MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM REPORT FY25

Prepared by MSHN Quality Manager – November 2025
Reviewed by MSHN Leadership – November 19th, 2025
Reviewed and Approved by MSHN Quality Improvement Council – November 26th, 2025
Reviewed by the Regional Consumer Advisory Council: December 12th, 2025
Reviewed by MSHN Operations Council: December 15th, 2025
Reviewed and Approved by MSHN Board – March 3rd, 2026

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ABOUT US

Mid-State Health Network (MSHN) is a regional public entity established under Michigan's Mental Health Code (1974 P.A. 258, as amended; MCL §330.1204b). Formed by its Community Mental Health Services Program (CMHSP) participants, MSHN serves as the Prepaid Inpatient Health Plan (PIHP) for the 21-county Region 5, as designated by the Michigan Department of Health and Human Services (MDHHS).

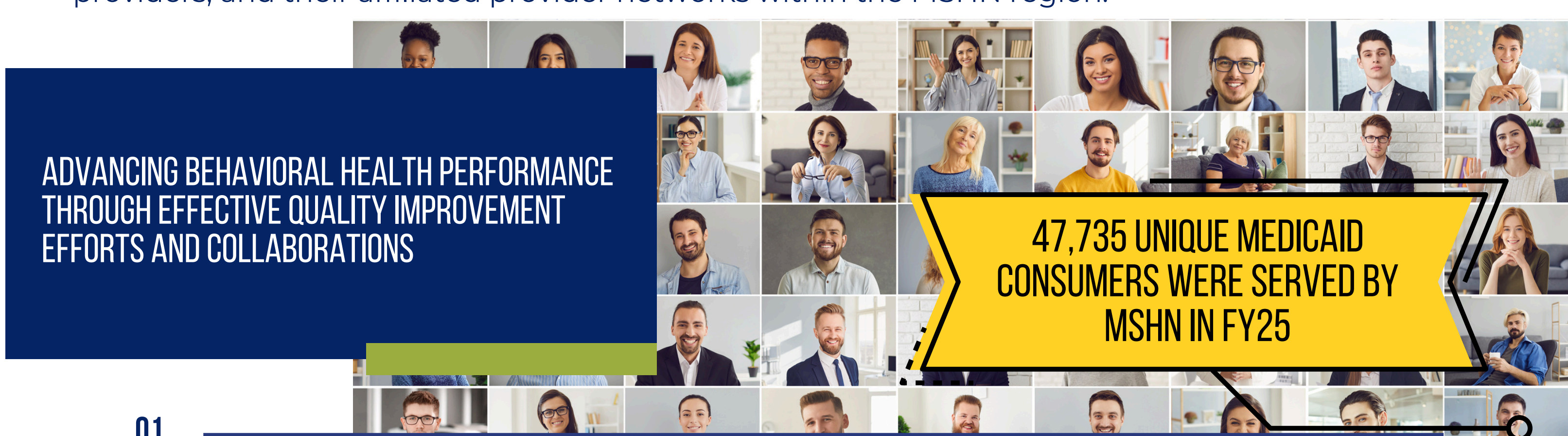
Since its inception in 2014, MSHN has maintained a contractual partnership with the State of Michigan to manage Medicaid-funded behavioral health services. Through subcontracts with its CMHSP participants, MSHN oversees the delivery of high-quality, accessible, and person-centered services for individuals with mental illness, substance use disorders, and developmental disabilities.

CMHSP participants include: Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door, and Tuscola Behavioral Health Systems.

Each year, MSHN's Quality Assessment and Performance Improvement Program (QAPIP) is evaluated to ensure the continued effectiveness of quality and performance improvement activities. The annual review includes:

- Assessment of compliance with state and federal requirements
- Analysis of QAPIP Workplan activities and their impact on key performance outcomes
- Review of committee and council accomplishments with updated goals for the upcoming year

The FY25 QAPIP Plan and associated Workplan demonstrated measurable progress toward improving access, outcomes, and quality of care across the MSHN region. Recommendations and improvement strategies identified through this evaluation have been incorporated into the FY26 QAPIP Plan. This QAPIP report/evaluation covers the measurement period from October 1, 2024 through September 30, 2025, encompassing all CMHSP participants, substance use disorder providers, and their affiliated provider networks within the MSHN region.

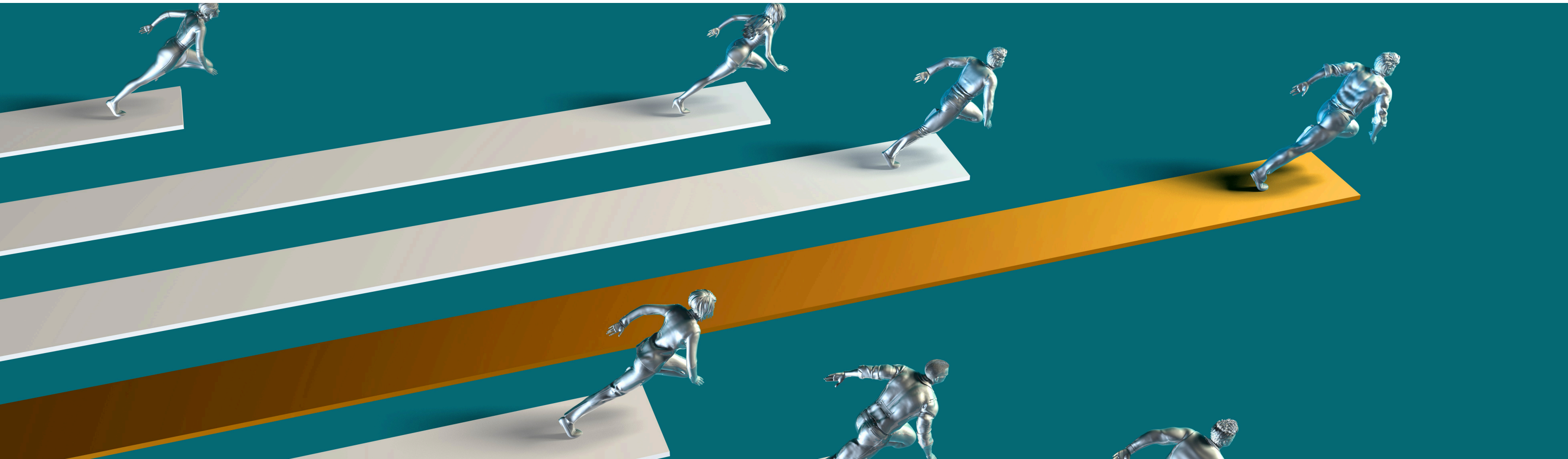


PERFORMANCE MEASUREMENT

MSHN continuously monitors performance through a comprehensive system of data collection, trend analysis, and outcome evaluation designed to assess the effectiveness, efficiency, and quality of services delivered across the region. Performance measurement serves as the cornerstone of MSHN's QAPIP, ensuring that decision-making at every level is guided by valid and reliable data.

Performance data is collected through multiple validated sources, including MDHHS-required indicators, regional dashboards, the Balanced Scorecard, satisfaction surveys, provider monitoring reviews, and audit outcomes. Where available, MSHN uses standardized performance measures aligned with the MDHHS Behavioral Health Quality Program and the National Committee for Quality Assurance (NCQA) domains of access, effectiveness, and experience of care.

MSHN evaluates longitudinal performance by analyzing regional and local trends over time, comparing results against both the previous measurement period and established benchmarks, such as state and national averages (where available), contractual performance thresholds, and internally set targets. Each measure receives a performance status of "Met" or "Not Met." When a performance target is not met, the responsible provider collaborates in a structured quality improvement process. This process follows the Plan-Do-Study-Act (PDSA) framework and includes root cause analysis, barrier identification, and implementation of targeted interventions. These interventions are developed under the guidance of the assigned committee or council, often in collaboration with other relevant MSHN workgroups, to ensure that improvement efforts are regionally coordinated and data-informed.



Following data analysis, each council/committee evaluates each measure and recommends one of the following actions for the measure in the upcoming QAPIP plan:

- Continue – Maintain current measurement and monitoring cycle due to demonstrated value or ongoing relevance
- Discontinue – Retire measure due to consistent achievement or obsolescence (e.g., replacement by new MDHHS indicators)
- Modify – Adjust target, data source, or monitoring frequency based on emerging trends, updated benchmarks, or revised regulatory requirements

These recommendations ensure that MSHN's performance measurement activities remain dynamic, targeted, and align with the region's evolving service needs and quality priorities. Performance results are disseminated quarterly through regional committees, councils, and leadership forums, and annually through the QAPIP Report to the MSHN Board of Directors and MDHHS.

QAPIP WORKPLAN FY25 REVIEW

MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM (MMBPIS)

MDHHS, in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes through The Michigan Mission Based Performance Indicator System (MMBPIS). Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance and meeting standards for these indicators.

FY25 STATUS

MSHN exceeded the State Average performance on nine of the 18 indicators as demonstrated in the MMBPIS PIHP Final Report FY25Q3. Of note, population breakdowns for indicators 2 and 3 do not have standards associated, however, total results for these indicators have standardized benchmarks established by MDHHS as noted. Figure one demonstrates the status of each MMBPIS indicator along with FY25 results (where available).

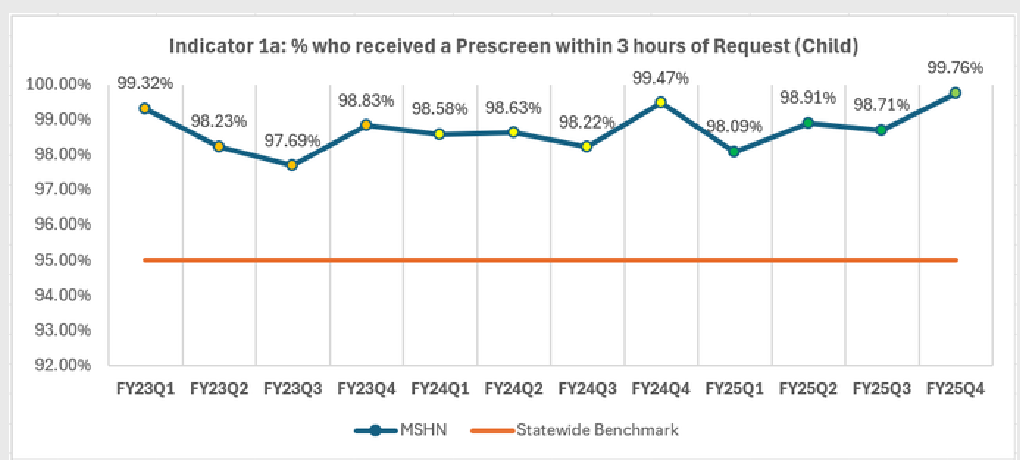
MMBPIS Indicator	Population	Standard	FY24	FY25Q1	FY25Q2	FY25Q3	FY25Q4	FY25	Status
Indicator 1: Percentage who received a Prescreen within 3 hours of request	Children	≥95%	98.58%	98.09%	98.91%	*98.71%	99.76%	98.92%	●
	Adults	≥95%	*99.67%	*99.70%	*99.58%	*99.68%	99.36%	99.58%	●
Indicator 2: Percentage of new persons who have completed Bio-psychosocial Assessment within 14 Days	MI Child	>62.3%	*61.79%	*58.89%	59.19%	*61.92%	67.24%	60.85%	■
	MI Adults			59.26%	61.14%	62.54%	69.25%		
	DD Child			47.29%	44.38%	32.21%	48.88%		
	DD Adult			56.12%	56.14%	*50.46%	66.97%		
	Total			58.29%	59.01%	59.52%	66.74%		
Indicator 2e: Percentage of new persons receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service	SUD	>75.3%	*72.40%	*69.63%	*78.93%	*80.43%	Data not yet Available from MDHHS	Full FY data not yet available from MDHHS	●
Indicator 3: Percentage of new persons who had a medically necessary service within 14 days	MI Child	>72.9%	59.72%	54.86%	58.27%	63.26%	66.77%	65.74%	■
	MI Adults			63.24%	68.68%	64.75%	68.53%		
	DD Child			78.31%	83.28%	72.20%	80.74%		
	DD Adult			67.47%	68.63%	67.42%	67.31%		
	Total			61.76%	66.62%	65.08%	69.34%		
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit	Children	≥95%	*94.67%	95.48%	*98.11%	*96.18%	96.48%	97.70%	●
	Adults	≥95%	*95.20%	95.61%	*95.81%	*96.15%	96.21%	96.16%	●
	MSHN SUD	≥95%	95.02%	95.27%	91.53%	93.83%	93.45%	94.08%	■
Indicator 10: Percentage who had a Re-admission to Psychiatric Unit within 30 Days	Children	≤15%	*9.36%	*8.56%	12.05%	*6.67%	8.18%	8.42%	●
	Adults	≤15%	*10.73%	*10.12%	*12.92%	*12.51%	10.40%	11.50%	●

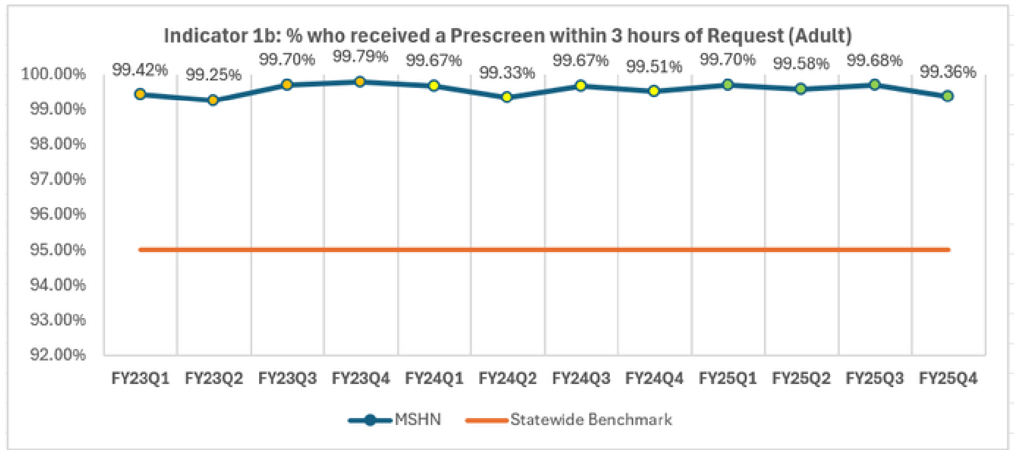
* indicates MSHN exceeded the Michigan State Performance for the Performance indicator for that quarter (please note that data for FY25Q4 and full FY25 has not yet been obtained from MDHHS for comparison)

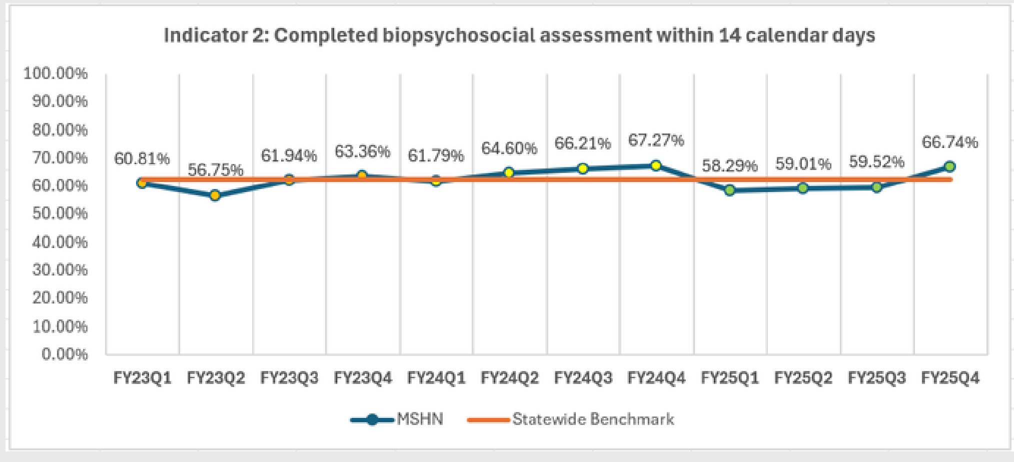
Orange highlighting indicates indicators that have not met established MDHHS performance standards in FY25

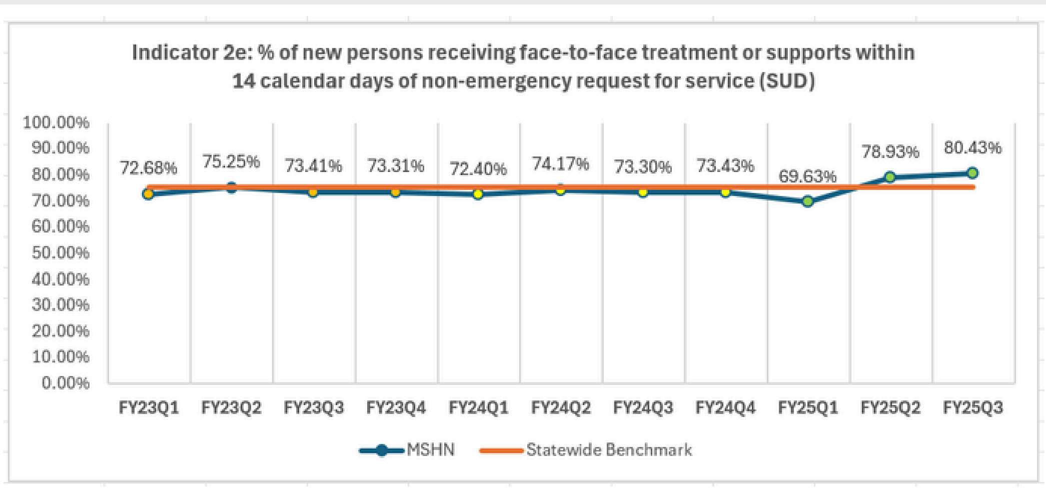
Data collected and reviewed within MSHN's QIC indicates the main reasons for not meeting indicator 2 and 3 standards were due to consumer choice (no shows/cancellations, decision not to pursue services, consumer refusing appointments within required timeframes, and consumer reschedules). Ongoing improvement discussions were held quarterly within QIC and interventions were implemented during FY25 to address priority areas.

MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM (MMBPIS) CONTINUED









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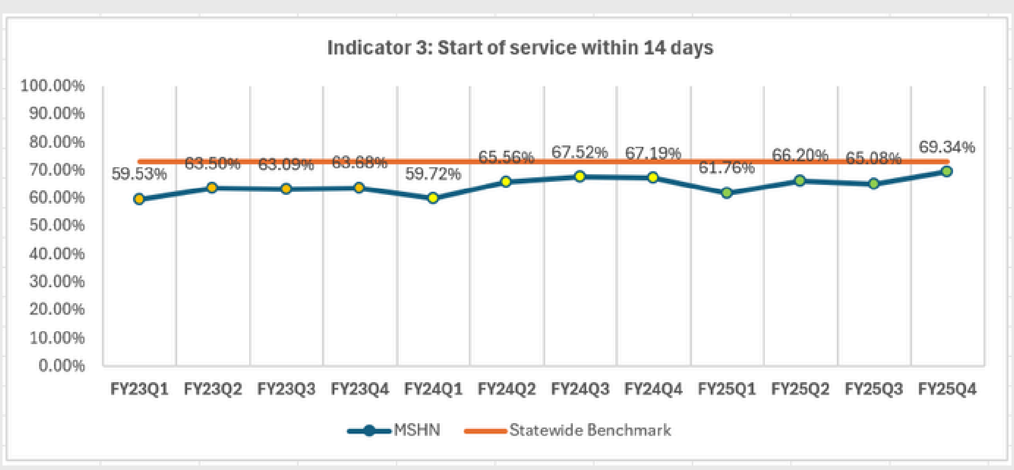

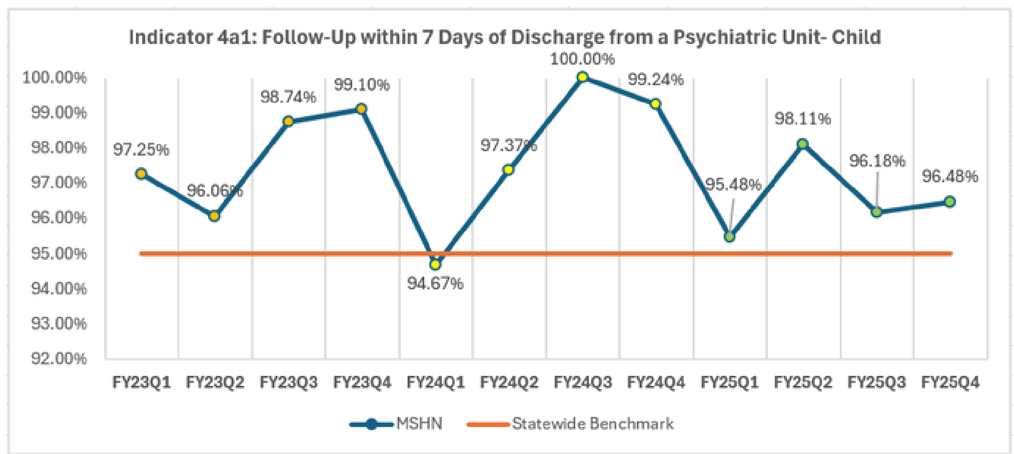

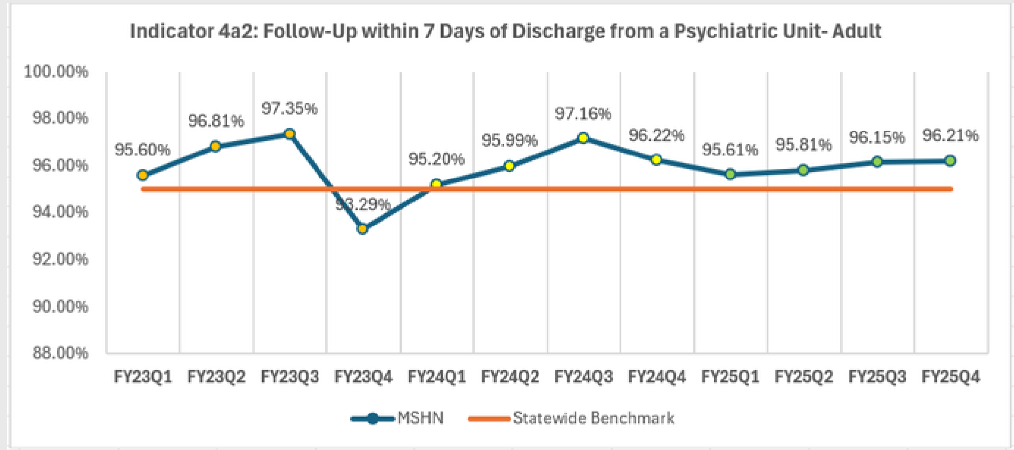

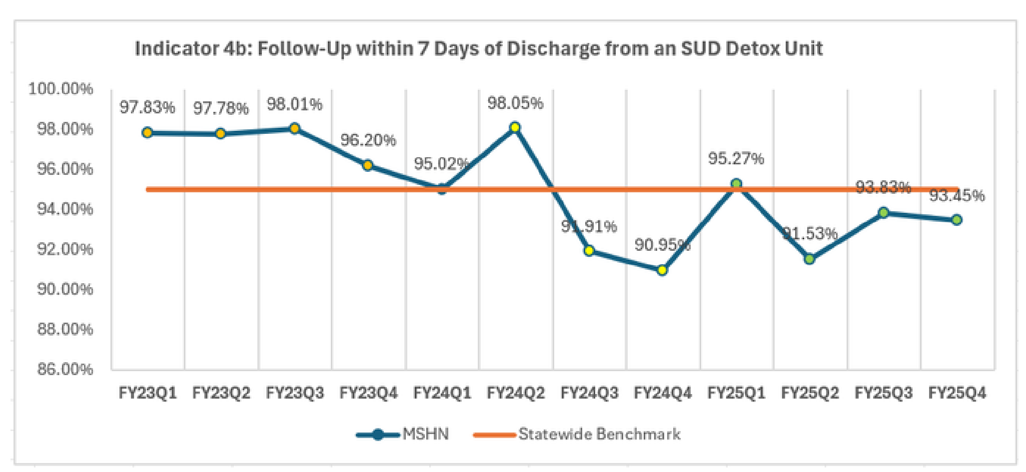

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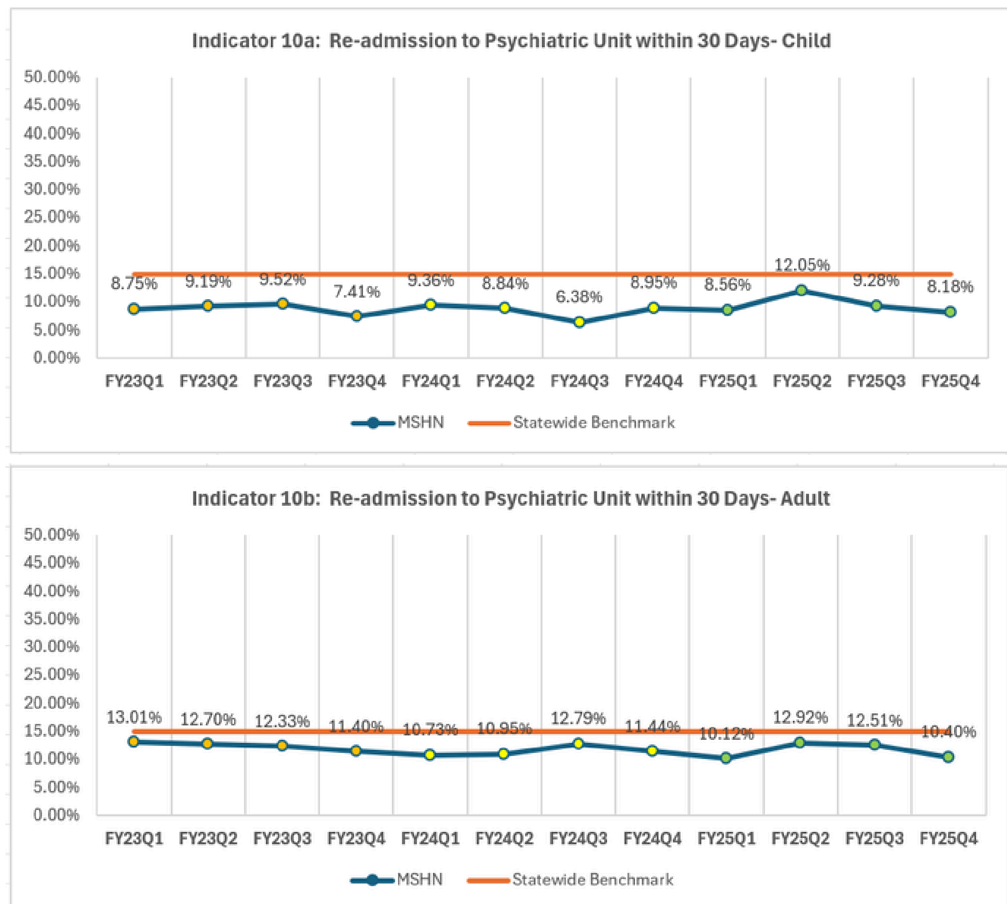


IDENTIFIED BARRIERS AND INTERVENTIONS

As indicated above, consumer no shows/cancellations/requests outside the 14-day requirement for appointments were widespread barriers in meeting indicator 2 and 3 MMBPIS metrics. Interventions relating to cancellations include staff completing appointment reminder phone calls as well as automated phone calls/text message adoption. Effectiveness reviews show that these interventions have had mixed effectiveness based on CMH in reducing cancellations/no shows.

In addition, the following barriers were identified and interventions put in place for FY25:

- **Barrier:** Staff vacancies and turnover among licensed clinicians impacted timeliness of biopsychosocial assessments and follow-up appointments (persistent workforce shortages across CMHSPs and SUD providers)
- **Intervention(s):**
  - Direct service capacity enhancements by adding licensed staff and restructuring intake scheduling practices
  - Pursuit of staff retention and workplace satisfaction improvements
- **Effectiveness of Interventions:** Interventions were minimally effective in reducing this barrier as there was an increase in the number of cancellations/reschedules due to staffing issues in FY25 compared to previous fiscal years

- **Barrier:** Variability in access scheduling processes across CMHSPs
- **Intervention(s):**
  - Ongoing collaborative discussions within MSHN’s QIC meeting to discuss practices and what is currently working and not working for each CMHSP to review replication of practices where effective
- **Effectiveness of Intervention:** This intervention was not measurable in terms of effectiveness, but rather was a way for CMHSPs to develop interventions collaboratively

MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM (MMBPIS) CONTINUED

IDENTIFIED BARRIERS AND INTERVENTIONS

- **Barrier:** Limited capacity for same-day access or flexible scheduling for new consumers (limited weekend and after-hours appointment options)
- **Intervention(s):**
  - Early outreach and appointment-setting protocols through targeted staff engagement, clear expectations, and training to reduce delays in access and initial service delivery
  - Expansion of clinic hours to accommodate later appointments
  - Integrating a new opt-in text/voice reminder system with rollout training to support compliance
  - Elimination of paperwork time and leveraging cancellation lists for virtual intakes
- **Effectiveness:** CMHSPs that implemented additional hours and flexibility within scheduling had increases in scheduling and attendance with these appointments making these interventions effective

- **Barrier:** Data discrepancies between electronic health record (EHR) extraction and MDHHS specifications (for indicator 3) created inconsistent reporting amongst the PIHPs, this created a lack of comparable data to drive improvement efforts in FY25
- **Intervention(s):** No changes were made within MSHN's tracking or reporting of data, however, discussions were had within the MDHHS Statewide QIC meeting to discuss the differences in interpretation and reporting of indicator 3. MDHHS clarified that due to these discussions, Indicator 3 rates will be reflected as informational only in this year's PMV reports and will not be held or evaluated against the associated performance indicator percentile benchmarks

FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will meet or exceed the MMBPIS Standards for Access (Indicators 1, 2, 3, and 4) and Outcomes (Indicator 10) as required by MDHHS	Partially Effective	Discontinue Indicators 4 and 10 due to removal by the State. Continue Indicator 1 for Network Adequacy Assessment, Indicator 2 for MDHHS MMBPIS requirements, and Indicator 3 for Performance Improvement Project (CY25). Remaining indicators will have interventions clearly tracked and monitored for effectiveness in FY26.

ACCESS - PRIORITY POPULATIONS

Increasing compliance with access standards for priority populations has been a targeted area of improvement for MSHN since FY23.

- **Barrier:** One of the barriers/causal factors that was identified in previous fiscal years was low rates of timely admission to SUD withdrawal management and residential services for pregnant individuals.
- **Intervention:** During FY25 MSHN implemented an intervention of centralizing access to SUD withdrawal management and residential services for all individuals, including pregnant individuals.
- **Effectiveness:** In FY23, the average rate of compliance for pregnant individuals was 35% compared to an average rate of compliance for pregnant individuals of nearly 60% at the end of FY25. The rate of compliance for non-pregnant priority population individuals also showed a modest improvement throughout FY25 increasing from 80% during FY25 Q1 to 87% at the end of Q3. This suggests that targeted interventions have been effective, however there is still room for further improvement to consistently comply with admission timeliness standards for all priority populations, especially for pregnant individuals.

FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will demonstrate an increase in compliance with access standards for the priority populations	Effective	Continue goal with all improvement activities in 2026 for continuation of monitoring of effectiveness.

PERFORMANCE BASED INCENTIVE MEASURES (PBIP)

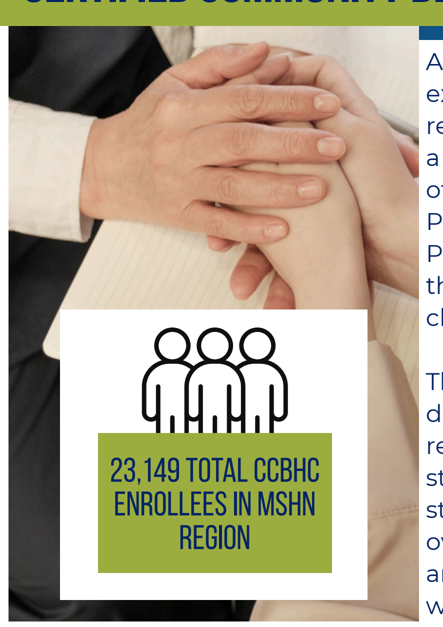
Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Ensuring member access and engagement in the areas of comprehensive care, patient-centered practices, coordination among multiple systems of care, accessible services, quality, and safety continued to be targeted priorities for MSHN during FY25. The full listing of PBIP metrics and descriptions can be found at MDHHS's FY25 PIHP Performance Bonus Incentive Program.

Data is currently available through CY25Q1 due to delays in CareConnect360 published data. Please note that the PBIP Measurement for FY25 is based off of Calendar Year 2024. Additional measurement points provided for CY25Q1 for comparison purposes. Disparities are calculated using the scoring methodology developed by MDHHS to detect statistically significant differences.

Strategic Priority	Metrics	Standard	CY22	CY23	CY24	CY25Q1	Status
Better Care	J.2.a. Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days - The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge (FUH-Data Source CC360)	58%	70%	69%	70%	70%	Green
	J.2.b. Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days- The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge (FUH- Data Source CC360)	79%	88%	85%	88%	89%	Green
	J.2.c. Racial/ethnic group disparities will be reduced- Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (for adults and children)	No Disparity	No Disparity	Disparity	Disparity	Disparity	Red
	J.3.a. Initiation of AOD Treatment- The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis (IET-14TOT)	40%	Unknown	37%	37%	37%	Red
	J.3.b. Engagement of AOD Treatment- The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit	14%	Unknown	13%	13%	13%	Red
	J.3.c. Racial/ethnic group disparities will be reduced for AOD- Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for those Initiating or Engaging in AOD treatment	No Disparity	Unknown	Disparity	Disparity	Disparity	Red
	J.4.a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence	No benchmark	43%	38%	40%	39%	Green
	J.3 b. Racial/ethnic group disparities will be reduced for FUA- Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use	No Disparity	Disparity	Disparity	Disparity	Disparity	Red

FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will meet or exceed the PBIPs measure performance using standardized indicators including those established by MDHHS in the Medicaid contract	Partially Effective	Continue monitoring at same frequency for ongoing improvement efforts for areas falling below MDHHS standard benchmark performance and for ongoing reduction in disparities in these metrics.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS



A Certified Community Behavioral Health Clinic (CCBHC) is a clinic designed to enhance and extend a comprehensive range of mental health and substance use services to a county or region. The Certified Community Behavior Health Clinics within the MSHN region review data on a quarterly basis to identify any areas of improvement needed and to share best practices with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures under the CCBHC programs. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect360 to monitor performance throughout the year. The data in the table below is obtained from CC360 and is only available through March 31, 2025 due to claims data lag within CC360.

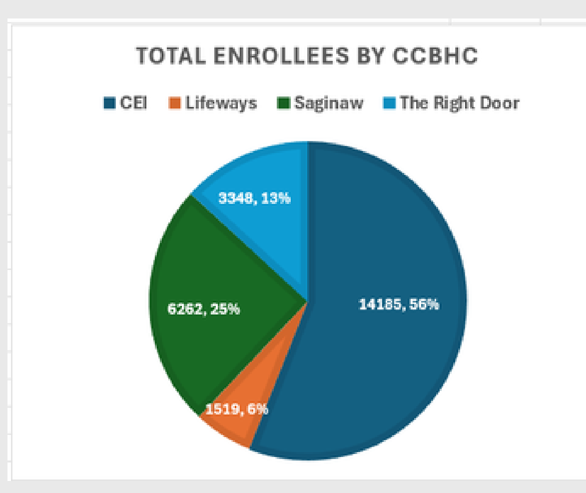
The clinics that perform below the standard are responsible for analyzing their organizations data and developing improvement strategies throughout the fiscal year. If causal factors are related to a system issue and a regional response is required by the lead entity, improvement strategies are developed and monitored for effectiveness. During FY25, a regional improvement strategy was not required for any areas. Due to transitions within the MDHHS framework of the oversight of CCBHC's for FY26, MSHN is no longer the Lead Entity responsible for the monitoring and oversight of CCBHC programs, and therefore these metrics along with associated workgroup will be discontinued for FY26.

