressing SAG COC implementation issues and challenges. Centralized UR is now in place, work continues on the annual data analytics reporting process, the SAG COC service authorization grid has been published on the R10 website, and planning/flowcharting is underway with the centralized ABD system design. Also, HSAG CAP ABD reporting is in place, and committee review continues to monitor and address issues pertaining to report timeliness and completeness.** **The AMS semi-annual report was completed and reviewed by committee and submitted to QIC for final review. Quarterly community/wellness reports identify a broad range of relevant activities as well as appropriate response to community needs impacted by the pandemic.** **Q 4 (July-Sept):**

				Annual workplan goals were developed and submitted. OASIS User Group continues to meet on design tasks, and centralized ABD system planning has been expanded. Next AMS report is not yet due. Quarterly ABD reports have been received, with progress noted in CMH report completion and report submissions from SUD programs. Quarterly BTPRC reports have received and reviewed, with no systems or service issues identified. **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continuation goal** Continue Objective(s)? ☒ Yes ☐ No

Corporate Compliance	The goals for FY2021 Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements.	• Review requirements • Identify and document responsible entities • Identify and document supporting evidence / practice • Policy review • Review PIHP Corporate Compliance Plan updates	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The PIHP celebrated Corporate Compliance & Ethics Week with several activities to bring about education and awareness of standards. Staff were receptive with a high level of participation. The Q1 Compliance Department message was emailed to PIHP staff and Network Providers with topics including Code of Conduct and Compliance Standards from the PIHP's Mission & Vision.** **Q 2 (Jan-Mar):** **The Compliance Committee reviewed the Q1 and Q2 compliance department message. Using compliance department messages as opportunity to educate staff on compliance topics was discussed.** **Q 3 (Apr-June):** **The Q3 Compliance Department message was emailed to PIHP staff and Network Providers with topics including who the PIHP compliance staff are and their key roles in the development and implementation of the PIHP compliance program. The purpose of this message was to educate staff on who the PIHP compliance department**

				staff are, as well as that any of those individuals can assist in reporting a compliance related concern. Using compliance department messages as opportunity to educate staff on compliance topics was discussed with the compliance committee. **The FY22 Corporate Compliance Plan was presented and approved by the Compliance Committee.** **Q 4 (July-Sept):** **The Q4 PIHP Compliance Department message was emailed to PIHP staff and Network Providers with information related to Secure Emails. The message included the PIHP's HIPAA Privacy and Security Measures Policy for reference. Additional communication was also emailed to PIHP and Network staff on the topic of protecting yourself during COVID-19 from the Office of Inspector General (OIG).** **In addition, the Corporate Compliance Plan was approved by the PIHP Board.** **Evaluation: This goal has demonstrated progress including the Corporate Compliance Committee reviewing program integrity requirements and identifying supporting evidence/practice related to program integrity. In addition, communications**

				have gone out to the PIHP and Network staff that included policy review. Lastly, the Compliance Committee reviewed the Corporate Compliance Plan and approved updates prior to Management Team, CEO, and PIHP Board approval. **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Support reporting requirements (quarterly and ongoing) as defined by MDHHS, OIG, PIHP, etc.	• Review of reporting process	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **FY20 Q4 Program Integrity Report and Annual Contracted Entities Report were submitted to the OIG in November.** **Q 2 (Jan-Mar):** **FY21 Q1 Program Integrity Report was submitted to the OIG in February.** **Corporate Compliance Committee reviewed reporting requirement extensions including the Program Integrity Report. Q2 is due 4/30/21 instead of 4/15/21.** **Q 3 (Apr-June):** **FY21 Q2 Program Integrity Reports and Corporate Compliance Complaint Reports were received form**

				the Provider Network in April. FY21 Q2 Program Integrity Report was submitted to the OIG in May (included data mining activity). **Q 4 (July-Sept):** **FY21 Q3 Program Integrity Report and Corporate Compliance Complaint Reports were received by the Network and submitted to the OIG. The Corporate Compliance Committee reviewed the Program Activities Guidance Document and discussed additional education/training opportunities.** **Evaluation: This goal has demonstrated ongoing progress including improved timeliness of report submission from Network Providers and content enhancements. Improvements in reporting directly relates to improved quality of care and services for enrollees as with enhanced documentation and reporting the Network can identify trends and improve outcomes in Corporate Compliance.** **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Corporate Compliance	The goals for FY2021 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes.	• Review regional PIHP contract monitoring results • Review current CMH Subcontractor contract monitoring process / content	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **FY20 Annual Contract Monitoring desk audits were completed by the compliance subject matter expert.** **Q 2 (Jan-Mar):** **Corporate Compliance Committee reviewed the FY21 monitoring cycle with no concerns.** **Q 3 (Apr-June):** **The PIHP Compliance Subject Matter Expert (SME) completed Provider desk audits for annal contract monitoring and is in the process of reviewing the desk audit provider responses, as well as any submitted documentation, prior to PIHP annual monitoring of its network.** **Q 4 (July-Sept):** **The PIHP Compliance Subject Matter Expert (SME) completed Annual Contract Monitoring in Corporate Compliance. In addition, record reviews of the MDHHS (5515) Consent to Share Behavioral Health Information Form were initiated. Enhancements were made to this record review process including the Corporate Compliance Administrative Coordinator completing the record review.**

				Evaluation: This goal demonstrated ongoing progress including completion of Annual Contract Monitoring and reviewing the results. Enhancements were made to record reviews for the MDHHS (5515) Consent to Share Behavioral Health Information Form. Ongoing work will be completed in the following FY related to CMH subcontractor contract monitoring process/content. By reviewing results of Annual Contract Monitoring and following through on Corrective Action Plans, the quality of care and services for enrollee(s) served is directly impacted including a higher standard of care and documentation in the area of Corporate Compliance. **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Improve reciprocity and efficiency within the PIHP Provider Network.	• Review MDHHS Network Management Reciprocity & Efficiency Policy • Create Regional Corporate Compliance Complaint Form	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **No update.** **Q 2 (Jan-Mar):** **New FY21 goal on hold. No updates.** **Q 3 (Apr-June):**

		(for Complainant Use) • Create Regional Corporate Compliance Complaint Summary Form (for Compliance Office Use) • Create Regional HIPAA Breach Notification Letter Templates • Review PIHP and Provider Corporate Compliance Webpage Content		**No updates.** **Q 4 (July-Sept):** **This goal will be continuing in FY22 as it was on hold during FY21 to provide relief to Network Providers.** **Evaluation: This goal will be initiated in FY22.** **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Provider Network	The goals for FY2021 Reporting are as follows: • Address service capacity concerns and ensure resolution of identified gaps in the network based on Gap Analysis Reports.	• Review CMH Gap Analysis Reports • Review SUD Network gaps • Address cultural and linguistic needs of members. • Review capacity concerns identified (e.g. Autism, Mobile Intensive Crisis Stabilization).	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The PIHP's SUD OTP RFP concluded in October 2020 with the recommended provider (CPI) reviewed and approved at the Management Team and the PIHP Board meetings in November. Work continued on the creation of a Letter of Agreement, which will assist the Provider with locating an office in the Port Huron area. The PIHP continues to see a need for additional opioid treatment services, as well as residential services for adolescents (females in particular).** **Q 2 (Jan-Mar):**

				The Provider Network Committee members heard updates from PIHP staff and engaged in discussion at the PIHP Provider Network Committee meeting in March. Discussion included service capacity and compliance monitoring updates in the areas of Autism, CWP, SEDW, and HSW. **Work continues on the creation of a Letter of Agreement with Community Programs, Inc. (CPI), which will assist the Provider with locating an office in the Port Huron area to provide needed Opioid Treatment Services. The PIHP continues to see a need for additional opioid treatment services.** **Q 3 (Apr-June):** **The Provider Network Committee members heard updates from PIHP staff and engaged in discussion at the PIHP Provider Network Committee meeting in June. Discussion included service capacity, compliance monitoring updates in the areas of Autism, CWP, SEDW, and HSW, the PIHP Annual Contract Monitoring Process, and the PIHP's efforts to finalize a Network Adequacy Plan.** **Q 4 (July-Sept):** **At their quarterly meeting in September 2021, the PIHP**

				Provider Network Committee members heard updates from PIHP staff and engaged in discussion regarding autism program updates, HCBS activities, the provider network directory requirements, the annual contract monitoring process, and the PIHP's Network Adequacy Plan. Additionally, the committee approved FY2022 Goals. **During annual contract monitoring processes in the area of Quality Improvement, the CMH Network scored above 90%, but it was noted that one (1) CMH Provider needs improvement in timely data reporting regarding Autism requirements.** **The PIHP continues to work with Community Programs, Inc. (CPI), assisting the Provider with locating an office in the Port Huron area to provide needed Opioid Treatment Services. There has been a need identified for Outpatient Treatment Providers in Sanilac County. The PIHP is seeking a qualified and interested substance use disorder (SUD) Provider to offer outpatient services specifically in Sanilac County.** **Evaluation: This goal will be continued in FY2022. While a new OTP Provider has been**

				identified, the new location and contracting process has not yet been completed. This service will bring much needed opioid treatment relief to the St. Clair County area. Additionally, the PIHP is making efforts to bring needed outpatient services to Sanilac County. **The PIHP continues to work with the CMH Providers to close service gaps in the area of Autism services.** **Barrier Analysis: Staff capacity issues at the PIHP and the Network of Service Providers.** **Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Provider Network	The goals for FY2021 Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards.	• Review MDHHS standards and current Network Adequacy • Address Network Adequacy concerns	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **PIHP staff are continuing to review MDHHS standards and the PIHP Network Current Adequacy to determine next steps.** **Q 2 (Jan-Mar):** **The Provider Network Committee members heard updates from PIHP staff and engaged in discussion at the PIHP Provider Network Committee meeting in March. A discussion point included an update from PIHP staff regarding PIHP efforts to identify and move forward with a Network Adequacy Project. An outline of steps to take and items to address is being created.** **Q 3 (Apr-June):** **The PIHP is working on the Network Adequacy Plan. Updates and requests for information were discussed at the June Provider Network Committee. The initial draft was completed and submitted to Executive Leadership on July 1. It is anticipated that the finalized plan will be ready by August 1 for Provider Network Committee Review and PIHP Board Approval.** **Q 4 (July-Sept):**

				The PIHP is continuing work on the Network Adequacy Plan. Due to staffing capacity issues, it is anticipated that the finalized plan will be ready in the fall for Provider Network Committee Review and PIHP Board Approval. **Evaluation: This goal will be continued in FY2022. The PIHP Network Adequacy Plan has not yet been completed. Additionally, it is anticipated that the PIHP will be issued a Plan of Correction from HSAG as preliminary results of the 2021 Compliance Review opportunities for improvement in this area. Barrier Analysis: Staff capacity issues at the PIHP. Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Provider Network	The goals for FY2021 Reporting are as follows: • Ensure Provider Directories are updated monthly and provide MDHHS-required information for individuals served.	• Review MDHHS requirements • Address opportunities for reporting efficiency and effectiveness • Identified staff participate in PIHP Provider Directory Workgroup	Katie Forbes Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The Provider Directory Workgroup was a success with all four (4) CMH Providers in full compliance with their provider directories. The PIHP will continue to monitor directories during semi-annual and annual contract monitoring.**

				Q 2 (Jan-Mar): Update provided to Provider Network Committee: All four (4) CMH Providers are in full compliance with their Provider Directories. No questions/concerns from committee. **Q 3 (Apr-June):** **CMH Provider Directories are in full compliance. Customer service staff will continue to monitor through committee and FY21 Annual Contract Monitoring.** **Q 4 (July-Sept):** **The Provider Network Committee received notification that the PIHP Provider Directory Workgroup will be re-engaged to ensure compliance with Provider Directories that includes all current federal and contractual requirements.** **Evaluation: Ongoing progress has been successful for this goal including reviewing MDHHS requirements related to Provider Directories. Staff have reviewed federal and contractual language for updates to Provider Directory content. In addition, the Provider Network Committee identified staff to engage in a Provider Directory Workgroup to ensure compliance with Provider**

				Directories. The workgroup has been re-engaged to continue efforts towards Provider Directory compliance. Ensuring compliance with Provider Directories directly impacts the quality of care and access to services for our enrollee(s) served. **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Provider Network	The goals for FY2021 Reporting are as follows: • Review most recent FY PIHP Contract Monitoring Results.	• Review FY Contract Monitoring Aggregate Report • Discuss trends and improvement opportunities	Amanda Zabor Provider Network Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The FY2020 contract monitoring process is complete. All Provider audits have been completed, and Provider final summary reports with plans of correction have been sent. The Contract Monitoring Aggregate Report is complete and has been reviewed at PIHP Management Team and PIHP Board meetings.** **Q 2 (Jan-Mar): The Provider Network Committee members heard updates from PIHP staff and engaged in discussion at the PIHP Provider Network Committee meeting in March. A timeline for FY2021 Annual Monitoring was shared with**

				committee members, with short discussion occurring. PIHP staff remain on target with deadlines to begin virtual visits with Providers for annual monitoring. The virtual audits have been scheduled with all providers, the monitoring tool templates are complete, and PIHP staff are customizing the tools for each Provider. **Q 3 (Apr-June):** **The PIHP remains on target to complete annual audits and reporting by August 1. The Provider Network Committee was provided an update on the contract monitoring process at their June meeting with an opportunity for discussion and questions.** **Q 4 (July-Sept):** **The FY2021 contract monitoring process is complete. All Provider audits have been completed, and Provider final summary reports with plans of correction have been sent. The Contract Monitoring Aggregate Report is complete and has been reviewed at PIHP Management Team and PIHP Board meetings. Overall, the PIHP Network of Service Providers scored very well during the Annual Contract Monitoring Process. Areas of strength for both CMH and SUD Providers included maintaining sound**

				Information Systems policies, procedures, and process, Utilization Management activities and documentation, improvements in Enrollee Grievance Process and Enrollee Rights & Protections procedures and policies, and improved Privileging & Credentialing adverse determination documentation and processes. **In the area of Quality Improvement, the CMH Network scored above 90%, but it was noted that one (1) CMH Provider needs improvement in timely data reporting regarding Autism requirements.** **In the area of Customer Service, the CMH Network scored above 90%, but it was noted that one (1) CMH Provider needs improvement in their Provider Network Directory as posted on their website.** **For the SUD Network in the area of Appeals, two (2) Providers were identified as needing updates to their policies and procedures regarding adverse benefit determination notices. In the area of Disclosures, six (6) SUD Treatment Providers and three (3) SUD Prevention Providers were identified as needing updates to their policies and procedures on the timeliness of regarding disclosures made by their staff.**

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<td>Evaluation: This goal will be continued in FY2022. The PIHP Contract Monitoring process is an ongoing and formal process.
Barrier Analysis: None.
Next Steps: Goal to be continued into the following FY.