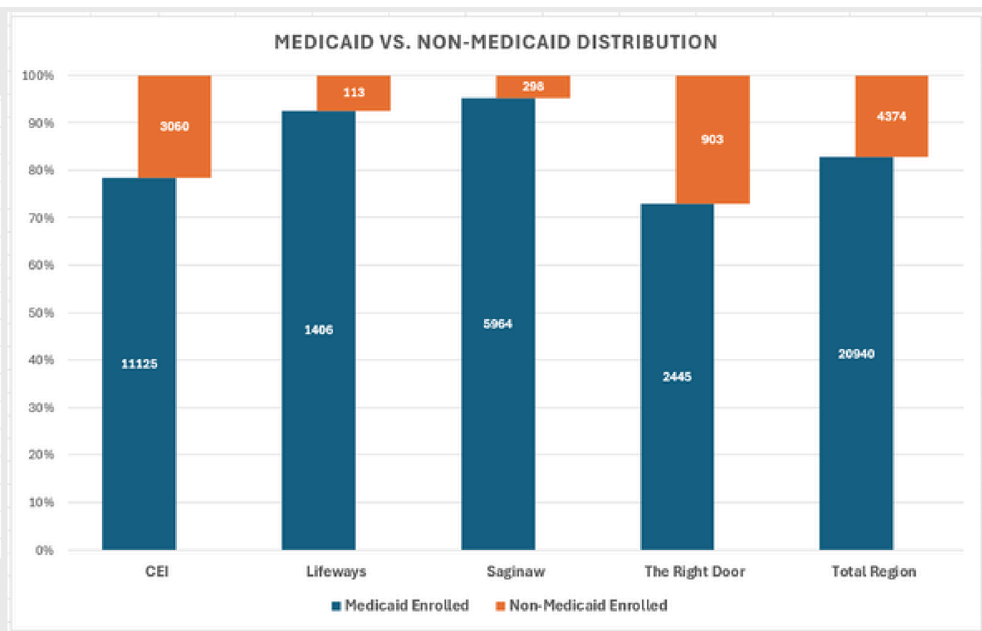
Metric Key	Measure	Definition	CCBHC	Numerator	Denominator	Rate	QBP/Program Benchmark	Status
FUH-30AD	Follow-Up within 30 days after Hospitalization for Mental Illness - Adult (FUH-30AD)	Percentage of discharges for beneficiaries age 21 - 64 who are hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	11,203	17,151	65.32%	75%	■
			MSHN Total	2,151	3,072	70.02%		
			CCBHC Program Total	**6,811**	**9,745**	**69.89%**		
			CEI	513	820	62.56%		
			TRD	65	79	82.28%		
			Lifeways	270	392	68.88%		
			SCCMHA	396	532	74.44%		
FUH-7AD	Follow-Up within 7 days after Hospitalization for Mental Illness - Adult (FUH 7AD)	Percentage of discharges for beneficiaries ages 18 - 64 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Michigan Medicaid Total	7,313	17,151	42.64%	48%	■
			MSHN Total	1,383	3,072	45.02%		
			CCBHC Program Total	**4,448**	**9,745**	**45.64%**		
			CEI	341	820	41.59%		
			TRD	41	79	51.90%		
			Lifeways	163	392	41.58%		
			SCCMHA	249	532	46.80%		
FUH-30CH	Follow-Up within 30 days after Hospitalization for Mental Illness - Child (FUH-30CH)	Percentage of discharges for beneficiaries age 6 - 20 who are hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	2,896	3,581	80.87%	88%	■
			MSHN Total	570	643	88.65%		
			CCBHC Program Total	**1,970**	**2,387**	**82.53%**		
			CEI	165	181	91.16%		
			TRD	18	20	90.00%		
			Lifeways	64	75	85.33%		
			SCCMHA	84	108	77.78%		
FUH-7CH	Follow-Up within 7 days after Hospitalization for Mental Illness - Child (FUH 7CH)	Percentage of discharges for beneficiaries ages 6-17 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Michigan Medicaid Total	2,131	3,581	59.51%	60.0%	●
			MSHN Total	430	643	66.87%		
			CCBHC Program Total	**1,459**	**2,387**	**61.12%**		
			CEI	130	181	71.82%		
			TRD	12	20	60.00%		
			Lifeways	45	75	60.00%		
			SCCMHA	57	108	52.78%		
IET 14 AD	Initiation of SUD Treatment - Adult Total (IET-AD)*	Percentage of new substance use disorder (SUD) episodes for beneficiaries 18 years and older that result in the following: Initiation of Treatment - percentage of new SUD episodes that result in treatment initation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days.	Michigan Medicaid Total	15,736	42,767	36.79%	41%	●
			MSHN Total	2,668	7,135	37.39%		
			CCBHC Program Total	**3,209**	**7,907**	**40.58%**		
			CEI	239	541	44.18%		
			TRD	39	97	40.21%		
			Lifeways	125	364	34.34%		
			SCCMHA	140	338	41.42%		
IET 34 AD	Engagement of SUD Treatment - Adult Total (IET-AD)	Percentage of new substance use disorder (SUD) episodes for beneficiaries 18 years and older that result in the following: Engagement of Treatment - percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Michigan Medicaid Total	4,816	42,767	11.26%	14.0%	●
			MSHN Total	879	7,135	12.32%		
			CCBHC Program Total	**1,109**	**7,907**	**14.03%**		
			CEI	91	541	16.82%		
			TRD	24	97	24.74%		
			Lifeways	35	364	9.62%		
			SCCMHA	45	338	13.31%		

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS CONTINUED

PCR	Plan All Cause Readmission (PCR)	For beneficiaries 18 - 64, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	5,878	60,505	9.71%	≤ 10%	
			MSHN Total	1,005	10,087	9.96%		
			CCBHC Program Total	**1,196**	**11,048**	**10.83%**		
			CEI	101	860	11.74%		
			TRD	11	123	8.94%		
			Lifeways	36	347	10.37%		
			SCCMHA	61	568	10.74%		

The following data is as of September 30, 2025:





FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will meet or exceed the Certified Community Behavioral Health Clinic Performance Metrics standards in accordance with the PIHP Medicaid contract	Partially Effective ⚠	Discontinue due to MSHN no longer having Lead Entity responsibilities according to MDHHS changes with CCBHC oversight

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

MDHHS requires Pre-Paid Inpatient Health Plans (PIHPs) to complete a minimum of two performance improvement projects per waiver renewal period. MSHN has approved the two Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region for CY22 through CY25. Due to the procurement process, MDHHS informed the PIHPs in August of 2025 that MDHHS has elected for PIHPs to continue the current PIPs with a 3rd remeasurement period to demonstrate improvement and/or to demonstrate sustainment of performance for submission to HSAG in July 2026.

Performance Improvement Project Goal 1: Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment without a decline in performance for the White population?

Indicator 1: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

- Numerator: Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment
- Denominator: Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid State Health Network region and are determined eligible for ongoing services

Measurement: CY2025 YTD Remeasurement vs. CY2021 Baseline - When comparing the percentage of compliance for the Black/African American population between baseline (CY2021) and remeasurement period 3 (CY2025 YTD), the percentage positively increased from 64.68% to 65%. In reviewing this with a two-proportion z-test, the difference in compliance between the two time periods was significant because the p-value is greater than 0.05.

Indicator 1: The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Rate (%)	Mandated Goal if applicable	*p* Value
01/01/2021–12/31/2021	*Baseline*	837	1294	64.68%	N/A for baseline	Reference
01/01/2023–12/31/2023	Remeasurement 1	822	1371	59.96%	Increase	P value .01329
01/01/2024–12/31/2024	Remeasurement 2	777	1273	61.04%	Increase	P value .06135
01/01/2025 – 06/30/2025	Remeasurement 3	390	600	65%	Positive	P value .91582

Indicator 2: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

- Numerator: Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment
- Denominator: Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services

Measurement: CY2025 YTD Remeasurement vs. CY2021 Baseline - When comparing the percentage of compliance for the White population between the baseline (CY2021) and remeasurement period 3 (CY2025 YTD), data shows a statistically significant decrease (69.25% to 65.09%). Using a two-proportion z-test, the difference in compliance between the two time periods shows a statistically significant decrease due to the p-value being less than 0.05.

Indicator 2: The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal, if applicable	*p* Value
01/01/2021-12/31/2021	*Baseline*	6050	8737	69.25%	N/A for baseline	Reference
01/01/2023 - 12/31/2023	Remeasurement 1	5649	8968	62.99%	≥69.49%	P value 0
01/01/2024– 12/31/2024	Remeasurement 2	4874	7450	65.42%	≥69.49%	P value 0
01/01/2025 – 06/30/2025	Remeasurement 3	2234	3432	65.09%	≥69.49%	P value .00001

Indicator 3: The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

- Metric: A comparison of the percentage of compliance between the black and white populations for each time period with a two-proportion z-test. This is used to determine if the difference in rates are statistically significant

CY2025 YTD Remeasurement Findings- A two-proportion z-test comparing compliance rates between Black/African American and White populations for remeasurement period 3 (CY2025 YTD) against the baseline (CY2021) did not show a statistically significant difference (65.09% vs. 65%) for this measurement period between 1/1/2025 to 6/30/2025. **Since p > 0.05, the disparity between these two populations for remeasurement period 3 (YTD) has been statistically eliminated. This confirms that MSHN's interventions that have been put in place are having a positive impact in removing the disparity across the region.**

Indicator 3: The percentage of new persons who are Black/African American or White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment								
Time Period	Indicator Measurement	White Numerator	White Denominator	Percentage	Black Numerator	Black Denominator	Percentage	p-Value (Goal p value <0.500)
01/01/2021 - 12/31/2021	Baseline	6050	8737	69.25%	837	1294	64.68%	.00108
01/01/2023 - 12/31/2023	Remeasurement 1	5649	8968	62.99%	822	1371	59.96%	.03297
01/01/2024 – 12/31/2024	Remeasurement 2	4874	7450	65.42%	777	1273	61.04%	.00274
01/01/2025 – 06/30/2025	Remeasurement 3	2234	3432	65.09%	390	600	65%	1

PERFORMANCE IMPROVEMENT PROJECTS (PIPS) CONTINUED

Performance Improvement Project Goal 2: Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the Black/African American penetration rate and the index (White) penetration rate of those who are eligible for Medicaid services?

PIP #2 utilizes administrative data for analyses: the data source is a standard report within REMI which includes a pull from claims/encounter data and the 834 eligibility file.

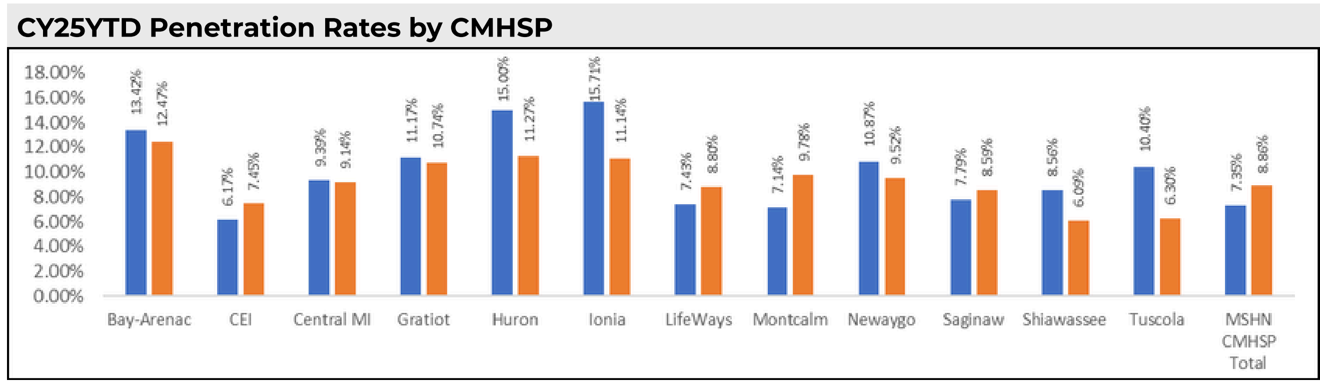
Indicator 1: The percentage of individuals who are black/African American and eligible for Medicaid and have received a PIHP managed service

- Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service (CMHSPs Combined)
- Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region (CMHSPs Combined)

Indicator 2: The percentage of individuals who are white and eligible for Medicaid and have received a PIHP managed service

- Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service (CMHSPs Combined)
- Denominator: The number of unique Medicaid eligible individuals within the Mid State Health Network region (CMHSPs Combined)

Measurement Period	Indicators-Race	# Total Medicaid Enrollees	# Medicaid Enrollees Served	Penetration Rate	Disparity Rate
CY21 (Baseline)	African American / Black	70,267	5,236	7.45%	2.06%
	White	373,783	35,532	9.51%	
CY22	African American / Black	72,377	5,241	7.24%	1.80%
	White	385,878	34,891	9.04%	
CY23	African American / Black	74,833	5,500	7.35%	1.71%
	White	391,423	35,448	9.06%	
CY24	African American / Black	71,678	5,762	8.04%	1.45%
	White	364,481	34,576	9.49%	
CY25YTD (1/1/2025-6/30/2025)	African American / Black	58,462	4,297	7.35%	1.51%
	White	297,384	26,363	8.86%	



CY2025 YTD Findings- In reviewing the data in Table 1, over the PIP project, the disparity rate between Black/African American and White penetration rates has steadily declined. In CY21, the disparity rate was 2.06%, and then decreased to 1.80% in CY22, 1.71% in CY23, 1.45% in CY24, and slightly increased to 1.51% for the first half of CY25. **This trend suggests a gradual improvement in the access to services for Black/African American Medicaid enrollees relative to their White counterparts and a reduction in disparity, however, the disparity has not yet been eliminated.**

FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will reduce or eliminate the ethnic disparity between the Black/African American population and the White population for PIP #1 and PIP #2	Effective	Continue current interventions for FY26 and Remeasurement Period 3 (CY2025).

PERFORMANCE IMPROVEMENT PROJECTS (PIPS) CONTINUED

The below interventions are currently being monitored through the Quality Improvement Council for ongoing improvement efforts for the Performance Improvement Projects for Remeasurement Year 3 (CY2025):

Improvement Strategies					
Barrier		Interventions			
Priority Ranking	Description of Barrier	Implementation Date	Intervention Description	Status	Intervention Type (Member, Provider, System)
1	No shows/lack of appointment follow up	Intervention Tracking identifies implementation dates by CMHSP	• Implement appointment reminder system completed by a staff person/peer	Continued	Provider Intervention
			• Implement/modify process for coordination between providers (warm hand off)	Continued	Provider Intervention
2	Workforce shortage-Lack of qualified - culturally competent clinicians resulting in limited available appointments within 14 days		• Recruitment of student interns and recent graduates from colleges and universities with diverse student populations	Continued	Provider Intervention
			• Utilization of external contractors to provide services	Continued	Provider Intervention
			• Utilize financial incentives/scholarships to obtain/retain adequate staffing	New	Provider Intervention
3	Minority Groups are not aware of services offered		• Identify and engage with partner organizations that predominantly serve communities of color (examples: faith-based/religious groups, community recreation centers, tribal organizations, etc.)	Continue, revise the timeline	Provider Intervention
	Minority Groups are not aware of services offered		• Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color	Continue, revise the timeline	Provider Intervention

STAKEHOLDER AND ASSESSMENT OF MEMBER EXPERIENCES

MSHN collects, analyzes, and reports survey and assessment data in collaboration with the Quality Improvement Council and the Regional Consumer Advisory Council. These bodies review results to identify trends, determine areas for improvement, and recommend targeted actions.

Regional and national benchmarks are used for comparison to evaluate performance and guide continuous quality improvement. When opportunities for improvement are identified, findings are incorporated into a regional improvement plan. At the local level, network providers review individual survey responses as appropriate to address concerns, investigate sources of dissatisfaction, ensure timely follow-up with consumers, and to identify local areas of improvement.

Results are presented to the MSHN Board, Operations Council, and other regional committees, and are made available to stakeholders through the MSHN website, advisory councils, staff and provider meetings, and other communication channels.

To increase accessibility and participation, MSHN developed an electronic version of the tool using SurveyMonkey, with instructions, tools, and submission links provided through the MSHN website for SUD providers.

The tools used for each population group are as follow:

- **Mental Health Statistics Improvement Program (MHSIP):** Adults receiving services for a mental health condition, intellectual/developmental disability, substance use disorder, or long-term supports and services.
- **Youth Satisfaction Survey (YSS):** Youth receiving treatment for a Severe Emotional Disturbance (SED), intellectual/developmental disability, or long-term supports and services.

STAKEHOLDER AND ASSESSMENT OF MEMBER EXPERIENCES CONTINUED

In addition to the survey tools listed above, MDHHS also conducts surveying for individuals receiving long-term supports and services (LTSS):

- **National Core Indicator (NCI) Survey**

MSHN also obtains feedback directly from providers relating to oversight of services through the:

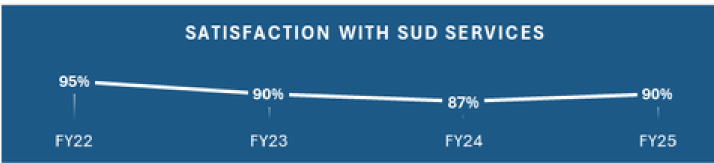
- **Provider Network Survey:** Administered every other year to organizations contracting with MSHN
- **Committee/Council Survey:** Conducted every other year with provider representatives participating on MSHN committees and councils

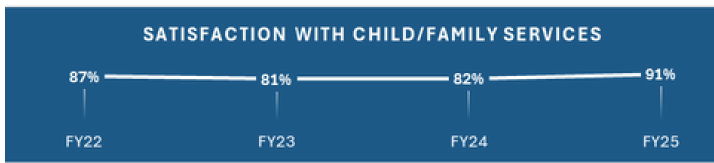
90% INDICATED SATISFACTION WITH SUD SERVICES

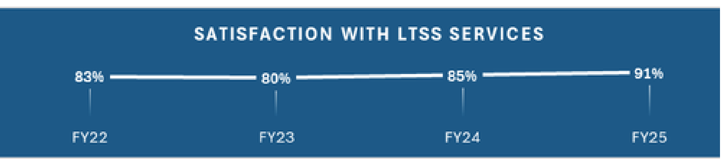
91% INDICATED SATISFACTION WITH CHILDREN/FAMILY MENTAL HEALTH SERVICES

91% INDICATED SATISFACTION WITH LONG TERM SUPPORTS AND SERVICES

91% INDICATED SATISFACTION WITH ADULT MENTAL HEALTH SERVICES



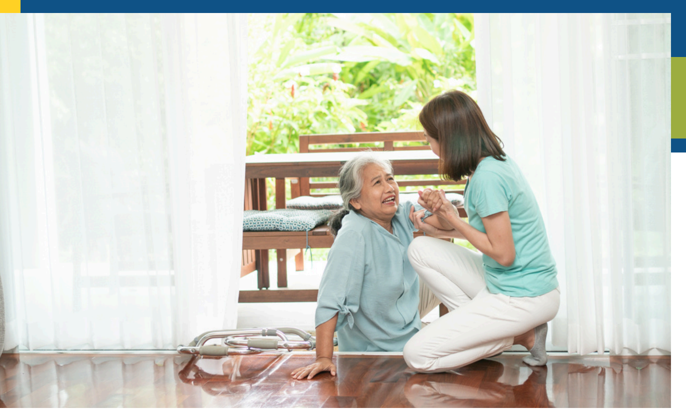


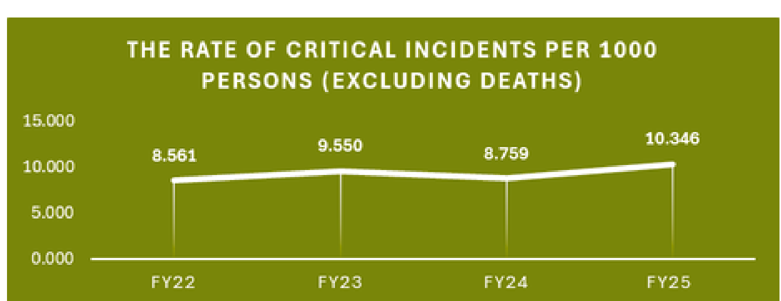


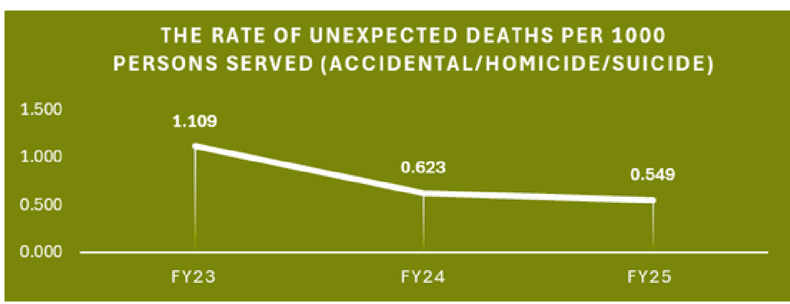
FY25 Workplan Goal	Status	Next Steps for FY26
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations (including members receiving LTSS)	Effective	Conduct same surveying process in Summer of 2026 for comparative data and re-evaluation of improvements implemented in FY26. New surveying - Consumer Assessment of Healthcare Providers and Systems (CAHPS) will begin in FY27 in conjunction with MDHHS's 3 year Behavioral Health Quality Overhaul Strategy.