Continue Objective(s)?
☒ Yes ☐ No</td>
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<tr>
<td>Customer Service Inquiries</td>
<td>The goals for FY2021 Reporting are as follows:
• To review and analyze baseline customer service inquiry data for the region for FY2021.

<table>
<tr><th colspan="8">Reporting Period: FY2021</th></tr>
<tr><th rowspan="2"></th><th rowspan="2">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>36</td><td>28</td><td>39</td><td>7</td><td>1</td><td>17</td><td>128</td></tr>
<tr><td>Lapeer</td><td>0</td><td>1</td><td>1</td><td>1</td><td>0</td><td>1</td><td>4</td></tr>
<tr><td>PIHP</td><td>3</td><td>7</td><td>4</td><td>2</td><td>0</td><td>1</td><td>17</td></tr>
<tr><td>Sanilac</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>St. Clair</td><td>4</td><td>1</td><td>2</td><td>1</td><td>0</td><td>0</td><td>8</td></tr>
<tr><td>SUD</td><td>8</td><td>6</td><td>3</td><td>3</td><td>0</td><td>0</td><td>20</td></tr>
<tr><td>TOTAL</td><td>51</td><td>44</td><td>49</td><td>14</td><td>1</td><td>19</td><td>178</td></tr>
<tr><th colspan="7">Inquiry Resolution Categories:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>15</td></tr>
<tr><td colspan="7">Grievance</td><td>4</td></tr>
<tr><td colspan="7">Referral to Access</td><td>41</td></tr>
<tr><td colspan="7">Rights Complaint</td><td>0</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>69</td></tr>
<tr><td colspan="7">Other</td><td>46</td></tr>
<tr><td colspan="7">Pending</td><td>3</td></tr>
</table>
</td>
<td>• To track and trend internally the customer service inquiries on a quarterly basis.
• Identify consistent patterns related to member customer service inquiries.
• Develop interventions to address critical issues within the organization.</td>
<td>Katie Forbes

Quality Improvement Committee</td>
<td>Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
The total number of inquiries for Q1 was fifty-one (51) which is a decrease from FY20 Q1 which had sixty-nine (69).

Breakdown:
• GHS accounts for approximately 70% of inquiries numbers,
• Access at 12%,
• SUD Provider Network at 10%
• St. Clair CMH at 8%.

Type of Inquiry:
• Approximately 24% of the inquiries were a referral to access which is similar to FY19 Q1 which had 26% of inquiries referred to access. The most common reason for a referral</td>
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				to access is the Enrollee was not engaged in services for more than 60 days and received an ABD Notice but wished to get back into services. • **Approximately 27% of inquiries were a referral to Provider.** **Q 2 (Jan-Mar):** **The total number of inquiries for Q2 was forty-four (44) which is a decrease from FY20 Q2 which had fifty-four (54) inquiries.** **Breakdown:** • **GHS accounts for approximately 63% of inquiries, SUD Provider Network at 13%, Access at 15%, and LCMH, Sanilac, and St. Clair combined at 7%.** **Resolution Category:** • **9% of total inquiries resulted in appeals.** • **30% of inquiries resulted in a referral to Access for a screening.** • **34% of inquiries resulted in a referral back to the Provider.** • **7% resulted in a grievance**

				• **20% were in the other category.** **Q 3 (Apr-June):** **The total number of inquiries for Q3 was forty-eight (48) which is an increase from FY20 Q3 which had thirty-two (32) inquiries.** **Breakdown:** • **GHS accounts for approximately 80% of inquiries, SUD Provider Network at 8%, Access at 6%, and LCMH, Sanilac, and St. Clair combined at 6%.** **Resolution Category:** • **6% of total inquiries resulted in appeals.** • **11% of inquiries resulted in a referral to Access for a screening.** • **52% of inquiries resulted in a referral back to the Provider.** • **0% resulted in a grievance** • **25% were in the other category.** • **6% are pending resolution.** **Q 4 (July-Sept):** **There was a total of thirty-four (34) customer service inquiries which is a decrease from FY20 Q4 which had forty-six (46) inquiries.**

				Breakdown: • **GHS accounted for approximately 73% of inquiries, LCMH at 6 %, PIHP at 9%, St. Clair at 3%, and SUD at 9%** **Resolution Category:** • **6% resulted in appeal.** • **3% resulted in a grievance.** • **27% resulted in an "other" category.** • **24% resulted in a referral to Access.** • **32% resulted in a referral to a Provider.** • **8% are pending** **Evaluation: PIHP Customer Service staff had ongoing success in this goal completion including tracking customer service inquiries on a quarterly basis. Staff were able to identify consistent patterns related to customer inquiries. One trend identified is that Genesee Health System (GHS) accounts for approximately 72% of all customer service inquiries. Also, approximately 62% of inquiries resulted in connecting the enrollee to either Access to a Provider for services. Only 8% of inquiries resulted in an**

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<td>appeal and 2% resulting in a grievance. There have not been any critical issues identified resulting in interventions by the PIHP.
Barrier Analysis: No barriers identified.
Next Steps: Objective to be continued in the following FY.

Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>Appeals</td>
<td>The goals for FY2021 Reporting are as follows:
• To review and analyze baseline appeals data for the region for FY2021.

<table>
<tr><th colspan="8">Reporting Period: FY2021</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th colspan="3">Q4</th><th>Total</th></tr>
<tr><th></th><th></th><th></th><th></th><th>Jul</th><th>Aug</th><th>Sep</th><th></th></tr>
<tr><td>GHS</td><td>7</td><td>2</td><td>4</td><td>0</td><td>0</td><td>2</td><td>15</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>PIHP</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>SUD</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL</td><td>7</td><td>4</td><td>4</td><td>0</td><td>0</td><td>3</td><td>18</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Grievance not resolved within 90 days</td><td>0</td></tr>
<tr><td colspan="7">Grievance not resolved within allowed days</td><td>0</td></tr>
<tr><td colspan="7">Request not acted on within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Denial</td><td>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>0</td></tr>
<tr><td colspan="7">Service Suspension</td><td>0</td></tr>
<tr><td colspan="7">Service Termination</td><td>7</td></tr>
</table>
</td>
<td>• To track and trend internally the appeals on a quarterly basis.
• Identify consistent patterns related to member appeals.
• Develop interventions to address critical issues within the organization.</td>
<td>Katie Forbes

Quality Improvement Committee</td>
<td>Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
There was a total of seven (7) appeals in Q1 which is no change from FY20 Q1 which also had seven (7) appeals. All of the 7 appeals were a result of a type of service denial. (e.g., service termination).

Q 2 (Jan-Mar):
There was a total of four (4) appeals in Q2 which is a decrease from FY20 Q2 which had eleven (11) appeals.

All of the four (4) appeals were a result of a type of service denial (e.g., service termination).

Q 3 (Apr-June):
There was a total of four (4) appeals in Q3 which is an increase from FY20 Q3 which had zero (0) appeals.</td>
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				All of the four (4) appeals were a result of a service denial or service termination. **Q 4 (July-Sept):** **There was a total of three (3) appeals in FY21 Q4. This is a decrease from FY20 Q4 which had four (4). All appeals for Q4 were either service denials or service terminations. The PIHP and Provider Network did not have one appeal related to not meeting timeframes for grievance resolution, service request timeliness, or service initiation timeliness.** **Evaluation: PIHP Customer Service staff had ongoing success with this goal including tracking appeals on a quarterly basis, identifying any trends related to appeals, and reviewing for consistent patterns. Staff identified trends including all appeals were either related to a service denial or service termination. While reviewing appeals data for trends and patterns, staff identified that the PIHP and Network did not have one (1) appeal related to going out of timeframes for service request decisions or service initiation. This provides evidence that the PIHP and Network are successfully making service decisions and initiating services appropriately within the**

				required timeframes. This directly impacts the access to care and quality of care for our enrollee(s) served. **Through internal tracking of appeals, PIHP staff did not identify any critical issues within the organization related to appeals.** **Barrier Analysis: No barriers identified.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Grievances

The goals for FY2021 Reporting are as follows:

- To review and analyze baseline grievance data for the region for FY2021.

Reporting Period: FY2021							
	Q1	Q2	Q3	Q4			Total
				Jul	Aug	Sep	
GHS	9	4	21	n/r	n/r	n/r	34
Lapeer	0	1	0	n/r	n/r	n/r	1
PIHP	0	0	0	0	0	0	0
Sanilac	0	0	0	n/r	n/r	n/r	0
St. Clair	0	0	1	n/r	n/r	n/r	1
SUD	0	3	0	1	0	1	5
TOTAL	9	8	22	1	n/r	1	41

Reason for Grievance:	Total
Financial Matters	0
Quality of Care	27
Service Concerns / Availability	11
Service Environment	0
Suggestions / Recommendations	0
Other	3

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

Katie Forbes

Quality Improvement Committee

Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
There was a total of nine (9) grievance reported in Q1 which is a decrease from FY20 Q1 which had twelve (12). Not all grievance data has been reported. The most common reason for a grievance was quality of care which accounts for approximately 78% of our Q1 grievances.

The PIHP is reviewing reporting requirements for monthly grievance reporting with a potential short-term change to quarterly to assist the CMH Provider Network during the COVID Pandemic.

Q 2 (Jan-Mar):
There was a total of four (4) grievances reported in Q2. Not all grievance data has been reported with a Network reporting extension to 4/30/21 for Q2 data.

Breakdown of Reason:

- **60% of grievances are a quality-of-care concern.**
- **27% are a service concern/availability reason.**
- **13% are listed in the "other" category.**

Q 3 (Apr-June):

				The grievance data reported to date have shown no grievances reported in Q3. **Not all grievance data has been reported with quarterly submission approved in lieu of monthly due dates. Q3 data is due 7/15/21.** **Q 4 (July-Sept):** **There has been a total of two (2) grievances reported in Q4. Additionally, Q4 grievance data has not been received from the CMH Providers due to recent reporting changes that requires grievance data be reported on the 15th of the month following each quarter.** **Evaluation: PIHP Customer Service staff had ongoing success with goal completion including tracking grievances on a quarterly basis and identifying trends. Staff have collected PIHP and Network grievance and reviewed to identify consistent patterns and to develop interventions when critical issues were identified within the organization. MDHHS reporting requirements have provided more detailed reporting of grievance outcomes and interventions completed for a substantiated grievance. This enhancement to documentation and process directly improves the quality of care for enrollee(s) served**

				related to grievances submission and follow through. **Barrier Analysis: MDHHS reporting requirements were implemented mid-way through the FY. Therefore, a full analysis of improved grievance reporting is not available for the entire FY. Staff are only able to track and trend the revised language changes (e.g., interventions listed for substantiated grievances) from the time the reporting change was implemented into Electronic Health Records (EMR) systems.** **Next Steps: Objective to be continued in the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Complete Privileging and Credentialing reviews and approval process of Organizational Applications for CMH and SUD Providers.	○ Review all Organizational Applications: ○ Current Providers ○ New Providers ○ Existing Provider Renewals / Updates ○ Provider Terminations / Suspensions / Probationary Status ○ Provider Adverse	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **No Organizational Provider P & C applications were received during FY2021 1Q for P & C Committee Review.** **Q 2 (Jan-Mar):** **The P & C Committee received information on additional locations added to the current Vision Quest Recovery P & C application and contract, as well as an additional location added to the current Holy Cross**

		Credentialing Determinations		**Services P & C application and contract.** **Q 3 (Apr-June):** **One Organizational Provider P & C applications was received for P & C Committee Review (June 2021), which was subsequently approved by the P & C Committee. Many Providers are approaching the end of their current term of credentialing (9.30.2021). The committee will be reviewing many applications for re-credentialing throughout the summer.** **Q 4 (July-Sept):** **A total of 16 Organizational Provider P & C applications were processed and approved between June and September 2021, many with multiple locations (which requires additional forms). All providers whose terms were ending 9.30.2021 have been renewed in a timely manner with appropriate notifications sent. The goal to have Provider credentialing applications reviewed and processed in a timely manner (before October 1, 2021) was achieved. All 16 applications were accurately completed by the Providers and approved by the P & C Committee with no gap in credentialing terms. This was the result of improved internal PIHP Processes. Additionally, the**

				PIHP began a new process whereby Providers were reviewed by the PIHP Customer Service Department to determine if there were any quality, grievance, and/or appeal issues with the Provider. This enhancement allows the P & C Committee to make an informed and well-rounded decision when voting on P & C applications to ensure quality services are provided to enrollees. **Evaluation: This goal will be continued in FY2022. The PIHP Privileging and Credentialing review and approval process is an ongoing and formal part of the PIHP P & C Committee. Much improvement in documentations and procedures resulted in a smooth process for re-credentialing this year. It is anticipated that continued improvements will be made this upcoming fiscal year. The PIHP P & C Committee expressed their appreciation to PIHP staff for improving the flow and processing of the applications.** **Barrier Analysis: None.** **Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Credentialing / Privileging	The goals for FY2021 Reporting are as follows: o Complete Privileging and Credentialing reviews and approval process of all applicable Region 10 staff.	o Review all Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, Access Clinicians [leased staff and direct hires]): o Current Practitioners o New Practitioners o Existing Practitioner Renewals / Updates o Practitioner Terminations / Suspensions / Probationary Status o Practitioner Adverse Credentialing Determinations	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Three (3) practitioner applications were reviewed and approved by the P & C Committee during FY2021 1Q for Port Huron Access Staff Shelby Johnston and GHS Access Staff Angela Bavar and Sara Schmidt. All received full privileges.** **Q 2 (Jan-Mar):** **One (1) practitioner application was reviewed and approved by the P & C Committee during FY2021 2Q for GHS Access Staff Theresa Martines. She received full privileges.** **Q 3 (Apr-June):** **No Practitioner P & C applications were received for P & C Committee Review. Many Practitioners are approaching the end of their current term of credentialing (9.30.2021). The committee will be reviewing many applications for re-credentialing throughout the summer.** **Q 4 (July-Sept):** **A total of 16 Individual Practitioner P & C applications were processed and approved between June and September 2021. All practitioners whose terms were ending 9.30.2021 have**