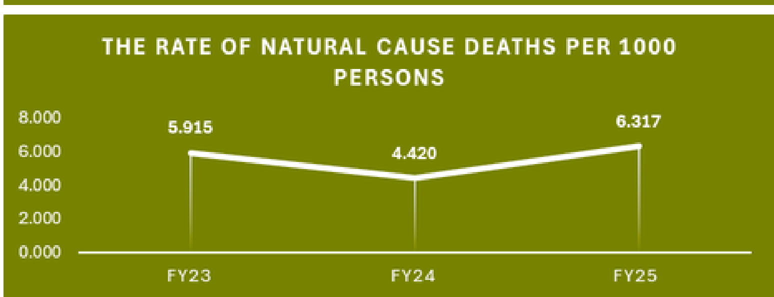
ADVERSE EVENT MONITORING/CRITICAL INCIDENTS

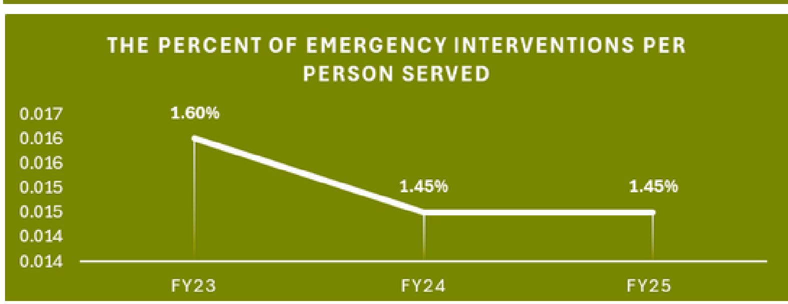
Mid-State Health Network prioritizes the safety of individuals within its Provider Network. The QAPIP monitors and reviews adverse events to identify root causes, implement preventive measures, and enhance individual safety. Adverse events are incidents that deviate from expected outcomes and may require further review. Some events qualify as "reportable adverse events" per the MDHHS Critical Incident and Event Notification requirements, including sentinel events, critical incidents, unexpected deaths and risk events.











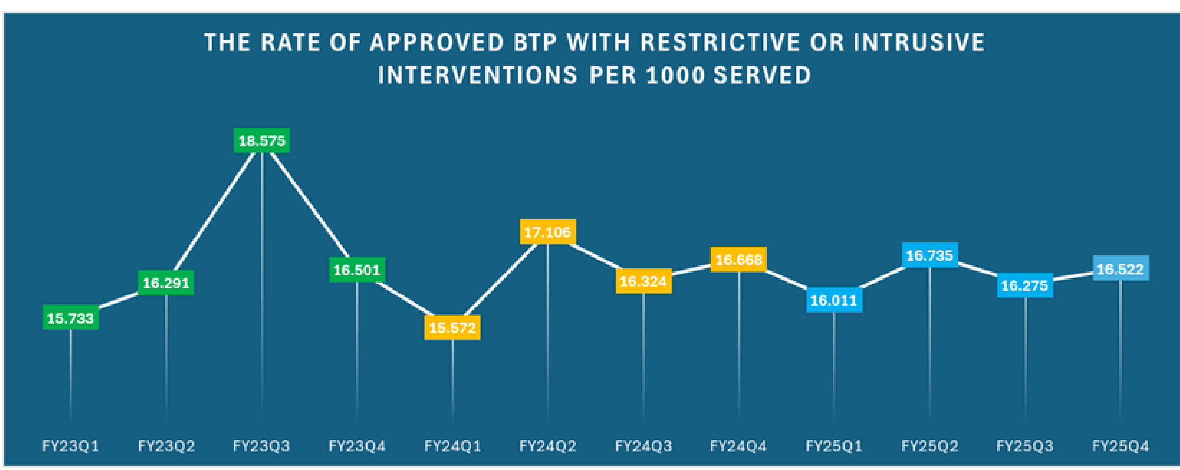
Strategic Priority	Goals	FY22	FY23	FY24	FY25	Status
Better Care	The rate of CMHSP critical incidents per 1000 persons served will demonstrate a decrease from the previous year (excluding deaths)	8.561	9.550	8.759	10.346	⚠
	The rate, per 1000 persons served, of CMHSP unexpected deaths will demonstrate a decrease from previous year (Accidental, Homicide, Suicide)	Not Collected	1.109	0.623	0.549	●
	The rate of natural cause deaths, including the leading causes of death	Not Collected	5.915	4.420	6.317	⚠
	The percent of physical interventions per person served during the reporting period will decrease from previous year	Not Collected	1.60%	1.45%	1.45%	●

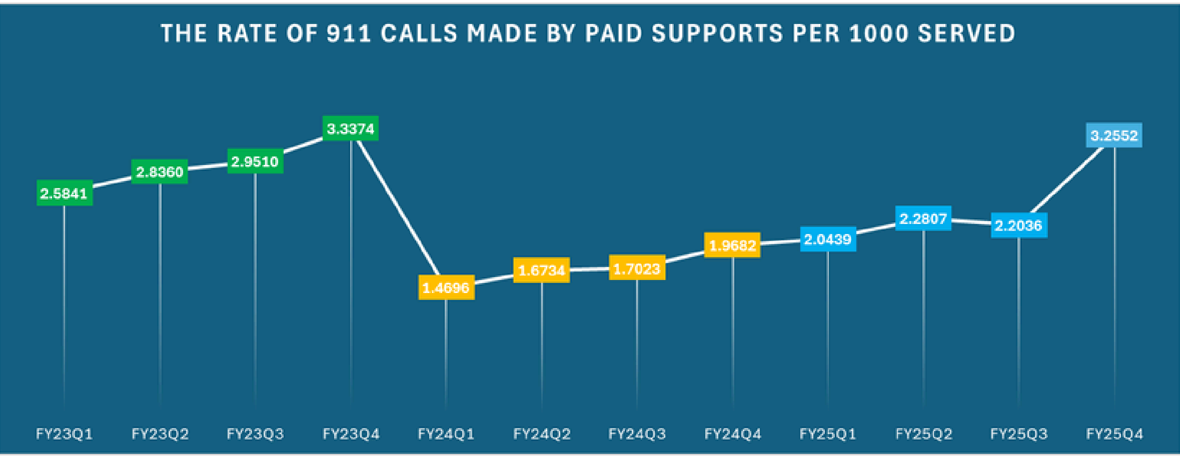
FY25 Workplan Goal(s)	Status	Next Steps for FY26
MSHN will ensure Adverse Events and Immediately Reportable events are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy	Partially Effective ⚠	Ongoing monitoring of all Adverse Events will continue in to FY26. Timeliness of reporting will be targeted for improvement interventions as the number of MDHHS remediations have increased in the last two quarters of FY25. Individual CMH consultation will take place where appropriate and improvements will take place.
MSHN will analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents	Effective ●	This goal will be carried forward into FY26 due to contractual requirements. Quarterly monitoring will take place and improvement opportunities will be discussed as appropriate.

BEHAVIOR TREATMENT

MSHN delegates each CMHSP Behavior Treatment Review Committee the responsibility for collecting, evaluating, and reporting behavior treatment data, and for assessing the effectiveness of their committees. These reviews are an integral part of each CMHSP's Quality Program. Only restrictive or intrusive interventions permitted under the MDHHS Behavior Treatment Technical Requirements and approved through the Person-Centered Planning process may be used with individuals receiving services. CMHSPs submit quarterly reports to MSHN where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Data provided includes the number of interventions per person and the duration of intervention used per person. This data and reporting is vital to provide oversight and protection to safeguard the rights of vulnerable individuals, including those receiving Long-Term Supports and Services (LTSS).

Compliance with all behavior treatment standards is assessed through these oversight activities, and results are available to MDHHS upon request as is required in Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section IX.





FY25 Workplan Goal	Status	Next Steps for FY26
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where Intrusive or restrictive techniques have been approved for use with members	Effective	Ongoing reporting and analysis of this metric will continue into FY26 by BTPRC. Interventions will be discussed as appropriate and implemented for any adverse trends that are noted.
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis	Effective	Ongoing reporting and analysis of this metric will continue into FY26 by BTPRC. Interventions will be discussed as appropriate and implemented for any adverse trends that are noted.

CLINICAL PRACTICE GUIDELINES

MSHN promotes and requires the consistent use of nationally recognized clinical practice guidelines and evidence-based practices (EBPs) to ensure that individuals receive services grounded in research, proven to achieve positive outcomes, and that represent best value in the delivery and purchase of care.

Adherence to these guidelines is monitored through data analysis, regional site reviews, and the annual assessment of network adequacy. These processes verify that network providers are implementing mutually agreed-upon clinical practices within their organizations.

The expectation for EBP implementation is outlined in all provider contracts. Practice guidelines are reviewed annually, or more frequently as standards evolve, and updates are disseminated through relevant committees, councils, and workgroups to ensure alignment across the network.

All approved practice guidelines are publicly accessible on the MSHN website and are incorporated into MSHN's ongoing quality improvement and provider monitoring activities.

FY25 Goal: MSHN will adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. In addition, MSHN will disseminate all guidelines to all affected providers and members upon request.

FY2025 Activity: MSHN formally adopted clinical practice guidelines for all 1915(i) State Plan Amendment (SPA) services and made them publicly available through the MSHN website. A list and description of these services were also incorporated into the MSHN Consumer Handbook to support transparency and informed decision-making for members.

MSHN reviews and updates these guidelines annually, or as needed, to reflect changes issued by the Michigan Department of Health and Human Services (MDHHS). MDHHS now conducts annual site reviews that include evaluation of these services. MSHN continues to share regional utilization data and encourages provider education on the guidelines to promote awareness and increase access among eligible individuals.

FY25 Goal: The PIHP shall continually evaluate its oversight of vulnerable individuals to determine opportunities for improving oversight of their care and outcomes.

FY2025 Activity: MSHN completes monthly reporting on the three C-Waivers, Autism Benefit, and 1915(i) SPA program activities and developments. The Chief Behavioral Health Officer (CBHO) compiles a quarterly summary of these activities and shares the findings regionally. Ongoing feedback is provided to CMHSP Participants through monthly reviews of individual plans of service to ensure goals are appropriate and documentation meets standards, particularly when restrictive or intrusive interventions are utilized for health and safety reasons.

MSHN collaborates regularly with MDHHS to address systemic and individual care concerns aimed at improving quality and safety for individuals served both within the region and statewide. Corrective action processes are continuous and integrated into site review activities, coordinated directly with the responsible CMHSP.

MSHN also intends to conduct a comprehensive assessment of the member experience with the Home and Community-Based Services (HCBS) Rule, in coordination with MDHHS, which is exploring the potential use of the CAHPS survey as a standardized tool for this effort.

MSHN ensures that Long-Term Supports and Services (LTSS) are delivered in a manner that promotes community integration while prioritizing the health, safety, and welfare of individuals, families, providers, and stakeholders. The quality and appropriateness of care are assessed through both data-driven analysis and clinical review activities.
Using population health analytics, MSHN monitors service utilization trends, identifies adverse or disproportionate patterns, and works to reduce health disparities across the region. At the individual level, clinical chart reviews conducted during program-specific site reviews ensure that assessed needs are reflected in person-centered treatment plans and addressed during care transitions. In addition to behavior treatment and adverse event data, MSHN monitors key performance measures approved by the Operations Council to evaluate the overall quality and accessibility of LTSS.

Community integration is encouraged to occur multiple times per week and is routinely discussed during person-centered planning to ensure individual preferences and goals are captured. Oversight reviews consistently demonstrate that community integration is well-documented and implemented as part of routine service delivery. Current review findings indicate no systemic issues related to community integration across the region.

FY25 Goal: MSHN will adhere to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.

FY2025 Activity: The Utilization Management (UM) Committee monitored the average utilization of ACT services throughout FY25 and continued to observe trends of regional underutilization when compared to the target average utilization (as established in the EBP- Assertive Community Treatment Michigan Field Guide). Two CMHSPs in the MSHN region were in full compliance or substantial compliance with the EBP and these CMHSPs shared best practices such as continuous community outreach and use of telehealth to improve client engagement and increase service utilization.

FY25 Goal: MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans.

FY2025 Activity: In FY2025, MSHN and its regional partners implemented several targeted interventions to strengthen oversight, compliance, and clinical effectiveness related to behavior treatment planning and the use of restrictive or intrusive interventions. These efforts focused on ensuring timely implementation of Corrective Action Plans (CAPs), enhancing workforce knowledge, and improving the consistency and quality of Behavior Treatment Plans (BTPs) across the region. MSHN collaborated closely with CMHSP Participants and regional workgroup members to ensure that approved CAPs were implemented within 90 days of approval.

MSHN, in partnership with CMHSP Behavior Treatment and Clinical Leadership representatives, explored and developed strategies to expand direct care worker knowledge of standards governing the use of restrictive and intrusive interventions. This included dissemination of training materials, updates on technical requirements, and reinforcement of person-centered and least restrictive approaches

FY25 Workplan Goal(s)	Status	Next Steps for FY26
The PIHP will adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. The PIHP disseminates guidelines to all affected providers and members and potential members (upon request)	Effective	This goal will be continued for FY26 as it is focused on the work and advocacy that is well-aligned in addressing systems issues that beneficiaries face. In addition, it will be continued due to the unknown outcome of the RFP procurement process.
MSHN will adhere to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer	Effective	Continue the identified improvement activities for FY26 to monitor effectiveness of intervention strategies.
The PIHP shall continually evaluate its oversight of "vulnerable" individuals to determine opportunities for improving oversight of their care and outcomes. The MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable individuals	Effective	This goal will be continued for FY26 as it is focused on the work and advocacy that is well-aligned in addressing systems issues that beneficiaries face. In addition, it will be continued due to the unknown outcome of the RFP procurement process.
MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans.	Effective	This goal will be continued for FY26 as it is focused on the work and advocacy that is well-aligned in addressing systems issues that beneficiaries face. In addition, it will be continued due to the unknown outcome of the RFP procurement process.

UTILIZATION MANAGEMENT

MSHN ensures timely and equitable access to publicly funded behavioral health services in compliance with the MDHHS PIHP Contract, the Medicaid Provider Manual, and the Michigan Mental Health Code. MSHN, directly or through delegation to network providers, operates a comprehensive Utilization Management (UM) system. Contracted providers are responsible for UM functions for individuals they serve, whether through directly operated or contracted services.

FY25 Goal: MSHN will establish a UM Plan in accordance with MDHHS requirements.

FY2025 Activity: MSHN maintains a comprehensive Regional Utilization Management (UM) Plan in accordance with MDHHS contractual requirements. The plan outlines processes for service authorization, medical necessity determination, and utilization review to ensure equitable access to services and appropriate use of resources across the region. The Regional UM Committee reviews the plan annually to confirm continued alignment with MDHHS guidance and regional priorities. The most recent review and approval occurred in June/July 2025.

During FY25, MSHN did not develop a monitoring report to assess service authorizations in relation to MichiCANS outcomes, nor did it establish regional guidance for documenting variances between authorized services and the MichiCANS-recommended service array. The primary concern identified with the current version of the MichiCANS tool is its tendency to over-recommend restrictive services, such as SED Waiver and Home-Based programming. MDHHS, in partnership with the University of Kentucky, is actively working to adjust the tool's sensitivity; however, the timeline for completion remains undetermined. As a result, activities related to MichiCANS analysis and guidance development have been temporarily paused and will be carried forward into FY26 upon release of the revised instrument.

In April and May 2025, the UM Committee reviewed several tools and methodologies for determining medical necessity of Community Living Supports (CLS) and began defining core components of regional best practice. This initiative was temporarily paused to allow focus on higher-priority system activities but remains a standing objective for FY26.

Throughout FY25, the UM Committee continued to monitor regional utilization trends for both waiver and non-waiver services, identifying areas for ongoing review and standardization. The committee's work remains integral to ensuring that utilization management practices across the MSHN region are consistent, data-informed, and aligned with person-centered care principles.

FY25 Goal: MSHN will ensure that decisions for utilization management, member education, coverage of services, and other areas are consistent with established guidelines.

FY2025 Activity: The UM Committee engaged in a review of existing practices for authorization of respite services in April/May 2025 and began to identify core components for regional best practice. This work was paused to prioritize other activities and will be continued in FY26.

FY25 Goal: The Service Authorizations Denial Report will demonstrate 90% or greater compliance with timeframe requirements for service authorization decisions and Adverse Benefit Determination (ABD) notices.

FY2025 Activity: A key accomplishment for FY25 was MSHN's success in maintaining 90% or greater compliance with service authorization timeframe requirements across all quarters. This achievement reflects strong adherence to regional utilization management standards and consistent oversight by the Utilization Management (UM) Committee. To support sustained accuracy and performance, MSHN provided targeted training and technical assistance to CMHSP Participants and network providers. This included distribution of a Service Authorization Denial Report job aid and tip sheet, designed to improve data reporting accuracy and ensure consistent documentation practices across the region.

In addition, MSHN implemented an enhanced corrective action monitoring process for CMHSPs falling below the 90% compliance threshold. These efforts have strengthened regional accountability, improved data integrity, and reinforced the importance of timely service authorization decisions within the MSHN network.

UTILIZATION MANAGEMENT CONTINUED

FY25 Goal: MSHN will demonstrate an increase in compliance with access standards for the priority populations.

FY2025 Activity: Improving compliance with access standards for priority populations has remained a focused quality improvement goal for MSHN since FY23. One of the primary barriers identified in previous fiscal years was the low rate of timely admission to Substance Use Disorder withdrawal management and residential services for pregnant individuals. In FY25, MSHN implemented a key intervention by centralizing access to SUD withdrawal management and residential services for all individuals, including pregnant persons. This initiative streamlined referral processes, improved coordination across providers, and reduced variability in admission timeliness.

As a result, the average compliance rate for pregnant individuals increased from 35% in FY23 to nearly 60% by the end of FY25. Similarly, compliance for non-pregnant priority populations improved from 80% in FY25 Quarter 1 to 87% by Quarter 3, demonstrating a positive regional trend.

These outcomes indicate that targeted access interventions are having a measurable impact. However, additional strategies will be required to achieve full and consistent compliance with timeliness standards, particularly for pregnant individuals, who continue to represent a population of high clinical priority.