				been renewed in a timely manner with appropriate notifications sent. The goal to have Practitioner credentialing applications reviewed and processed in a timely manner (before October 1, 2021) was achieved. All 16 applications were accurately completed by the Practitioners and approved by the P & C Committee with no gap in credentialing terms. This was the result of improved internal PIHP Processes. Additionally, the PIHP began a new process whereby Practitioners were reviewed by the PIHP Customer Service Department to determine if there were any quality, grievance, and/or appeal issues with the Practitioner. This enhancement allows the P & C Committee to make an informed and well-rounded decision when voting on P & C applications to ensure quality services are provided to enrollees. **Evaluation: This goal will be continued in FY2022. The PIHP Privileging and Credentialing review and approval process is an ongoing and formal part of the PIHP P & C Committee. Much improvement in documentations and procedures resulted in a smooth process for re-**

				credentialing this year. It is anticipated that continued improvements will be made this upcoming fiscal year. The PIHP P & C Committee expressed their appreciation to PIHP staff for improving the flow and processing of the applications. **Barrier Analysis: None.** **Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards.	○ Review policy content. ○ Review for alignment between policy and applications ○ Revise and clarify language where needed	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **PIHP staff continue to review the P & C policy for updates, revisions, etc.** **Q 2 (Jan-Mar):** **Minor revisions were made the P & C policy to align with MDHHS and HSAG requirements. These updates were shared with PIHP Management Team and the PIHP P & C Committee.** **Q 3 (Apr-June):** **Review continues on the P & C policy.** **Q 4 (July-Sept):** **During 4Q 2021, review of the P & C policy was slowed by the re-credentialing process for 32 Providers and Practitioners, as well as PIHP staff capacity issues. The goal**

				was not met for FY2021. However, while there were barriers to completing a comprehensive review and revision process, the delay did not have a negative impact on quality of services for enrollees as the policy is comprehensive but just needs updating to streamline and clarify information. **Evaluation:** **While there were updates to the P & C policy to align with MDHHS and HSAG requirements, this goal will be continued in FY2022 as there is more work to be done. It is anticipated that continued improvements will be made this upcoming fiscal year.** **Barrier Analysis: PIHP Staff Capacity Issues.** **Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Maintain current and comprehensive Privileging and Credentialing applications for Organizational Providers and Individual Practitioners inclusive of MDHHS and Medicaid standards.	○ Review application content: ○ Clarify and streamline Organizational Provider Applications ○ Clarify and streamline Individual Practitioner Applications	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **PIHP staff continue to edit the PIHP Organizational Provider P & C application template to improve the flow of the application, as well as to clarify information being requested. Once the Organizational Provider application is complete, work will begin on the Individual**

		○ Enhance Application Review Process		**Practitioner application template.** **Q 2 (Jan-Mar):** **PIHP staff are researching P & C application requirements in an effort to determine what items need to be on an Organizational Provider application and on Individual Practitioner applications. This will assist staff in determining how to streamline and organize the applications. Research efforts have included input from PIHP P & C Committee members.** **Q 3 (Apr-June):** **Several small formatting and one technical correction were made to the Organizational Provider and Individual Practitioner applications to ready them for the re-credentialing efforts this summer. The revised applications have been posted on the PIHP website.** **Q 4 (July-Sept):** **No update. The goal was not met for FY2021. However, while there were barriers to completing a comprehensive review and revision process of the applications, the delay did not have a negative impact on quality of services for enrollees as the applications are comprehensive but just need updating to streamline and clarify information.**

				Evaluation: While there were updates to the P & C applications throughout the fiscal year to clarify and simplify the applications, this goal will be continued in FY2022 as there is more work to be done. It is anticipated that continued improvements will be made this upcoming fiscal year. **Barrier Analysis: PIHP Staff Capacity Issues.** **Next Steps: Goal to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Autism Program

The goals for FY2021 Reporting are as follows:

- The PIHP will monitor and bring system-wide improvement to the ABA program.

A) Reduce the number of beneficiaries waiting to start ABA services, as measured by the number of persons on the overdue list and length of stay on the overdue list before beginning services.

		FY21 1Q	FY21 2Q	FY21 3Q	FY21 4Q		
		Dec	Mar	Jun	July	Aug	Sept
GHS	**Overdue List Total**	**150**	**152**	**189**	**195**	**216**	**218**
	≥90 (Days)	131	150	152	158	161	190
	60-89	3	0	5	4	30	3
	30-59	11	0	3	30	3	22
	0-29	5	2	29	3	22	3
Lapeer	**Overdue List Total**	**2**	**1**	**7**	**9**	**8**	**10**
	≥90	0	0	0	0	1	2
	60-89	1	1	0	3	1	3
	30-59	1	0	3	3	3	3
	0-29	0	0	4	3	3	2
Sanilac	**Overdue List Total**	**3**	**3**	**2**	**2**	**3**	**2**
	≥90	1	2	0	0	0	1
	60-89	0	0	0	1	1	0
	30-59	2	0	2	1	0	0
	0-29	0	1	0	0	2	1

- Monitor persons on autism services overdue list total
- Monitor completion of behavioral plans of care
- Monitor service provision in specified areas
- Monitor documentation submission to Waiver Support Application (WSA)
- Monitor services (encounters) using the funding Source Bucket Report (FSBR)

Lauren Bondy / Leah Julian

Monitored by Quality Improvement Committee (QIC)

Goal Met: ☐ Yes ☒ No

Quarterly Update:
Q 1: (Oct-Dec):
A. The PIHP hosted a virtual CMH Autism Coordinator meeting in October. These meetings will be held quarterly with the CMH Autism Leads. In October, the group reviewed the FY20 QI Program Workplan Annual Report. Each CMH provided an update on their ABA Programs and operations during the COVID-19 pandemic. During October, GHS also reported referrals have been made to the new ABA Providers in their network. GHS also reports an ABA Provider in their network will be tripling in capacity and another ABA Provider has started training new staff to take additional referrals. In November, phone calls began with GHS to discuss ongoing concerns related to overdue cases and documentation concerns. These phone calls will continue bi-weekly to help facilitate open communication with the GHS Autism lead. At the close of FY2021 Q1 GHS, Sanilac, and St. Clair have individuals waiting 90 days or more to begin ABA services.