FY25 Workplan Goal(s)	Status	Next Steps for FY26
MSHN will establish a UM Plan in accordance with MDHHS requirements	Effective	This goal will be continued for FY26 with all associated improvement activities according to dates listed and frequency of review for 2026.
MSHN will ensure that decisions for utilization management, member education, coverage of services, and other areas are consistent with established guidelines.	Effective	This goal will be continued for FY26 with all associated improvement activities according to dates listed and frequency of review for 2026.
The Service Authorizations Denial Report will demonstrate 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices.	Effective	This goal will be continued for FY26 with all associated improvement activities according to dates listed and frequency of review for 2026.
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Effective	This goal will be continued for FY26 with all associated improvement activities according to dates listed and frequency of review for 2026.

INTEGRATED CARE

MSHN has established a Population Health and Integrated Care Plan to guide regional strategies, set best practice standards, and promote coordination across the behavioral and physical health continuum. Integrated care initiatives aim to improve individual and population health outcomes throughout the MSHN region.

MSHN participated in the following integrated care programs in FY25:

- Certified Community Behavioral Health Clinics (CCBHCs)
- Behavioral Health Homes (BHH)
- Substance Use Disorder Health Homes (SUDHH)

FY25 Goal: MSHN will establish effective quality improvement programs for Health Homes.

FY2025 Activity: During FY25 MSHN held monthly quality subgroup meetings with its health home partners. Objectives of the quality subgroup included development/monitoring of the regional Continuous Quality Improvement (CQI) plan, quarterly review of health home performance data (including individual clinic performance), development of regional improvement strategies for pay-for-performance measures, and development of a regional health home performance monitoring dashboard. All integrated health data is pulled from CareConnect360 (CC360).

CCBHC Metrics (Data pulled for 3/30/2024-3/30/2025)

FY2025 Activity: CCBHC metric data was compiled and a regional dashboard was created to track ongoing performance and identify areas of improvement. Additionally, each CCBHC was provided their individualized data to actively work on improving their performance for each metric:

Metric Key	Measure	Definition	CCBHC	Rate	QBP/ Program Benchmark	Status
FUH-30AD	Follow-Up within 30 days after Hospitalization for Mental Illness - Adult (FUH-30AD)	Percentage of discharges for beneficiaries age 21 - 64 who are hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	65.32%	75%	
			MSHN Total	70.02%		
			CCBHC Program Total	**69.89%**		
FUH-7AD	Follow-Up within 7 days after Hospitalization for Mental Illness - Adult (FUH 7AD)	Percentage of discharges for beneficiaries ages 18 - 64 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Michigan Medicaid Total	42.64%	48%	
			MSHN Total	45.02%		
			CCBHC Program Total	**45.64%**		
FUH-30CH	Follow-Up within 30 days after Hospitalization for Mental Illness - Child (FUH-30CH)	Percentage of discharges for beneficiaries age 6 - 20 who are hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	80.87%	88%	
			MSHN Total	88.65%		
			CCBHC Program Total	**82.53%**		
FUH-7CH	Follow-Up within 7 days after Hospitalization for Mental Illness - Child (FUH 7CH)	Percentage of discharges for beneficiaries ages 6-17 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Michigan Medicaid Total	59.51%	60.00%	
			MSHN Total	66.87%		
			CCBHC Program Total	**61.12%**		
IET-14 AD	Initiation of SUD Treatment - Adult Total (IET-AD)*	Percentage of new substance use disorder (SUD) episodes for beneficiaries 18 years and older that result in the following: Initiation of Treatment - percentage of new SUD episodes that result in treatment initation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days.	Michigan Medicaid Total	36.79%	41%	
			MSHN Total	37.39%		
			CCBHC Program Total	**40.58%**		
IET-34 AD	Engagement of SUD Treatment - Adult Total (IET-AD)	Percentage of new substance use disorder (SUD) episodes for beneficiaries 18 years and older that result in the following: Engagement of Treatment - percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Michigan Medicaid Total	11.26%	14.00%	
			MSHN Total	12.32%		
			CCBHC Program Total	**14.03%**		
PCR	Plan All Cause Readmission (PCR)	For beneficiaries 18 - 64, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. For this measure, the Event Date is the Discharge Date.	Michigan Medicaid Total	9.71%	≤ 10%	
			MSHN Total	9.96%		
			CCBHC Program Total	**10.83%**		

BHH Metrics (Data pulled for 3/30/2024-3/30/2025)

FY2025 Activity: A regional dashboard was created along with visualizations for BHH partners to track ongoing performance and identify any areas where improvement is needed. The follow-up within 7 days after hospitalization for mental illness (FUH-7) metric has been an ongoing area of discussion and follow-up within each QI BHH meeting takes place to ensure that improvement efforts are taking place to positively impact future quarters of data:

INTEGRATED CARE CONTINUED

ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES (AAP)

	Michigan MA Total	MSHN MA Total	State Wide BHH Total	MSHN BHH Total
FY24Q1	75.04%	75.86%	98.83%	97.81%
FY24Q2	76.60%	77.45%	98.49%	98.12%
FY24Q3	78.31%	78.88%	98.63%	98.92%
FY24Q4	79.24%	79.59%	98.86%	100.00%
FY25Q1	79.24%	79.65%	99.05%	99.43%
FY25Q2	79.71%	80.16%	99.63%	100.00%

CONTROLLING HIGH BLOOD PRESSURE (CBP)

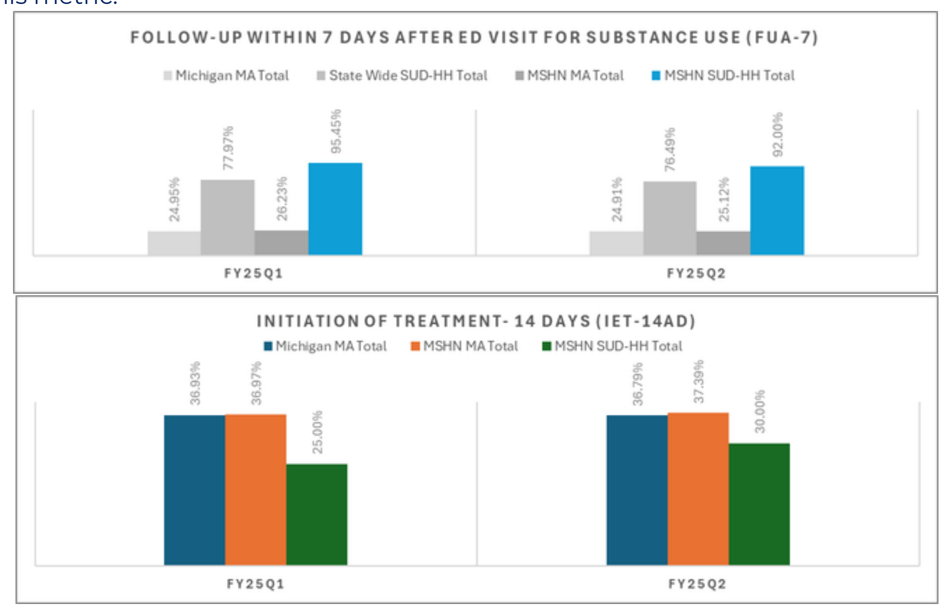
	Michigan MA Total	MSHN MA Total	State Wide BHH Total	MSHN BHH Total
FY24Q1	33.17%	36.61%	35.43%	100.00%
FY24Q2	35.70%	39.75%	39.86%	50.00%
FY24Q3	38.77%	42.28%	43.40%	64.86%
FY24Q4	40.74%	44.18%	46.49%	65.38%
FY25Q1	41.44%	44.53%	45.98%	67.65%
FY25Q2	41.81%	44.91%	45.98%	62.07%

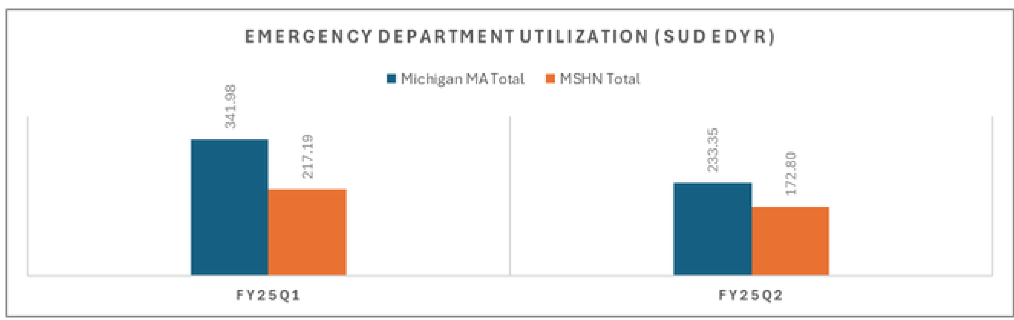
FOLLOW-UP WITHIN 7 DAYS AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH-7)

	Michigan MA Total	MSHN MA Total	State Wide BHH Total	MSHN BHH Total
FY24Q1	44.43%	47.46%	54.62%	53.33%
FY24Q2	43.73%	46.44%	52.63%	53.85%
FY24Q3	44.35%	47.07%	53.66%	44.12%
FY24Q4	45.43%	48.60%	55.68%	38.89%
FY25Q1	45.96%	49.37%	54.55%	48.39%
FY25Q2	45.56%	48.83%	53.13%	45.45%

SUDHH Metrics (Data pulled for 3/30/2024-3/30/2025)

FY2025 Activity: A regional tracker was established for SUDHH partners to track ongoing performance and identify any areas where improvement is needed. The initiation of treatment (14 days) metric (IET-14) has been historically beneath the Michigan Medicaid totals in comparison, and ongoing discussions are taking place to target areas of improvement and coordination that could positively impact this metric:



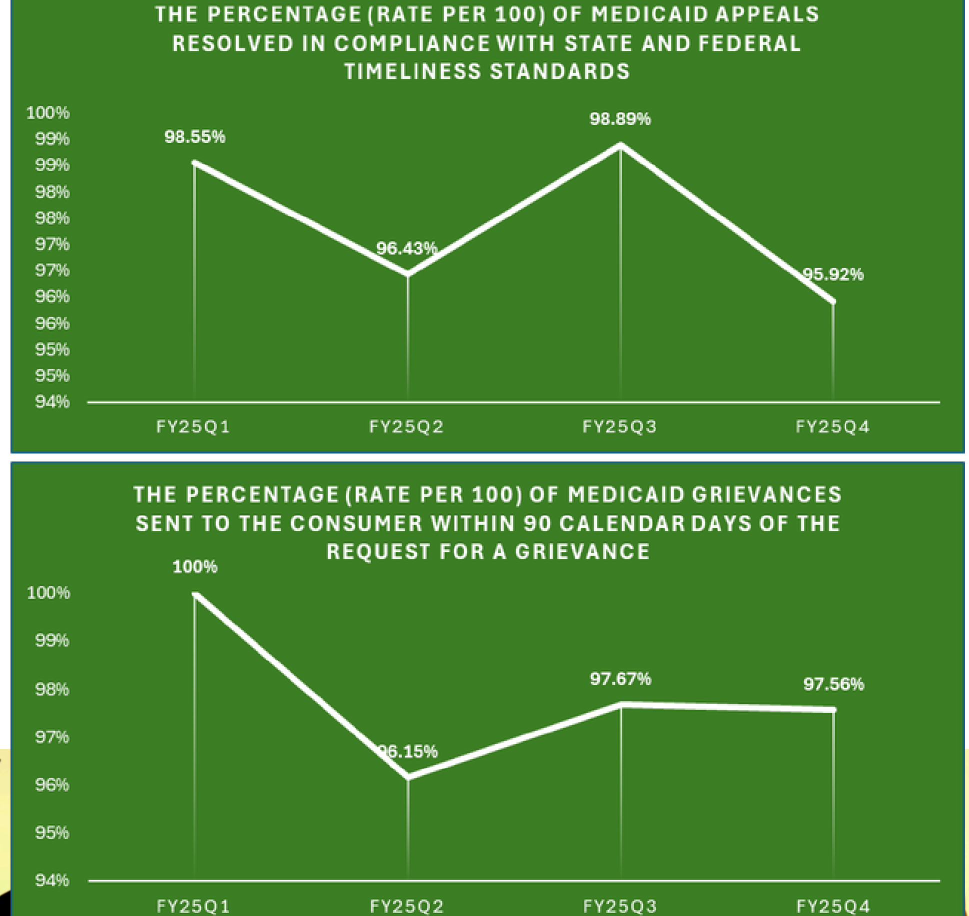


FY25 Workplan Goal(s)	Status	Next Steps for FY26
MSHN will establish effective quality improvement programs for Health Homes	Partially Effective ⚠	Continue goal with all improvement activities according to dates listed and frequency of review in 2026. In addition, focus will be placed on metrics where benchmarks/standards have not been met to increase improvement opportunities in these areas.

CUSTOMER SERVICE

MSHN's Customer Service department serves as a vital connection point between consumers, providers, and system partners, ensuring that individuals can easily access information, file concerns, and receive timely assistance. In alignment with MDHHS contractual requirements, Customer Service is responsible for processing inquiries, coordinating responses, and facilitating communication to ensure transparency, responsiveness, and accountability throughout the region.

The following section summarizes FY25 appeals and grievance timeliness activity across the MSHN region:



CUSTOMER SERVICE CONTINUED

FY25 Workplan Goal(s)	Status	Next Steps for FY26
MSHN will meet the benchmark of 95% to resolve appeals within state and federal timeliness standards (including the written disposition letter (30 calendar days) of a standard request for appeal)	Effective	This goal will be continued for FY26 due to MDHHS requirements.
MSHN will meet the benchmark of 95% to resolve grievances within 90 calendar days of the request for a grievance	Effective	This goal will be continued for FY26 due to MDHHS requirements.

PROVIDER MONITORING

PROVIDER QUALIFICATIONS

FY25 Goal: MSHN will ensure that staff shall possess the appropriate qualifications and are qualified to perform their services.

MSHN maintains comprehensive credentialing and re-credentialing policies and procedures in alignment with the MDHHS Credentialing and Re-Credentialing Policy to ensure that all members of the provider network are appropriately qualified to deliver high-quality, safe, and effective care. Credentialing activities are completed upon initial employment or contract initiation and at least once every three (3) years thereafter. MSHN's policies also require that non-licensed providers meet qualification standards consistent with the Michigan PIHP/CMHSP Provider Qualifications for Medicaid Services and HCPCS/CPT Codes Chart, ensuring all staff are competent to perform their assigned duties.

MSHN is responsible for credentialing, privileging, primary source verification, and qualification of its own employees and contracted staff. Credentialing and verification of network provider staff, as well as their subcontractors, are contracted functions. MSHN monitors compliance with federal, state, and local requirements through ongoing oversight activities, including desk reviews, site verifications, and other monitoring strategies.

An enhanced monitoring process was implemented to ensure the timeliness of credentialing and re-credentialing decisions. CMHSPs report their compliance biannually, and any organization falling below 90% compliance is subject to increased monitoring until performance standards are met. Overall, MSHN found that six CMHSPs reviewed were 65% compliant with documentation requirements and 75% compliant with annual assessments, ongoing sanctions, and license verifications. The CMHSPs that were not compliant were required to complete plans of correction, and those were verified six months later.

FY25 Goal: MSHN will implement Universal Credentialing.

The MDHHS Universal Credentialing System launched in FY25. This new system, developed in response to state legislation, serves as a centralized credentialing repository for all PIHPs and CMHSPs and stores required documentation for both licensed providers and organizational network entities in accordance with MDHHS policy. The MSHN region was the first PIHP group trained on the system and MSHN assisted users (providers and CMHs) during the implementation process. MSHN and all 12 CMHs are utilizing the MDHHS Universal Credentialing system as required.

PROVIDER QUALIFICATIONS CONTINUED

FY25 Workplan Goal(s)	Status	Next Steps for FY26
MSHN will ensure that staff shall possess the appropriate qualifications and are qualified to perform their services	Effective	This goal will be continued for FY26 due to MDHHS requirements.
MSHN will implement Universal Credentialing	Effective	This goal will be discontinued as it was completed in FY25.

PROVIDER MONITORING AND EXTERNAL REVIEWS

MSHN conducts annual monitoring of its provider network, including all affiliated organizations and subcontractors contracted to perform managed care functions such as service delivery, supports coordination, and administrative operations. Oversight activities ensure that all contracted entities maintain compliance with federal and state regulations, MDHHS contract requirements, and MSHN policy standards.

Monitoring activities are conducted through a combination of desk reviews, site reviews, verification activities, and other targeted oversight strategies designed to evaluate performance, quality, and adherence to contractual obligations. When performance deficiencies are identified, MSHN requires the provider to develop and implement a Corrective Action Plan (CAP) within established timeframes.

Providers that do not demonstrate satisfactory improvement may be subject to enhanced monitoring, additional interventions, or sanctions, up to and including contract termination. This structured oversight process ensures accountability across the network and promotes continuous improvement in the quality, safety, and effectiveness of care provided to individuals served throughout the MSHN region.

FY25 External Reviews Overview

MDHHS requires periodic reviews to ensure compliance with state and federal regulations. The MDHHS Federal Compliance department conducts the 1915(i) and 1915(c) waiver reviews. The MDHHS contracts with the Health Services Advisory Group, Inc. (HSAG) to serve as the External Quality Review Organization (EQRO) for Medicaid behavioral health programming.

MSHN participated in six reviews in FY25; five were conducted by the HSAG and one by the MDHHS. The below summaries provide details for each review:

MDHHS 1915(i) and 1915(c) Waiver Review

Scope/Purpose

The Michigan Department of Health and Human Services (MDHHS) conducted an interim review of 1915(c) Waivers (Habilitation Services Waiver (HSW), Children's Waiver Program (CWP), Serious Emotional Disturbances Waiver (SEDW)) and the 1915(i) waiver for the MSHN region in June and July 2025.The review focused on ensuring the implementation of approved plans of correction from the comprehensive evaluation of the previous year.

Results/Next Steps

The review was not scored; instead, it was determined to be compliant or non-compliant. MSHN was found to be compliant, and no further action was needed. A full review will be conducted in Spring/Summer FY26.

HSAG Compliance Review

Scope/Purpose

The HSAG Compliance reviews take place over three years and focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs encompass 13 program areas, referred to as standards. FY25 was year two of the three-year cycle and reviewed eight of the thirteen standards.

Results/Next Steps

The table below provides an overview of MSHN review results:

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard II—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard VII—Provider Selection	25	25	22	3	0	**88%**
Standard VIII—Confidentiality	22	22	21	1	0	**95%**
Standard IX—Grievance and Appeal Systems	39	39	31	8	0	**79%**
Standard X—Subcontractual Relationships and Delegation	6	6	6	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems	9	9	7	2	0	**78%**
Standard XIII—Quality Assessment and Performance Improvement Program	24	24	24	0	0	**100%**
Total	**145**	**145**	**131**	**14**	**0**	**90%**

M = Met; NM = Not Met; NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Findings were identified during the review, and an example is provided below. A more detailed description of the findings and recommendations can be found by accessing the full report on the MSHN website.