B. Percentages for FY2020 4Q were calculated using available encounter data in October and November.

St. Clair	Overdue List Total	10	11	15	8	14	15
	≥90	1	4	4	1	1	1
	60-89	5	1	0	4	2	0
	30-59	3	5	8	3	0	8
	0-29	1	1	3	0	11	6

B) Autism benefit enrollees will receive one or more Family Behavior Treatment Guidance service per quarter.

Percentage of individuals receiving ≥1 Family behavior Treatment Guidance service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY20 4Q	FY21 1Q	FY21 2Q	FY21 3Q
Genesee	53.5%	50.0%	48.6%	45.8%
Lapeer	75.0%	84.0%	96.3%	100.00%
Sanilac	75.0%	84.6%	92.0%	95.8%
St. Clair	81.8%	75.4%	77.8%	74.7%

Standard: 100% of individuals will receive ≥ 1 Family Behavior Treatment Guidance Service per quarter, as measured using the FSBR report.

C) Autism Benefit enrollees with an active plan of service will receive one or more ABA service per quarter.

Percentage of individuals receiving ≥ 1 ABA service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY20 4Q	FY21 1Q	FY21 2Q	FY21 3Q
Genesee	56.3%	54.2%	56.3%	57.0%
Lapeer	83.3%	96.0%	96.3%	100.0%
Sanilac	85.7%	88.5%	92.0%	100.0%
St. Clair	87.3%	90.8%	87.5%	87.3%

Each CMH demonstrated an increase in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees between FY2020 Q3 and FY2020 Q4. Percentages for FY2021 1Q were calculated using available encounter data. Each CMH demonstrated a decrease in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees between FY2020 4Q and FY2021 1Q. It is likely the provision of Family Behavior Treatment Guidance continues to be impacted by the COVID-19 pandemic. The PIHP Autism Team will continue to monitor.

C. Percentages for FY2020 4Q were calculated using available encounter data in October and November. Each CMH demonstrated a slight increase in providing ABA services for Autism Benefit enrollees with a plan of service. Percentages for FY2021 1Q were calculated using available encounter data. Both GHS and St. Clair showed a decrease in providing ABA services for Autism Benefit enrollees with a plan of service between FY2020 4Q and FY2021 1Q. Lapeer and Sanilac showed an increase in providing ABA services for Autism Benefit enrollees with a plan of

	Standard: 100% of individuals will receive ≥ 1 ABA service per quarter, as measured using FSBR report.			**service between FY2020 4Q and FY2021 1Q. It is likely the provision of ABA services continues to be impacted by the COVID-19 pandemic. The PIHP Autism Team will continue to monitor.** **Q 2 (Jan-Mar):** **A. The PIHP hosted a virtual CMH Autism Coordinator meeting in January. Each CMH provided an update on their ABA Programs and operations during the COVID-19 pandemic. Findings from the PIHP's FY2020 clinical case record reviews were shared, noting many items were not scored due to COVID-19 relaxations. The group also discussed upcoming changes as written in the MSA Bulletin 2063-BHDDA. GHS reports an increase in referrals to ABA Providers to serve individuals waiting to begin ABA services and reduce their overdue totals. GHS also reports they have five (5) ABA providers with capacity to take referrals currently. At the close of FY2021 2Q GHS, Sanilac CMH, and St. Clair CMH have individuals waiting 90 days or more to begin ABA services.** **B. Percentages for FY2021 1Q were calculated and finalized using updated available encounter data. The finalized calculations reflect a**

				decrease in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees at GHS and St. Clair CMH between FY2020 4Q and FY2021 1Q. Lapeer CMH and Sanilac CMH demonstrated consistent improvement in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees over the last three quarters. Percentages for FY2021 2Q were calculated using updated available encounter data. GHS, Lapeer, and St. Clair CMH demonstrated a decrease in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees between FY2021 1Q and FY2021 2Q. Sanilac CMH demonstrated an increase in providing Family Behavior Treatment Guidance services to Autism Benefit enrollees between FY2021 1Q and FY2021 2Q. It is likely the provision of Family Behavior Treatment Guidance continues to be impacted by the COVID-19 pandemic. The PIHP Autism Team will continue to monitor. **C. Percentages for FY2021 1Q were calculated and finalized using updated available encounter data. Lapeer, Sanilac CMH, and St. Clair CMH demonstrated an increase in providing ABA**

				services for Autism Benefit enrollees with a plan of service over the last three quarters. GHS shows a slight decrease in providing ABA services for Autism Benefit enrollees with a plan of service between FY2020 4Q and FY2021 1Q. Percentages for FY2021 2Q were calculated using updated available encounter data. Both Lapeer CMH and St. Clair CMH showed a decrease in providing ABA services for Autism Benefit enrollees with a plan of service between FY2021 1Q and FY2021 2Q. Sanilac CMH showed an increase in providing ABA services for Autism Benefit enrollees with a plan of service between FY2021 1Q and FY2021 2Q. GHS showed no change in their provision of ABA services for Autism Benefit enrollees with a plan of service between FY2021 1Q and FY2021 2Q. The PIHP continues to note the provision of ABA services continues to be impacted by the COVID-19 pandemic. **Q 3 (Apr-June):** **A. The PIHP and CMH Autism Leads met in April for the Quarterly Autism Leads Meeting. This meeting was held virtually with all CMHs in attendance. All CMHs reported that ABA services are being delivered**

				in-home, at centers and virtually. Sanilac CMH, St. Clair CMH and Lapeer CMH reported that spikes in COVID-19 cases impacted some ABA service delivery. GHS reported that three (3) new providers are taking referrals, and this is decreasing the number of individuals waiting to begin ABA services at GHS. GHS also reported that an additional support staff has been hired to help the GHS Autism Lead. At the close of FY2021 Q3 GHS and St. Clair CMH have individuals waiting 90 days or more to begin ABA services. **B. In April, discrepancies in WSA reports were discovered. Additional tracking and reviews were added to the PIHP process to ensure accurate calculations for FY21 Q3. These same measures will be used when calculating totals for upcoming FY21 quarters. Percentages for FY2021 Q2 were calculated and finalized using updated available encounter data. The finalized calculations reflect an increase in the provision of Family Behavior Treatment Guidance between F21 Q1 and Q2 for Lapeer CMH, Sanilac CMH and St. Clair CMH. GHS shows a decrease in the provision of Family Behavior Treatment**

				Guidance between FY21 Q1 and Q2. Percentages for FY2021 Q3 were calculated using updated available encounter data. These calculations show a decrease in the provision of Family Behavior Treatment Guidance between FY21 Q2 and FY21 Q3 for all CMHSPs. It is likely the provision of Family Behavior Treatment Guidance continues to be impacted by the COVID-19 pandemic. The PIHP Autism Team will continue to monitor. **C. In April, discrepancies in WSA reports were discovered. Additional tracking and reviews were added to the PIHP process to ensure accurate calculations for FY21 Q3. These same measures will be used when calculating totals for upcoming FY21 quarters. Percentages for FY2021 Q2 were calculated and finalized using updated available encounter data. The final calculations reflect an increase in the provision of ABA services at GHS, Lapeer CMH and Sanilac CMH between FY21 Q1 and Q2. St. Clair CMH shows a decrease between FY21 Q1 and Q2 related to the provision of ABA services. Percentages for FY2021 Q3 were calculated using updated available encounter data. These initial**