Provider Selection

- CMHSP organizational credentialing file did not include an on-site quality checklist for a completed site review of a non-accredited provider
- CMHSP individual practitioner files did not include all background check requirements: federal and state sex offender lists, ICHAT, or similar
- CMHSP organizational files did not meet liability insurance coverage requirements as outlined in contracts
- CMHSP organizational credentialing file did not include an on-site quality checklist for a completed site review of a non-accredited provider

Confidentiality

- There was no documented evidence that business associates (i.e., subcontractors) notified the PIHP upon discovering a breach of unsecured PHI

Grievance and Appeals System

- MSHN does not have a process in place to ensure that grievances and appeals are acknowledged within required timelines
- MSHN and CMHSPs do not have tracking mechanisms to ensure that the individuals who make appeal decisions are not involved in any prior level of review or decision-making, nor are subordinates of any such individual, and have the appropriate clinical expertise to treat the members' condition or disease
- MSHN and CMHSPs do not have tracking mechanisms in place to ensure that expedited appeals are resolved 72 hours after receiving the appeal

Health Information Systems

- Data elements, compliant with CMS interoperability final rules for the Patient Access API, could not be verified

MSHN has submitted a plan of correction to HSAG, which is currently undergoing review and approval. Once approved, MSHN will begin implementing the plan to ensure compliance with deficient standards and to identify ways to incorporate any HSAG recommendations into system processes.

HSAG Performance Measurement Validation (PMV)

Scope/Purpose

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements.

HSAG validated a set of performance indicators that were developed and selected by MDHHS. The review consisted of interviews, system demonstrations, review of data output files, primary source verification, observation of data processing, and review of data reports. Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

Results/Next Steps

The table below provides an overview of MSHN review results:

Area of Review	MSHN Results
Performance Indicator Error Validation	R*
Data Integration and Control	100%
Denominator Validation	100%
Numerator Validation	100%
Performance Measures	100%

**The validation designation for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be non-compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of DNR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R.*

HSAG includes strengths, weaknesses, and recommendations in the final report. This report provides some of those comments. To view all strengths, weaknesses, and recommendations, please view the full report on the MSHN website.

Strength: MSHN's CMHSPs have individually been launching various quality improvement strategies to close performance gaps. This is being done through regional knowledge sharing and localized innovation. Some examples include conducting in-depth analyses of disparities in children's first service engagement, developing new data dashboards, and offering consumer education sessions on Medicaid transportation to help mitigate no-shows, addressing both staff training and systemic process delays, integrating real-time data tracking into clerical workflows, and offering extended hours to meet overall demand for access to services. [Quality, Timeliness, Access]

Weakness: MSHN's indicator #2 total rate fell below the 75th percentile benchmark. [Quality and Timeliness]
Why the weakness exists: MSHN's indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have received a timely biopsychosocial assessment following a non-emergency request for service.

Recommendation: HSAG recommends that MSHN continue its improvement efforts related to indicator #2 to meet or exceed the 75th percentile benchmark and ensure timely, accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

No corrective action plan was required. However, MSHN will identify ways to incorporate recommendations into current systems and processes for FY26 to ensure remediation of weaknesses and to follow-up on all HSAG recommendations.

HSAG Network Adequacy Validation (NAV)

Scope/Purpose

Federal regulations require that reviews be conducted and that the MCO, PIHP, or PAHP network be validated to comply with the requirements set forth in the federal regulations if the State enrolls Indians in the MCO, PIHP, or PAHP. HSAG conducted validation of PIHP data for the MDHHS network adequacy indicators for the SFY 2025 reporting period.

Results/Next Steps

MSHN will review the aggregated report, expected to be posted to the MDHHS website in April/May 2026, and identify ways to incorporate recommendations into system processes. A plan of correction is not required for this review.

HSAG Encounter Data Validation (EDV)

Scope/Purpose

The FY25 EDV review was Year 3 of the HSAG three-year review cycle. The purpose of the review is to evaluate the extent to which encounters submitted by the PIHPs to MDHHS are complete and accurate by comparing data extracted from the PIHPs' and MDHHS's data systems. MDHHS and each PIHP will extract data from their systems in accordance with the exact specifications. HSAG compared the data, using the data elements identified in the table below.

Results/Next Steps

Results are not known at the time of this report. MSHN will review the aggregated report, expected to be posted to the MDHHS website in April/May 2026, and identify ways to incorporate recommendations into system processes. A plan of correction is not required for this review.

HSAG Performance Improvement Project (PIP)

Scope/Purpose

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

MSHN's Performance Improvement Project for 2022 through 2025 is: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population. Please note that, due to procurement efforts at MDHHS, the Performance Improvement Projects have been extended for another year. CY2025 will now be the third remeasurement period and will be reported in July of 2026.

Data for the baseline and comparison remeasurement periods can be found in the table below:

Indicator 3: The percentage of new persons who are Black/African American or White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment

Time Period	Indicator Measurement	White Numerator	White Denominator	Percentage	Black Numerator	Black Denominator	Percentage	p-Value (Goal p value <0.500)
01/01/2021 - 12/31/2021	Baseline	6050	8737	69.25%	837	1294	64.68%	.00108
01/01/2023 - 12/31/2023	Remeasurement 1	5649	8968	62.99%	822	1371	59.96%	.03297
01/01/2024 – 12/31/2024	Remeasurement 2	4874	7450	65.42%	777	1273	61.04%	.00274
01/01/2025 – 06/30/2025	Remeasurement 3	2234	3432	65.09%	390	600	65%	1

HSAG Performance Improvement Project (PIP)

Results/Next Steps

Validation Rating: Design and Implementation

- Percentage of Evaluation Elements Met: 100%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a High Confidence rating.

MSHN met 100 percent of the requirements for the data analysis and implementation of improvement strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

Validation Rating: Outcomes

- Percentage of Evaluation Elements Met: 33%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a No Confidence rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population) in CY2024. The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the second remeasurement period. Preliminary CY2025 results show that MSHN is approaching statistical significance in eliminating the existing disparity, and is expected to meet a high confidence rating for remeasurement period 3.

Based on recommendations from HSAG, MSHN will address the following:

- The performance indicators have not yet achieved the goals for the PIP. MSHN included intervention efforts occurring at the community mental health services program (CMHSP) level, but the PIHP will also include efforts that have occurred at the plan level in the final report for CY2025 (remeasurement 3).
- MSHN will revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that required development of interventions for both subgroups.
- MSHN will continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

FY25 COUNCIL REVIEWS OF EFFECTIVENESS

MID-STATE HEALTH NETWORK OPERATIONS COUNCIL

Team Leader: Joe Sedlock, MSHN Chief Executive Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The MSHN Board has created the Operations Council to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible (Article III, Section 3.2, MSHN/CMHSP Operating Agreement).

FY25 Goals/Accomplishments:

✓ ***Goal:*** Advocated for system reform changes that complied with the federal rule, are consistent with related state laws, and are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Barriers: Lack of engagement by MDHHS, PIHP Procurement Process
Recommendation for Goal: Continue into FY26

✓ ***Goal:*** Worked with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Barriers: Lack of engagement by MDHHS, PIHP Procurement Process
Recommendation for Goal: Continue into FY26

✓ ***Goal:*** Ensured effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.
Barriers: Financial Issues, PIHP Procurement Process
Recommendation for Goal: Continue into FY26

✓ ***Goal:*** As a region and as individual entities: address, reduce, and eliminate health disparities.
Barriers: Delay in data elements within CC360
Recommendation for Goal: Continue into FY26

Goal: Addressed funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements.
Barriers: Continued financial pressures
Recommendation for Goal: Continue into FY26

Goal: Monitored and expanded Behavioral Health Homes, Substance Use Disorder Health Homes and Certified Community Behavioral Health Clinics in the MSHN region.
Barriers: PIHP Procurement, Federal Policy Shifts, Financial Pressures
Recommendation for Goal: Continue into FY26

Additional Council Accomplishments:

- Reviewed and approved the FY24 Operations Council Annual Report
- Continued review and implementation of Regional Cost Containment Strategies
- Reviewed the FY24 QAPIP Report
- Approved the FY25 QAPIP Plan
- 12 /12 CMHSPs supported changes to board bylaws incorporating new open meetings act language- meeting 2/3 requirement for adoption
- Reviewed MDHHS new Network Adequacy Assessment Procedure
- Developed strategies for individual meetings, collective meetings, and potential regional legislative event for funding discussions
- Approved the FY25 Draft Compliance Plan for presentation to the MSHN Board
- Supported Regional Collective Impact Advocacy efforts related to revenue shortfalls to include meetings w/legislators and resolutions from County Boards of Commissioners to local legislators
- Supported MSHN pursuing and positioning itself to be a successful participant and bidder in the PIHP Procurement process
- Developed a Service Use Analysis report for CMHSPs to use for comparison review and identifying target areas for follow-up
- Reviewed the FY24 Network Adequacy Assessment report
- Discussed the MSHN Staff Retention Plan and will support MSHN if/when the time comes to loss of personnel at the MSHN level
- Monthly monitoring and discussions regarding ISF Replenishment to develop an implementation strategy for FY26
- Reviewed and supported Autism Policy recommendations
- Reviewed and approved the changes presented to the FY25 Compliance Plan – v.2 as required by the OIG
- Reviewed and approved the FY25 Privacy Notice revisions as required by the OIG
- Supported the FY25-26 Utilization Management Plan
- Supported continuation of the Autism smoothing plan that goes through 2028
- Began development of an automated process to track regional DAB eligibility changes
- Developed a regional COFR policy draft which was placed on hold due to uncertainties at the state and federal levels and will bring back in the future

MID-STATE HEALTH NETWORK OPERATIONS COUNCIL CONTINUED

FY26 Council Goals

- Engage in planning activities relating to PIHP Procurement Lawsuit and/or MSHN Procurement Response
- Relating to procurement process outcome(s), prepare the region for changes needed
- Consider centralization of utilization management as a major way to mitigate conflict free access and planning, changes that comply with the federal rule, are consistent with related state laws, and that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system
- Improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring and any gaps identified in the Network Adequacy
- Ensure effective and efficient regional operations and consider centralization of some managed care functions where efficiencies can be obtained
- As a region and as individual entities: address, reduce, and eliminate health disparities
- Consider alternative changes in board composition
- Monitor and expand Behavioral Health Homes, Substance Use Disorder Health Homes in the MSHN region

MID-STATE HEALTH NETWORK FINANCE COUNCIL

Team Leader: Leslie Thomas, Chief Financial Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

FY25 Goals/Accomplishments:

Goal: Obtained favorable fiscal and compliance audits: CMHSP and PIHP fiscal audits were performed between December 2024 and February 2025. The goal was to have all fiscal CMHSP reports by April 2024 and compliance exams by June 2025 which was met. The audits are available to the PIHP once they are reviewed by their respective Board of Directors.
Barriers: None of note
Recommendation for Goal: Complete for FY25, continue for FY26

Goal: Met targeted goals for spending and reserve funds: determination was made when the FY 2024 Final Reports due to MDHHS (March 31, 2025), were received from the CMHSPs. The goal for FY2025 was to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
Barriers: MSHN's region faced issues with revenue from MDHHS. Initially, the region was expected to overspend FY 25's revenue by $29 million but this number improved to a surplus of more than $9 million because of the State's amendment 3.
Recommendation for Goal: Continue into FY26

Goal: Worked toward a uniform costing methodology: The PIHP CFO participated in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council reviews rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council evaluated if action is needed based on Statewide comparisons.
Barriers: MDHHS is still developing the final methodology for the statewide Standard Cost Allocation
Recommendation for Goal: Continue into FY26

Goal: Improved accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
Barriers: The accuracy has varied due to the nature of revenue changes and ongoing increases in utilization which continually drive-up expense amounts
Recommendation for Goal: Continue into FY26

Goal: Developed regional and local cost containment strategies to align projected revenue and expenses.
Barriers: Cost containment strategies have been difficult to implement given increases in utilization
Recommendation for Goal: Continue into FY26

FY26 Council Goals

- Completion of FY2025 Favorable fiscal and compliance audit (fiscal audits will be performed between December 2025 and February 2026)
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2025 Final Reports due to MDHHS March 31, 2026, are received from the CMHSPs to the PIHP
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds
- Develop regional and local cost containment strategies to align projected revenue and expenses

INFORMATION TECHNOLOGY COUNCIL

Team Leader: Steve Grulke, MSHN Chief Information Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

FY25 Goals/Accomplishments:

✓ **Goal:** Representation from each CMHSP will participate at all meetings
Barriers: People like regular schedule, but only way to improve participation would be to schedule based on availability and with the high number of participants, it is unlikely to reach 100%
Recommendation for Goal: Continue for FY26

✓ **Goal:** Successfully submitted MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
Barriers: Changing rules with MDHHS and getting programming changed within EMRs is difficult
Recommendation for Goal: Continue into FY26

✓ **Goal:** Collaborated to develop systems/processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
Barriers: Lack of guidance from MDHHS has caused uncertainty in process and system changes
Recommendation for Goal: Continue into FY26

✓ **Goal:** Worked on outcome measure data management activities as needed.
Barriers: No barriers identified
Recommendation for Goal: Continue into FY26

✓ **Goal:** Improved balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
Barriers: No barriers identified
Recommendation for Goal: Continue into FY26

✓ **Goal:** Transitioned health information exchange (HIE) processes to managed care information system, to gain efficiencies in data transmissions.
Barriers: No barriers identified
Recommendation for Goal: Continue into FY26

✓ **Goal:** Met IT audit requirements (e.g., EQRO).
Barriers: No barriers identified
Recommendation for Goal: Continue into FY26

✓ **Goal:** Create an Analytics Workgroup tasked with assessing proposals for a potential new, HEDIS-certified Analytics vendor.
Barriers: MDHHS Procurement process disrupted this process
Recommendation for Goal: Goal will be on hold until outcome for procurement is known

✓ **Goal:** Continue to mitigate issues and concerns with EVV Vendor HHAX.
Barriers: Progress has been slow in working through individualized issues.
Recommendation for Goal: Continue into FY26

Additional Council Accomplishments:

- Successfully implemented the electronic visit verification (EVV) platform from HHAX (contractor for MDHHS) and got providers to follow the process and using the system. Still working on the billing/claims portion of this implementation
- Supported Behavioral Health Home implementation in the region by having an IT subgroup to work through any problems related to data collection and reporting
- Supported CCBHC demonstration in the region by having an IT subgroup to work through data collection and reporting and handling things similarly and efficiently
- Discussed several new areas to determine where we could gain efficiency and/or effectiveness by collaboration. Some of the biggest areas were Artificial Intelligence, WSA changes and LOCUS reporting
- Worked together to implement an upgrade to the MCG Parity software within the region
- Worked with the compliance group to support the implementation of the new Compliance Software – Healthicity

FY26 Council Goals

- Representation from Each CMHSP Participant at all Meetings
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness
- Collaborate to develop systems or processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
- Work on outcome measure data management activities as needed
- Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT
- Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions
- Meet IT audit requirements (e.g., EQRO)
- Continue to mitigate issues and concerns with EVV Vendor HHAX

QUALITY IMPROVEMENT COUNCIL

Team Leader: Kara Laferty, Quality Manager
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Quality Improvement Council has been established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council will be comprised of the Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by each respective CMHSP Participant Chief Executive Officer/Executive Director, consumer representatives appointed through an application process, and a MSHN SUD staff representing Substance Use Disorder services as needed. The Quality Improvement Council will be chaired by the Quality Manager. All CMHSP Participants will be equally represented on this council.

FY25 Goals/Accomplishments:

✓ **Goal:** Submitted Board approved QAPIP Plan, Evaluation and Workplan on 2/28/2025
Barriers: No barriers identified
Recommendation for Goal: Completed, Goal to be carried forward to FY26

✓ **Goal:** Achieved validation status for MSHN's HSAG External Quality Review- Performance Improvement Projects
Barriers: Difficulty in establishing region wide interventions due to differences within each CMH for intervention needs, Retroactive data can make actioning of real time interventions difficult, Lack of specific dates of implementation for interventions is a significant challenge to assessing effectiveness to replicate interventions across the region
Recommendation for Goal: Completed, goal to be carried forward for Remeasurement period 3 (CY2025)

✓ **Goal:** MSHN ensured Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths), Immediately Reportable events were collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy
Barriers: Timeliness and remediation issues have been an ongoing challenge, Lack of clarification from MDHHS relating to updated training on critical incidents and cancelled meetings for Critical Incident leads has been an ongoing challenge
Recommendation for Goal: Ongoing MDHHS requirement- goal to be carried forward to FY26

✓ **Goal:** MSHN worked to meet or exceed the standard for MDHHS standardized indicators (MMBPIS) in accordance with the PIHP Medicaid contract
Barriers: Ongoing barriers to meeting indicator benchmarks due to individual CMHSP barriers such as lack of staffing, etc., FY26 changes by MDHHS to the MMBPIS system caused uncertainty as to what indicators might need ongoing improvement and which would no longer be a focus
Recommendation for Goal: Ongoing MDHHS requirement- goal to be carried forward to FY26

✓ **Goal:** Improved member experience of care by addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS)
Barriers: Difficulty in tracking separate populations and service programs across all CMHSPs in FY26
Recommendation for Goal: Ongoing MDHHS requirement- goal to be carried forward to FY26

Additional Council Accomplishments:

- Approved Quality policies and procedures ensuring that they are in compliance with regulatory requirements and communicated to providers
- Development and implementation of updated Priority Measure report that captures Year 1 and 2 metrics established by MDHHS's Behavioral Health Quality Overhaul (3 Year Rollout strategy)

FY26 Council Goals

- Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2026
- MSHN will meet or exceed the standard (62.3%) for MDHHS indicator 2 in accordance with the PIHP Medicaid contract
- MSHN will address the findings of the External Quality Review (EQR)-Performance Measure Validation Review through its QAPIP
- PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/ African American population and the white population
- PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated
- MSHN will obtain a qualitative and quantitative assessment of member experiences for all populations (including those receiving LTSS) and will:
  - Assess issues of quality, availability, accessibility of care
  - Take specific action as needed, identifying sources of dissatisfaction
  - Outline systematic action steps
  - Evaluate the effects of improvement activities
- MSHN will ensure Adverse Events (including Sentinel, Critical, Risk, Unexpected Deaths, and Immediately Reportable events) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy

SUBSTANCE USE DISORDER (SUD) OVERSIGHT POLICY BOARD

Team Leader: Chairman Bryan Kolk, SUD Board Member
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

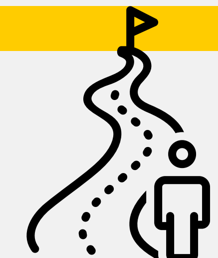
- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars.

FY25 Goals/Accomplishments:

- Received updates and presentations on the following: MSHN SUD Strategic Plan, MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY24 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY25 Budget Overview
- Received a presentation on PA2 funds Overview
- Received PA2 Funding reports – receipts & expenditures by County
- Received Quarterly Reports on Prevention and Treatment Goals and Progress
- Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
- Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Received written updates from Deputy Director including state and federal activities related to SUD
- Shared prevention and treatment strategies within region
- Approved changes to the SUD OPB bylaws to incorporate current Open Meetings language and to add language allowing counties to appoint an alternate and provides clarification on the voting rights of the alternate
- Received information and education on opioid settlement and strategies
- Received information on Adopting Low-Barrier Access to Medication for Opioid Use Disorder (MOUD) Treatment to Reduce Overdose Deaths in Michigan
- Received information on the Impact of Cannabis Legalization on Youth Following Passage of Proposal 1 in 2018

FY26 Council Goals

- Approve use of PA2 funds for prevention and treatment services in each county
- Improve communications with MSHN Leadership, Board Members and local coalitions
- Orient new SUD OPB members as reappointments occur
- Increase communication with local counties and coalitions regarding use of state and local opioid settlement funding
- Monitor SUD spending to ensure it occurs consistent with PA 500



CLINICAL LEADERSHIP COMMITTEE

Team Leader: Todd Lewicki, Chief Behavioral Health Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

FY25 Goals/Accomplishments:

✓ **Goal:** Regional input into Conflict Free Access and Planning.
- Review MDHHS requirements
- Address implementation plan, as appropriate

Barriers: Issuance of Procurement by MDHHS
Recommendation for Goal: On hold until finalized procurement details are obtained

✓ **Goal:** Review and address need for increasing access to children's services, including acute care
- Review CMH penetration rates for youth
- Review youth timeliness access data
- Identify plan as appropriate

Barriers: Staff time was diverted to procurement process and application
Recommendation for Goal: Continue for FY26

FY25 Goals/Accomplishments:

✓ **Goal:** Review and gauge CCBHC impact
- Receive reports from the participating CMHSPs
- Identify outcomes

Barriers: MDHHS removal of CCBHC from MSHN/Pre-paid Inpatient Health Plan oversight
Recommendation for Goal: Continue for FY26

✓ **Goal:** Address crisis resources uniformly across the region
- Assess region's crisis resources

Barriers: No barriers identified
Recommendation for Goal: Continue for FY26

✓ **Goal:** Address implementation of MichiCANS
- Begin regional workgroup
- Use input of workgroup to define consistent processes

Barriers: Ongoing MDHHS adjustments to decision support model
Recommendation for Goal: Continue for FY26

✓ **Goal:** Address Psychiatric Residential Treatment Facility (PRTF) and Intensive Community Transition Services (ICTS)
- Refine processes, including discharge planning

Barriers: No barriers identified
Recommendation for Goal: Goal was completed in FY25, however, ongoing monitoring will take place in FY26

✓ **Goal:** Identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any)
- Identify priority system reform objectives
- Create report identifying objectives and recommendations for groups to address

Barriers: No barriers identified
Recommendation for Goal: Continue for FY26

✓ **Goal:** Establish and/or work with providers to increase specialized housing options within the region
- Review data and create report addressing housing issues in MSHN region
- Convene group to address housing options
- Report on outcomes

Barriers: Time constraints of staff
Recommendation for Goal: Continue for FY26

Additional Council Accomplishments:
- Address MichiCANS and multiple agency use
- Input into autism procedure updates
- Address 1915(i) relative to MichiCANS and WHODAS updates
- BTP and HCBS Updates
- Established crisis residential monitoring
- Work on regional practice guidelines
- System advocacy regarding procurement
- Mental Health Framework preparation

FY26 Council Goals
- Address 1915(i) performance via approved CMS application
  - Identify 1915(i) outcomes and establish regional guidance
  - Update clinical MSHN Practice Guidelines
- Address WHODAS 2.0 implementation
  - Identify CMHSP partners interested in piloting
  - Address policy and procedural issues
  - Implement WHODAS 2.0 regionally
- The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year (Rolling 12 months)
  - Consensus on performance target
  - Increase performance to meet target
- Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64
  - Increase 2.8% to achieve performance objective
- Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS
  - Install new data tracking for autism services
  - Continue work through the workgroup to stress timely access

REGIONAL MEDICAL DIRECTORS

Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: As created by the MSHN Operations Council (OC), the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

FY25 Goals/Accomplishments:

✓ **Goal: Address youth access to CMH services**
- Review proposed measure for time to evaluation
- Review related access and timeliness data
- Review MichiCANS screener and comprehensive data

Barriers: Ongoing adjustments by MDHHS to the Decision Support Model
Recommendation for Goal: Continue for FY26

✓ **Goal: Improve health outcomes of the beneficiaries of the region**
- Contribute to regional plan development through review and advising on the following plans:
  - Population Health and Integrated Care
  - Utilization Management Plan
  - Quality Assurance and Performance Improvement Plan
  - Review appropriate annual plan and quarterly reports, identify priorities and coordinate with Clinical Leadership Committee.

Barriers: No barriers identified
Recommendation for Goal: Continue for FY26

✓ **Goal: Improve health and safety of individuals served**
- Review behavior treatment data report
- Review sentinel event and critical incident data
- Review IPOS data reports

Barriers: No barriers identified
Recommendation for Goal: Continue for FY26

Additional Council Accomplishments:
- Reviewed NAVIGATE on Demand for first episode psychosis
- Crisis residential options using DBT
- Youth crisis residential discussion and input
- Strategic planning input
- MDHHS neuropsych testing policy
- SUD screening process input
- Clozapine prescribing and tracking
- ECT referrals
- Discussion on Mental Health Framework
- HCBS 8 Elements discussion and review of requirements, including BTPs
- WHODAS 2.0 instrument discussion

FY26 Council Goals
- Address youth access to CMH services
  - Review proposed measure for time to evaluation
  - Review related access and timeliness data
  - Review MichiCANS screener and comprehensive data for decision support models
  - Review of Mental Health Framework
- Improve health and safety of individuals served
  - Review behavior treatment data report
  - Review sentinel event and critical incident data
  - Review IPOS data reports
- The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year (FY25 Baseline year)
  - Consensus on performance target
  - Increase performance to meet target
- Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64 (FY25 Baseline year)
  - Increase 2.8% to achieve performance objective
- Improve health outcomes of the beneficiaries of the region
- Contribute to regional plan development through review and advising on the following plans:
  - Population Health and Integrated Care
  - Utilization Management Plan
  - Quality Assurance and Performance Improvement Plan
  - Review appropriate annual plan and quarterly reports, identify priorities and coordinate with Clinical Leadership Committee

UTILIZATION MANAGEMENT COMMITTEE

Team Leader: Skye Pletcher, Chief Population Health Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

FY25 Goals/Accomplishments:

✓ **Goal:** Develop regional implementation recommendations for Conflict Free Access and Planning (CFAP) model once selected by MDHHS
Barriers: MDHHS did not implement policy requirements for CFAT during FY25. MDHHS has indicated that CFAP requirements will be addressed in FY27 PIHP contracts.
Recommendation for Goal: Discontinue due to procurement process

✓ **Goal:** Implemented regional process for addressing in-region COFR arrangements as directed by regional Operations Council, including dispute resolution process for in-region COFR arrangements
Barriers: None identified
Recommendation for Goal: Discontinue due to completion

✓ **Goal:** Monitored variance of authorized Michigan Child and Adolescent Services (MiCAS) from service/LOC recommendations from MichiCANS
- Develop report to monitor service authorization relative to MichiCANS decision support model recommended services. Include services that are not currently considered part of MiCAS array but are necessary such as outpatient, psychiatric, ABA, etc.
- Develop regional guidance for documenting clinical decision-making rationale when authorized services fall outside of MichiCANS decision support model recommendations. Consider implication for communicating these decisions to families and external partners such as local MDHHS child welfare staff.

Barriers: MDHHS is working to modify the decision support model of the MichiCANS. Development of a regional report is on hold pending changes to the decision support model.
Recommendation for Goal: Continue into FY26

✓ **Goal:** Establish a more robust process for monitoring of cutilization management functions through quarterly committee review of regional utilization data
- Review Medicaid subcontracted delegation grid and identify specific UM-contracted activities to develop value-added monitoring reports
- Develop quarterly report review process that includes data to reflect local-level similarities and differences in how contracted UM functions are performed (examples: number of requested, approved, and denied authorizations; interrater reliability review data; inpatient diversion rates; etc.)

Barriers: MDHHS announced that PIHPs will no longer be able to delegate managed care functions including utilization management beginning in FY27.
Recommendation for Goal: Discontinue due to procurement process and changes in contracted managed care functions

Goal: Recommended improvement strategies where adverse utilization trends are detected, and/or advocacy with MDHHS for local-level variance in response to community need
- Continue to monitor regional ACT utilization and fidelity to model for average minutes per week per consumer
- Others as identified through review of contracted UM function reports

Barriers: None identified
Recommendation for Goal: Goal will be modified for FY26 but continued

✓ **Goal:** Recommended opportunities for replication where best practice is identified
- Review tools for determining medical necessity for community living supports; recommend regional best practice
- Review existing practices for authorization of respite services and eligibility/service requirements. Recommend regional best practice

Barriers: None identified
Recommendation for Goal: Goal will be modified for FY26 but continued

✓ **Goal:** Addressed succession planning for UMC members relative to skill set needed by committee members
- Existing UMC members will identify a designated backup (with direction from CMH CEO) and provide mentoring regarding regional UM Plan and processes

Barriers: None identified
Recommendation for Goal: Completed, goal to be discontinued

✓ **Goal:** Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals.
- Develop report to monitor data
- Quarterly monitoring of report and identify any areas where improvement is needed

Barriers: None identified
Recommendation for Goal: Continue into FY26

UTILIZATION MANAGEMENT COMMITTEE CONTINUED

Additional Council Accomplishments:

- Regional input into inpatient access issues – continued monitoring of capacity in community-based hospitals and efforts to standardize UM practices with hospitals that contract with multiple in-region CMHSPs
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate. Maintained regional average rate of >/= 95% compliance with authorization decision timeliness standards
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >/= 95% adherence to medical necessity criteria
- Conducted regional data analysis for Applied Behavioral Analysis (ABA) services and developed regional best practice guidance for authorization of ABA services together with Clinical Leadership Committee
- Began regional planning related to MDHHS Mental Health Framework initiative and related requirements for FY26-FY27

FY26 Council Goals

- Monitoring variance of authorized MiCAS (Michigan Child and Adolescent Services) from service/LOC recommendations from MichiCANS
  - Develop report to monitor service authorization relative to MichiCANS decision support model recommended services. Include services that are not currently considered part of MiCAS array but are necessary such as outpatient, psychiatric, ABA, etc.
  - Develop regional guidance for documenting clinical decision-making rationale when authorized services fall outside of MichiCANS decision support model recommendations. Consider implication for communicating these decisions to families and external partners such as local MDHHS child welfare staff.
- Recommend improvement strategies where adverse utilization trends are detected and recommend opportunities for replication where best practice is identified.
  - Continue to monitor regional ACT utilization and fidelity to model for average minutes per week per consumer.
  - Review tools for determining medical necessity for community living supports; recommend regional best practice.
  - Review existing practices for authorization of respite services and eligibility/service requirements. Recommend regional best practice.
- Continued analysis of differences in amount, scope, duration of services received by individuals enrolled in waivers and non-waiver individuals.
  - Monitor utilization report and identify any areas where improvement is needed.

REGIONAL CONSUMER ADVISORY COUNCIL

Team Leader: Heather Nichols, Chairperson
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Regional Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Service Program (CMHSP) Participants of the region.

FY25 Goals/Accomplishments:

- Provided input on regional educational opportunities for stakeholders
- Reviewed and provide feedback on the MSHN FY25 Consumer Handbook
- Reviewed and advise the MSHN Board relative to strategic planning and advocacy efforts
- Provided group advocacy within the region for consumer-related issues
- Improved communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
- Collaborated with the MSHN Customer Service Committee to develop a staff professionalism training
- Reviewed and provided feedback on the MSHN Satisfaction Survey results
- Reviewed and provided feedback on the Michigan Medicaid Recovery Incentive (RI) Pilot
- Reviewed and provided feedback on the Michigan Opioid Settlement Fund
- Reviewed and provided feedback on MSHN RCAC Member Orientation Training
- Reviewed and provided feedback on MSHN Staff Professional Training
- Reviewed and provided feedback on MSHN RCAC Member Orientation Training

FY26 Council Goals

- Provide input on regional educational opportunities for stakeholders
- Provide input for ongoing strategies for the assessment of consumer satisfaction
  - Review regional survey results, including the SUD Satisfaction Survey and external quality reviews, Annual review, and provide feedback on the QAPIP
- Review and advise the MSHN Board relative to advocacy efforts
  - Provide group advocacy within the region for consumer related topics
  - Provide group advocacy on the PIHP Procurement Process
  - Provide group advocacy on Conflict Free Access and Planning
- Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
  - Incorporate open discussion on ways to strengthen Person Centered Planning, Independent Facilitation, and Self Determination Implementation

CUSTOMER SERVICES COMMITTEE (CSC)

Team Leader: Dan Dedloff, MSHN Customer Service & Rights Manager
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The CSC was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to ensure the handbook is maintained in a compliant format, and to support the development and implementation of monitoring strategies to ensure regional compliance with CS standards.

FY25 Goals/Accomplishments:

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY24 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
- Reviewed, analyzed, and reported regional customer service information for Grievances, Appeals, Medicaid Fair Hearings, and MCPAR
- Facilitated publication of the Spanish language PDF version of the MSHN Consumer Handbook for each of the in-region CMHSP and SUDSP providers
- Developed a staff professionalism training
- Explored the development of an Adverse Benefit Determination technical assistance training

FY26 Council Goals

- Review and revise the MSHN Consumer Handbook for publication and distribution
  - Review contract updates and regional changes for Handbook updates
  - Revise CMHSP local sections
  - Coordinate a print vendor and facilitate the printing of the Handbook
  - Regional distribution of the MSHN Consumer Handbook to CMHSP and SUDSP providers
- Reviewed, analyzed, and reported regional customer service information for Grievances, Appeals, Medicaid Fair Hearings, and MCPAR
  - Analyze reporting for any significant trends or concerns.
  - Complete corrective action plans for any untimeliness that occurred during the report quarter.

PROVIDER NETWORK COMMITTEE

Team Leader: Leslie Thomas, Chief Financial Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function coto Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions

FY25 Goals/Accomplishments:

Goal: Completed a Regional Network Adequacy Assessment (September 30th, 2025)
Barriers: None identified
Recommendation for Goal: Continue for FY26

Goal: Developed reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language
Barriers: None identified
Recommendation for Goal: Continue for FY26

Goal: Maintain a regional training plan in accordance with state requirements as identified in the MDHHS/MSHN Specialty Supports and Services Contract
Barriers: None identified
Recommendation for Goal: Continue for FY26

FY26 Council Goals

- Completion of a Regional Network Adequacy Assessment
- Development of reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language
- Maintain a regional training plan in accordance with state requirements as identified in the MDHHS/MSHN Specialty Supports and Services Contract
- Establishment of a regional contract boilerplate for legal requirements

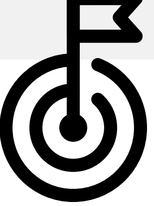
REGIONAL COMPLIANCE COMMITTEE

Team Leader: Kim Zimmeran, MSHN Chief Compliance and Quality Officer
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

FY25 Goals/Accomplishments:

✓ **Goal:** Identify compliance related educational opportunities including those aimed at training compliance officers
Barriers: Lack of compliance trainings offered locally related to investigations, etc.
Recommendation for Goal: This goal was partially completed in FY25, however will be continued for FY26

✓ **Goal:** Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
Barriers: Limited validated tools for use in behavioral health systems for risk assessment
Recommendation for Goal: This goal was partially completed in FY25, however will be continued for FY26



Additional Council Accomplishments:

- Participated in selection of a vendor for Compliance Software to be used region wide
- Tested compliance software and made recommendations for revisions/updates to forms and process
- Revised and approved the 2025 MSHN Compliance Plan
- Reviewed and approved the FY2024 Annual Compliance Summary Report inclusive of recommendations
- Operationalized updates/revisions to Office of Inspector General (OIG) quarterly report and fraud referral process
- Assisted in development of process for reporting OIG monthly overpayment report
- Revised Privacy Notice to include changes in federal requirements
- Provided evidence of compliance with confidentiality standards for external quality review resulting in 95% compliance score

FY26 Council Goals

- Identify compliance related educational opportunities including those aimed at training compliance officers
  - Identify training elements appropriate for staff
  - Identify training elements appropriate for board members
  - Utilize state and federal resources/websites for current training/educational opportunities
  - Use resources to develop new trainings as necessary
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
  - Research potential risk assessment tools to be used for behavioral health system
  - Review options for tools with MSHN and Regional Compliance Committee
  - Complete assessment, share results and develop recommendations for follow up as needed

REGIONAL EQUITY ADVISORY COMMITTEE FOR HEALTH (REACH)

Team Leader: Debbie Edokpolo (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: REACH is an advisory body of community stakeholders established for the following purposes:

- Ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI)
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma
- Address stigma and bias that may impact health outcomes

FY25 Goals/Accomplishments:

✓ **Goal:** Support and reinforce health equity as a perpetual focus across all departments, functions and strategic priorities
Barriers: Systemic instability at both federal & state levels since Jan. 2025, Executive Orders & policies designed to block or remove initiatives to reduce health disparities, increase diversity, etc.
Recommendation for Goal: Holding on how to frame goals contingent on procurement outcome and MSHN's future after FY26

✓ **Goal:** Increase data sharing around equity activities and reducing health disparities
Barriers: Redaction and/or elimination of equity-focused data sets/reports. Despite this, MSHN has reported out on our activities and available data on population health metrics at every meeting bimonthly
Recommendation for Goal: Continue sharing available and vetted data MSHN has access to

✓ **Goal:** Support community engagement to inform Learning Collaborative (LC) activities
Barriers: This has been most effective through partnerships with our Native American REACH representative who has been key to the Learning Collaborative's engagement with American Indian communities in Isabella and beyond
Recommendation for Goal: Continue goal into FY26

✓ **Goal:** Review Learning Collaborative Action Plans relative to impacting health disparities
Barriers: These were reviewed prior to the start of FY25 and implemented on 10/1/24
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Support for IDEA Workgroup's internal review of MSHN policies, hiring, etc.
Barriers: Like REACH, IDEA has been impacted by the instability at the state and federal levels as well as anti-DEI policies coming from the federal government. This has slowed IDEA's momentum but much of its work around hiring, and other HR policies was completed in FY23 and FY24
Recommendation for Goal: Modify goal for FY26

Additional Council Accomplishments:

- A critical function of REACH for MSHN's REACH-participating DEI leaders (Chief Clinical Officer, Chief Population Officer, Chief Executive Officer & IDEA Lead) has been increased awareness and sensitivity to lived experiences of Black, Hispanic, Native American and Muslim Region 5 community members.
- An unanticipated but also critical function for MSHN and REACH has been offering reciprocal and mutual support amidst frequent and highly damaging actions by federal, state and local authorities. This has been a safe space for sharing, debriefing and decompressing from the traumatic impacts of ongoing rights' violations for historically marginalized and targeted populations in our region.
- REACH members have served as valued resources for MSHN, for example, recruiting our Native American REACH member to partner with another Native American & LGBTQ individual to offer an All-Staff training for MSHN staff. This mirrored the All-Staff training done previously by another REACH member from Region 5's Black community.