				FY21 Q3 calculations show and increase between FY21 Q2 and FY21 Q3 for Sanilac CMH. A decrease in the provision of ABA services between FY21 Q2 and FY21 Q3 at GHS, Lapeer CMH and St. Clair CMH was reflected in the FY21 Q3 calculations. The PIHP continues to note the provision of ABA services continues to be impacted by the COVID-19 pandemic. **Q 4 (July-Sept):** **A. The PIHP and CMH Autism Leads met in July for the Quarterly Autism Leads Meeting. All CMHs were in attendance for this virtual meeting. Overdue totals continue to be calculated using reports from the WSA. These reports are reviewed and scrutinized by PIHP staff to ensure accuracy. Service delivery continues to be impacted the COVID-19 pandemic. There have been sporadic program closures due to exposure. At the close of FY21 Q4 GHS, Lapeer CMH, Sanilac CMH and St. Clair CMH have individuals waiting 90 days or more to begin ABA services. GHS and Lapeer CMH have individuals on inactive status due to parent choice, these inactive cases are not excluded from these totals.** **B. Percentages of autism benefit enrollees receiving one**

				or more Family Behavior Treatment Guidance service per quarter were calculated and finalized for FY21 Q3 using updated encounter data. These percentages show Lapeer CMH provided 100% of Autism benefit enrollees with one or more Family Behavior Treatment Guidance Services in FY21 Q3. Sanilac CMH provided 95.8%, St. Clair provided 74.7% and GHS provided 45.8% of their Autism benefit enrollees with one or more Family Behavior Treatment Guidance services in FY21 Q3. These calculations show a decrease in the provision of Family Treatment Guidance between FY21 Q2 and FY21 Q3 at GHS and St. Clair CMH. Lapeer CMH and Sanilac CMH increased the provision of Family Behavior Treatment Guidance services compared to FY21 Q2. The standard for this goal is that 100% of Autism benefit enrollees will receive one or more Family Treatment Guidance services per quarter. **C. Percentages of Autism benefit enrollees with an active plan of service that received one or more ABA service per quarter were calculated and finalized for FY21 Q3. These percentages were calculated using updated encounter data. The**

				standard for this goal is that 100% of Autism benefit enrollees with an active plan will receive one or more ABA service per quarter. Lapeer CMH and Sanilac CMH provided 100% of their Autism benefit enrollees with one or more ABA services in FY21 Q3. The current percentages for GHS, Lapeer CMH and Sanilac CMH, as calculated for FY21 Q3, have increased from their final totals for FY21 Q2. St. Clair CMH's current percentage, as calculated for FY21 Q3, has decreased from the final total for FY21 Q2. **Evaluation: Progress** **Barrier Analysis: No Barriers** **Next Steps: Objectives A and B will be continued to next FY.** Continue Objective(s)? ☒ Yes ☐ No

External Quality Review Corrective Actions	During the 2019-2020 External Quality Review of Region 10 PIHP, corrective action plans (CAPs) from the 2017-2018 and 2018-2019 Compliance Monitoring were reviewed. CAPs for the following areas were reviewed: Standard II. Quality Measurement and Improvement Standard V. Utilization Management Standard VI. Customer Service Standard VII. Enrollee Grievance Process Standard IX. Subcontracts and Delegation Standard XI. Credentialing Standard XIV. Appeals Standard XVI. Confidentiality of Health Information Standard XVII. Management Information Systems Per the 2020 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended Region 10 PIHP support future efforts MDHHS initiates to further improve upon performance indicator data accuracy and MDHHS Codebook clarity.	○ The Subject Matter Expert Lead staff for each area will provide updates regarding the status of corrective action plan activities	**Compliance Monitoring:** II. Quality Measurement and Improvement – Lauren Bondy V. Utilization Management – Katie Forbes VI. Customer Service – Katie Forbes VII. Enrollee Grievance Process – Katie Forbes IX. Subcontracts and Delegation – Katie Forbes XI. Credentialing – Amanda Zabor XIV. Appeals – Katie Forbes XVI. Confidentiality of Health Information – Katie Forbes XVII. Management Information Systems – Lauren Bondy **Performance Measurement Validation:** Lauren Bondy	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **<u>Quality Measurement and Improvement – Lauren Bondy:</u>** ***(Previous FY Completed Actions: PIHP developed process to ensure providers and persons receiving services are informed of assessment results. PIHP initiated work with QMC to develop a regional process for qualitative assessments.)*** ○ **FY21 Completed Actions: N/A** ○ **Pending Actions: PIHP continues work with QMC to develop a regional process for qualitative assessments.** **<u>Utilization Management – Katie Forbes:</u>** ***(Previous FY Completed Actions: Updated Adverse Benefit Determination (ABD) Notice and implemented (at PIHP and CMH levels); annual Contract Monitoring Tool updated; regional tracking mechanism created to address authorization and Notice timelines.)*** ○ **FY21 Completed Actions: Utilization Management Program Policy (draft) updated.** ○ **Pending Actions: Approval of Utilization Management Policy,**

				Implement ABD regional tracking mechanism (SUD Treatment Providers), update ABD Notice template format to include content regarding determination criteria, provide network training, enhance auditing of network ABD Notices. **<u>Customer Service – Katie Forbes:</u>** ***(Previous FY Completed Actions: Updated PIHP Customer Handbook and Grievance / Appeal Brochure; added staff capacity to Customer Service Department; Development of regional workgroup to address CMH Directories.)*** ○ **FY21 Completed Actions: CMH Directory compliance.** ○ **Pending Actions: PIHP Provider Directory compliance.** **<u>Enrollee Grievance Process – Katie Forbes:</u>** ***(Previous FY Completed Actions: Updated PIHP Grievance / Appeal Brochure; Updated PIHP Grievance & Appeal System Policy; added staff capacity to Customer Service Department; annual Contract Monitoring Tool updated; PIHP MIX module Acknowledgement & Resolution Letter template updates).***

				○ **FY21 Completed Actions: N/A – Oversight of Action Items continues.** ○ **Pending Actions: N/A** **<u>Subcontracts and Delegation – Katie Forbes:</u>** ***(Previous FY Completed Actions: Transitioned PIHP oversight of Appeals to PIHP direct hire staff; added staff capacity to Customer Service Department; annual Contract Monitoring Tool updated; updated contract language with CMH and SUD Providers).*** ○ **FY21 Completed Actions: N/A – Oversight of Action Items continues.** ○ **Pending Actions: N/A** **<u>Credentialing – Amanda Zabor:</u>** ***(Previous FY Completed Actions: SUD Provider contract language enhancements complete; annual Contract Monitoring Tool updated, Training created and sent to Network Providers.)*** ○ **FY21 Completed Actions: No update** ○ **Pending Actions: Credentialing Policy revisions, enhance contract monitoring (including review of CMH subcontractor credentialing), enhance procedures to develop a framework for review of**

				grievances, appeals and quality issues, provide network training. **<u>Appeals – Katie Forbes:</u>** ***(Previous FY Completed Actions: Updated Adverse Benefit Determination (ABD) Notice and implemented (at PIHP and CMH levels); Updated PIHP Grievance / Appeal Brochure; Updated PIHP Grievance & Appeal System Policy; added staff capacity to Customer Service Department; annual Contract Monitoring Tool updated; updated Provider contracts; updated PIHP record keeping process; PIHP MIX module Acknowledgement Letter updated; Training created and sent to Network Providers).*** o **FY21 Completed Actions: N/A** o **Pending Actions: Update MIX Grievance Module, enhance internal auditing and monitoring of Appeal Resolution Letter content.** **<u>Confidentiality of Health Information – Katie Forbes:</u>** ***(Previous FY Completed Actions: HIPAA Breach Notification written procedures and letter templates created; HIPAA Breach Notification Policy created and posted; SUD Provider contract language enhancements complete; annual Contract Monitoring Tool updated.)***

				○ **FY21 Completed Actions: N/A – Oversight of Action Items continues.** ○ **Pending Actions: N/A** **<u>Management Information Systems – Lauren Bondy:</u>** ***(Previous FY Completed Actions: Data Attestation form developed by Region 10 and submitted to MDHHS.)*** ○ **FY21 Completed Actions: Oversight of Action Items continues. PIHP will use draft template developed by MDHHS for future Data Attestation submissions.** ○ **Pending Actions: N/A** **<u>Performance Measurement Validation - Lauren Bondy</u>** **The PIHP PI Team will support MDHHS' efforts to improve data accuracy and codebook clarity.** **Q 2 (Jan-Mar):** **<u>Quality Measurement and Improvement – Lauren Bondy</u>** ○ **FY21 Completed Actions: Oversight continues with the QMC.** ○ **Pending Actions: Continued discussion regarding regional process for assessments of members' experience.** **<u>Utilization Management – Katie Forbes</u>**

				○ **FY21 Completed Actions: PCE has made module upgrades based on PCE Workgroup feedback specifically in the area of ABD Notice content. PIHP provided an ABD Training to CMH & SUD Treatment Networks with guidance on ABD Notice content changes. The ABD Tracking Log was implemented with the SUD Treatment Provider Network. Individual meetings with each Provider have been completed.** ○ **Pending Actions: Review of SUD Treatment ABD Tracking Log submissions (first due date 7/15/21). Enhanced auditing of ABD Notices across Network.** **<u>Customer Service – Katie Forbes</u>** ○ **FY21 Completed Actions: PIHP & PIHP Provider Directory compliance.** ○ **Pending Actions: N/A** **<u>Enrollee Grievance Process – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Subcontracts and Delegation – Katie Forbes</u>**

				○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Credentialing – Amanda Zabor</u>** ○ **FY21 Completed Actions: MDHHS/PIHP Medicaid Services contract reviewed as it relates to Primary Source Verification (PSV). Requirements for PSV have been incorporated into P & C policy where needed. Additionally, the P & C review worksheets and monitoring methodology have also been reviewed and updated. Additional methodology and review worksheets have been created to monitor CMH subcontractor credentialing.** ○ **Pending Actions: Enhancing procedures to develop a framework for review of grievances, appeals, and quality issues when credentialing or recredentialing.** **<u>Appeals – Katie Forbes</u>** ○ **FY21 Completed Actions: PCE has made changes to the MIX G&A Module including updating appeal resolution letter content to meet required**

				standards from our Corrective Action Plan. ○ **Pending Actions: Internal monitoring and auditing of appeal resolution letter content.** **<u>Confidentiality of Health Information – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Management Information Systems – Lauren Bondy</u>** ○ **FY21 Completed Actions: Oversight of Action Items continues** ○ **Pending Actions: N/A** **<u>Performance Measurement Validation - Lauren Bondy</u>** **The PIHP PI Team will support MDHHS' efforts to improve data accuracy and codebook clarity.** **Q 3 (Apr-June):** **<u>Quality Measurement and Improvement – Lauren Bondy</u>** ○ **FY21 Completed Actions: Oversight continues with the QMC.** ○ **Pending Actions: Requested evidence from Providers through annual contract monitoring process for assessments of members' experience with services.**

				<u>Utilization Management – Katie Forbes</u> ○ **FY21 Completed Actions: No update** ○ **Pending Actions: Monitor incoming SUD ABD Tracking Logs and continue to monitor CMH ABD Tracking Logs.** **<u>Customer Service – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Enrollee Grievance Process – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Subcontracts and Delegation – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Credentialing – Amanda Zabor</u>** ○ **FY21 Completed Actions: MDHHS/PIHP Medicaid Services contract reviewed as it relates to Primary Source Verification (PSV). Requirements for PSV have been incorporated**

				into P & C policy where needed. Additionally, the P & C review worksheets and monitoring methodology have also been reviewed and updated. Additional methodology and review worksheets have been created to monitor CMH subcontractor credentialing. Working with the Customer Services / Grievance & Appeals Department, staff have enhanced procedures to develop a framework for review of grievances, appeals, and quality issues when credentialing or recredentialing. Oversight of action items continues. o **Pending Actions: N/A** **<u>Appeals – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Confidentiality of Health Information – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Management Information Systems – Lauren Bondy</u>**

				○ **FY21 Completed Actions: The FY2020 Data Attestation Form was submitted using MDHHS template.** ○ **Pending Actions: N/A** **<u>Performance Measurement Validation - Lauren Bondy</u>** **The PIHP PI Team will support MDHHS' efforts to improve data accuracy and codebook clarity. The PIHP PI Team sends questions to MDHHS to ensure correct interpretation of the PI Codebook and to improve clarity.** **Q 4 (July-Sept):** **<u>Quality Measurement and Improvement – Lauren Bondy</u>** ○ **FY21 Completed Actions: Oversight continues with QMC.** ○ **Pending Actions: The PIHP's FY2021 Customer Satisfaction Survey is being administered. Qualitative assessments are being addressed through contract monitoring processes.** **<u>Utilization Management – Katie Forbes</u>** ○ **FY21 Completed Actions: Oversight of Action Items continues.** ○ **Pending Actions: N/A**

				<u>Customer Service – Katie Forbes</u> o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Enrollee Grievance Process – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Subcontracts and Delegation – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Credentialing – Amanda Zabor</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Appeals – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A** **<u>Confidentiality of Health Information – Katie Forbes</u>** o **FY21 Completed Actions: Oversight of action items continues.** o **Pending Actions: N/A**

				<u>Management Information Systems – Lauren Bondy</u> ○ **FY21 Completed Actions: Oversight of action items continues.** ○ **Pending Actions: N/A** **<u>Performance Measurement Validation - Lauren Bondy</u>** **The PIHP PI Team will support MDHHS' efforts to improve data accuracy and codebook clarity.** **Evaluation: The PIHP implemented corrective actions from past external quality reviews.** **Barrier Analysis: Some barriers included staff capacity and the impact of COVID-19 safety procedures on in-person groups.** **Next Steps: The PIHP will continue oversight of completed corrective actions. The PIHP will also continue oversight of providers through the contract monitoring process.** Continue Objective(s)? ☒ Yes ☐ No

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As of 10.04.2021