FY26 Council Goals

- REACH's broad goals and agenda(s) are on hold for FY26 pending new information on the PIHP procurement process & MSHN's future after FY26
- Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use (FUA)
  - REACH will provide feedback about factors that could lead to racial/ethnic disparities and offer recommended interventions to reduce barriers to care for individuals belonging to racial/ethnic minority groups
- Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (FUH)
  - REACH will provide feedback about factors that could lead to racial/ethnic disparities and offer recommended interventions to reduce barriers to care for individuals belonging to racial/ethnic minority groups

AUTISM BENEFIT WORKGROUP

Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The Autism Services Workgroup was established to initiate and oversee coordination of the autism services for the region. The Autism Services Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) autism services staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The Autism Services Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

FY25 Goals/Accomplishments:

✓ **Goal:** Improved and developed solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carry out treatment)
Barriers: ABA providers losing staff to schools, Families want ABA providers that provide additional services (OT, PT, ST, etc.), Families only want center-based ABA (instead of in-home)
Recommendation for Goal: Continue in to FY26

✓ **Goal:** Adjust to code changes and new policy language
Barriers: MDDHS Code changes were contradictory to other codes and current policy, new policy language was never released
Recommendation for Goal: Modify goal for FY26, but continue

✓ **Goal:** Ensured regional representation at quarterly MSHN Autism Workgroups
Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Ensured proper implementation of the MichiCANS screener and comprehensive as directed in FY25
Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

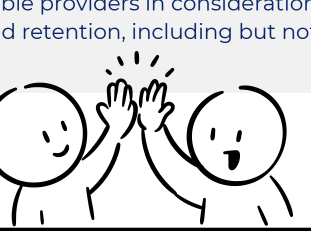
✓ **Goal:** Monitored QBHP staff credentialing and ensure transition to BCBA/LBA by September 30, 2025
Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

Additional Council Accomplishments:

- Worked in coordination with CMHSPs to work toward EMR data integration for purposes of Autism Services data monitoring and tracking
- Provided feedback and advocacy with MDHHS regarding proposed Autism policy updates
- Provided feedback and advocacy with MDHHS including Autism team, Behavior Treatment team, Recipient Rights team, and EDIT team regarding MDHHS direction related Behavior Treatment Plan implementation standards
- Provided feedback and advocacy with MDHHS regarding autism specific code changes impacting care of individuals served
- Provided feedback and advocacy with MDHHS and support to stakeholders related to ABA in schools guidance
- Planned, scheduled, and provided multiple, free QBHP support sessions in an effort to maintain workforce capacity by helping QBHPs pass licensing exam
- Increased regional community representation with multiple Autism leads participating in community outreach such as Autism Council meetings, Autism Alliance of Michigan meetings, etc.
- Gathered feedback and developed regional BHT/ABA recommendation plan

FY26 Council Goals

- Improve efficiencies related to ongoing tracking and monitoring of autism services
  - CMHSPs will build autism modules into their EMRs with specified data points
  - PIHP will develop data extraction/reporting system to resume tracking/monitoring efforts related to autism services
- Track, monitor, and provide feedback/support when any autism-related changes occur including code changes and policies
  - Become aware of and understand the changes that are implemented by MDHHS
  - Advocate for stabilization of policy to support quality service delivery
  - Inform network and stakeholders when policy changes are proposed and initiated
- Improve and develop solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carry out treatment)
  - Outreach to providers within the state to increase opportunities for autism benefit enrollees to participate in medically necessary services
  - Share list of available providers with the region as well as regional results of ongoing monitoring of current providers
  - CMHSP representatives will connect with available providers in consideration of additional contracts
  - CMHSPs to strengthen provider recruitment and retention, including but not limited to reducing barriers for contracting processes and offering options for trainings



HABILITATION SUPPORTS WAIVER (HSW) WORKGROUP

Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSP's are equally represented.

FY25 Goals/Accomplishments:

✓ **Goal:** Prepare for follow up from MDHHS regarding the HCBS review that took place in 2024
- Review corrective action presented by both the CMHSPs and MDHHS
- Collaborate with CMHSP HSW Leads to work through review
- Provide technical assistance and collaboration to CMHSPs to become compliant with Corrective Action Plans (CAPs)

Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Ensure all HSW initial applications are compliant with HCBS guidelines pertaining to restrictive/intrusive measures
- All initial HSW applications that have a BTP in place will be reviewed by the HSW Coordinator and the HCBS Coordinators to ensure compliance with HCBS Guidelines set forth by MDHHS
- Provide technical assistance to CMHSPs for cases that do not meet the guidelines and are pended back
- Waiver Coordinator will attend HSW PIHP Coordinator Meetings with MDHHS to serve as a conduit of information for the CMHSPs

Barriers: No barriers identified
Recommendation for Goal: Continue goal into FY26

✓ **Goal:** Eliminate monthly unsubmitted / past due HSW recertifications based on established due dates from MSHN and MDHHS
- Provide CMSHPs with a list of recertifications due, at least two months prior to required submission to MDHHS
- Provide a monthly reminder for past due recertifications to applicable CMHSPs through the HSW Monthly report emails

Barriers: No barriers identified
Recommendation for Goal: Continue goal for FY26

✓ **Goal:** Increase timeliness of response to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS
- Include a 'due by' date in all pend back responses to the CMHSP in the WSA
- Provide technical assistance to CMHSPs for cases that are pended back
- Provide monthly reminders regarding pended back cases for each CMHSP through the HSW Monthly report emails

Barriers: No barriers identified
Recommendation for Goal: Continue goal for FY26

✓ **Goal:** Ensure transition, as appropriate, from HSW to 1915(i) or all cases that are being disenrolled.
- CMHSPs will include if 1915(i) enrollment is required in all HSW disenrollment comments in the WSA
- PIHP HSW lead and PIHP iSPA lead will continue to work collaboratively related to these transitions
- The HSW-1915(i) Transition Workflow will be followed for all HSW disenrollments
- Waiver Coordinator will attend HSW PIHP Coordinator Meetings with MDHHS to serve as a conduit of information for the CMHSPs

Barriers: No barriers identified
Recommendation for Goal: Continue goal for FY26

Additional Council Accomplishments:

- Reached and maintained 95% slot allocation
- Completion of FY25 RLA Validation Project with full participation
- Distributed monthly HSW reports
- Worked through continued challenges related to monitoring initial HSW applications and recertifications for restrictive and intrusive techniques and/or Behavior Treatment Plans
- Established a routine in which updates regarding past due recertifications and consents, inactive cases, and pended back recertifications and initial applications are submitted to MSHN

FY26 Council Goals

- Maintain a minimum 95% utilization of allocated HSW slots for the region
  - Review slot allocation monthly and present date in the HSW Monthly report
- Ensure all HSW initial applications are compliant with HCBS guidelines pertaining to restrictive/intrusive measures
  - All initial HSW applications that have a BTP in place will be reviewed by the HSW Coordinator and the HCBS Coordinators to ensure compliance with HCBS Guidelines set forth by MDHHS
  - Provide technical assistance to CMHSPs for cases that do not meet the guidelines and are pended back
  - Waiver Coordinator will attend HSW PIHP Coordinator Meetings with MDHHS to serve as a conduit of information for the CMHSPs
- Ensure transition, as appropriate, from HSW to 1915(i) or all cases that are being disenrolled
  - CMHSPs will include if 1915(i) enrollment is required in all HSW disenrollment comments in the WSA
  - PIHP HSW lead and PIHP iSPA lead will continue to work collaboratively related to these transitions

CHILDREN'S WAIVER PROGRAM (CWP) WORKGROUP

Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

FY25 Goals/Accomplishments:

✓ **Goal:** Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite
Barriers: Provider interest and availability across region, CMHSP interest and/or ability to enter into contracts with additional service providers, Varying degrees of comfort with delivering services through allowable use of telehealth, Delays in contracting process related to communication, credentialing, fee structure/funding, etc.
Recommendation for Goal: Modify goal for FY26, but continue

✓ **Goal:** Work to ensure full Corrective Action Plan approval for CWP charts reviewed during FY24 MDHHS HCBS Waiver Site Review
Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

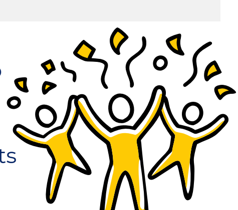
✓ **Goal:** Ensure proper implementation of the MichiCANS screener and comprehensive as directed in FY25
Barriers: Completing staff training, Ensuring consistent reporting, Decision support model errors
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are adequately informed and have the resources available to enroll and maintain a youth in the CWP
Barriers: Overlapping job responsibilities, Unexpected conflicts
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Ensure regional participation in MDHHS sponsored ICCW trainings during FY25 to allow and encourage utilization of this new state plan service for CWP enrollees
Barriers: No barriers identified
Recommendation for Goal: Discontinue goal as goal was completed in FY25

✓ **Goal:** Monitor status of CMS approval of CWP waiver renewal application and communicate changes that have been approved
Barriers: Inconsistent guidance related to implementation prior to policy change
Recommendation for Goal: Discontinue goal as goal was completed in FY25

Additional Council Accomplishments:



- Worked with community providers of equine therapy to advocate for additional provider qualifications to be added to MDHHS approved provider qualifications. MDHHS approved the additional provider qualifications
- Provided feedback and advocacy with MDHHS regarding proposed CWP waiver renewal and policy updates
- Within the fiscal year, there were seven invitations to enroll in the CWP successfully resulting in seven new enrollments
- With an increase in contracts with providers for activity therapies (music therapy, art therapy, recreational therapy), there was also an increase in the number of units provided of these therapies (FY24: 317 units; FY25: 363 units)

FY26 Council Goals

- Ensure appropriate provider capacity across region including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy, massage therapy), CLS, and respite
  - MSHN to determine current capacity and gaps
  - CMHSPs to strengthen provider recruitment and retention, including reducing barriers for contracting processes
  - CMHSPs to expand access to underserved areas
- Prepare for system-wide changes for FY26
  - Become aware of and understand changes that are implemented by MDHHS
  - Inform network and stakeholders when policy changes are proposed and initiated
  - Support regional CWP leads with resources and confidence to provide quality care in preparation for the proposed transition
- Assist with exposure to and development of qualified equine therapy providers across the region
  - Outreach to providers within the state to increase opportunities for CWP enrollees to participate in medically necessary services.
  - Share list of available providers with the region
  - CMHSP representatives will connect with available providers in consideration of additional contracts
- Work to decrease barriers for access to CWP enrollment and/or services
  - Become aware of barriers that exist for families seeking the CWP
  - Determine current process for families seeking CWP services and enrollment and identify gaps
  - CMHSPs to implement strategies to reduce barriers or gaps in service delivery
- Increase number of enrollees that are receiving specialty services (music therapy, art therapy, recreation therapy, equine therapy, massage therapy)
  - CMHSPs to inform families of specialty services that are available through the CWP
  - Ensure that families have a choice of providers for each specialty service
  - Ensure supports coordinators are aware of and informed about available services

HOME AND COMMUNITY BASED SERVICES (HCBS) WORKGROUP

Team Leader: Kara Hart, Waiver Administrator
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The HCBS Workgroup was established to initiate and oversee coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Administrator (Adults), Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HCBS Workgroup is chaired by the Waiver Administrator. All CMHSPs are equally represented.

FY25 Goals/Accomplishments:

✓ **Goal:** Work to resolve identified conflicts with HCBS compliance and licensing (LARA) recommendations to ensure fluidity with MDHHS guidelines and expectations

- Provide time during quarterly workgroup meetings to discuss potential conflicts between HCBS and LARA
- Regularly review 2024 LARA Joint Guidance document to ensure clarity and understanding with LARA and HCBS intersection

Barriers: LARA inconsistencies between counties, LARA unwillingness to collaborate with HCBS at MDHHS level
Recommendation for Goal: Modify goal for FY26, but continue

✓ **Goal:** Finalize monitoring process to ensure HCBS settings within Mid-State Health Network region maintain positive HCBS compliance status

- Utilization and review of Site Visit tool
- Complete and distribute Non-Residential Site Visit Tool
- Determine how to collect documentation of each AFC receiving HCBS review annually
- Determine how to divide enrolled individuals into thirds to pursue receiving HCBS review at least every three years
- Determine what the documentation of individual reviews will look like, be collected, and where stored
- Create a template for providers to receive after an ongoing monitoring review which indicates current compliance

Barriers: Awaiting guidance from MDHHS on database and reporting requirements
Recommendation for Goal: Discontinue goal as goal was completed in FY25

Goal: Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process, including integration of the required elements into the Individual Plan of Service

- MDHHS guidance and expectations will be discussed during workgroup meetings and dispensed to CMH leads by HCBS coordinators
- Workgroup members will share their experiences with completing MDHHS provisional approval process and collaborate on documentation suggestions when appropriate
- Case manager training created by MSU will be utilized to ensure all regional case management staff are trained fully in HCBS requirements

Barriers: Changing/shifting expectations
Recommendation for Goal: Modify goal for FY26, but continue

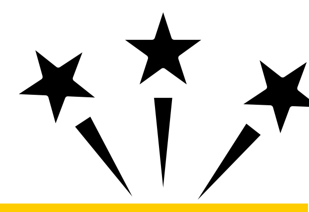
Goal: Develop a monthly HCBS report documenting provisional visits, ongoing monitoring, and HCBS updates

- Identify which data points from the HCBS tracking and monitoring tool will be used to create and update the HCBS report.
- Develop and implement a reporting process and procedure (e.g., on the first of the month, data is pulled from the tracking and monitoring tool and used to develop monthly report, which is reported to leadership and CMHSPs at workgroups).
- Regularly seek feedback and input from workgroup for data/information to report on in monthly report

Barriers: Awaiting guidance from MDHHS on database and reporting requirements
Recommendation for Goal: Discontinue goal as goal was completed in FY25

Additional Council Accomplishments:

- Provisional status- less back and forth needed for MDHHS approval
- Development, utilization, and sharing of effective implementation guide regarding the use of the eight HCBS elements, and provided this guidance to MDHHS and to statewide stakeholders
- Creation and utilization of an IPOS review tool
- Coordination of trainings for all case managers/supports coordinators in the region
- Relationships with providers- updated handbooks/policies for providers that were not in compliance



FY26 Council Goals

- Work to resolve identified conflicts with the HCBS compliance and LARA licensing recommendations to ensure fluidity with MDHHS guidelines and expectations
  - Provide time during quarterly workgroup meetings to discuss potential conflicts between HCBS and LARA
  - Follow up with MDHHS HCBS team on recurring and ongoing issues and document accordingly
- Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process
  - MDHHS guidance and expectations will be discussed during workgroup meetings and dispensed to CMH leads by HCBS coordinators.
  - Workgroup members will share their experiences with completing MDHHS provisional approval process and collaborate on documentation suggestions when appropriate.
  - Create and implement a system for tracking extensions for secured placements
- Prioritize the integration of the required HCBS elements into the Individual Plan of Service for those with an intrusive or restrictive intervention
  - MSHN HCBS staff will review HCBS plans with intrusive or restrictive interventions and provide feedback to CMHSPs

HABILITATION SUPPORTS WAIVER (HSW) WORKGROUP CONTINUED

FY26 Council Goals (Continued)

  - The HSW-1915(i) Transition Workflow will be followed for all HSW disenrollments
  - Waiver Coordinator will attend HSW PIHP Coordinator Meetings with MDHHS to serve as a conduit of information for the CMHSPs
- Increase timeliness of response to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS
  - Include a 'due by' date in all pend back responses to the CMHSP in the WSA
  - Provide technical assistance to CMHSPs for cases that are pended back
  - Provide monthly reminders regarding pended back cases for each CMHSP through the HSW Monthly report emails
- Eliminate monthly unsubmitted / past due HSW recertifications based on established due dates from MSHN and MDHHS
  - Provide CMSHPs with a list of coming due recertifications, at least two months prior to required submission to MDHHS
  - Provide a monthly reminder for past due recertifications to applicable CMHSPs through the HSW Monthly report emails

WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SEDW) WORKGROUP

Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2024 through 9.30.2025
Purpose of Council or Committee: The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

FY25 Goals/Accomplishments:

✓ **Goal:** Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite
Barriers: Provider interest and availability across region, CMHSP interest and/or ability to enter into contracts with additional service providers, Varying degrees of comfort with delivering services through allowable use of telehealth, Delays in contracting process related to communication, credentialing, fee structure/funding, etc.
Recommendation for Goal: Modify goal but continue into FY26

✓ **Goal:** Review and respond to system changes as influenced by Michigan Intensive Child and Adolescent Service Array (MICAS)
Barriers: Inconsistent guidance related to implementation prior to policy change, MDHHS is still in data collection process and recently rescinded policy bulletin regarding ICSS, New programs take time to fully implement
Recommendation for Goal: Modify goal but continue into FY26

✓ **Goal:** Work to ensure full Corrective Action Plan approval for SEDW charts reviewed during FY24 MDHHS HCBS Waiver Site Review
Barriers: No barriers identified
Recommendation for Goal: Completed in FY25, discontinue goal for FY26

✓ **Goal:** Ensure proper implementation of the MichiCANS screener and comprehensive as directed in FY25
Barriers: Completing staff training, Ensuring consistent reporting, Decision support model errors
Recommendation for Goal: Completed in FY25, discontinue goal for FY26

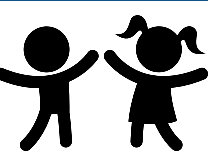
✓ **Goal:** Provide support to the region to ensure qualified staff receive appropriate training for Wraparound and/or ICCW, as needed, dependent upon the SEDW waiver application approval
Barriers: Delays in development and availability of MDHHS ICCW trainings, Challenges with consistencies across trainings, Implementation challenges related to this new program, Gap in required available trainings which contributed to workforce shortages during transition between Wraparound and ICCW
Recommendation for Goal: Completed in FY25, discontinue goal for FY26

✓ **Goal:** Monitor status of CMS approval of SEDW waiver renewal application and communicate changes that have been approved
Barriers: Inconsistent guidance related to implementation prior to policy change
Recommendation for Goal: Completed in FY25, discontinue goal for FY26

✓ **Goal:** Engage in region-wide efforts to improve implementation of established person-centered planning requirements related to youth enrolled in SEDW
Barriers: Variations in MDHHS site review guidance related to PCP requirements, Challenges related to interpretation of amount, scope, and duration requirements
Recommendation for Goal: Completed in FY25, discontinue goal for FY26

Additional Council Accomplishments:
- Worked with community providers of equine therapy to advocate for additional provider qualifications to be added to MDHHS approved provider qualifications. MDHHS approved the additional provider qualifications.
- Provided feedback and advocacy with MDHHS regarding proposed SEDW waiver renewal and policy updates.
- With an increase in contracts with providers for activity therapies (music therapy, art therapy, recreational therapy), there was also an increase in the number of youth utilizing these therapies (FY24: 46 youth; FY25: 86 youth) and number of units provided (FY24: 708 units; FY25: 1735 units).

WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SEDW) WORKGROUP CONTINUED



Additional Council Accomplishments (Continued):

- Increased overall net enrollment by 14 individuals over the fiscal year
- Adjusted to immediate CAFAS/PECFAS and MichiCANS requirement changes and assisted the region with tools and resources necessary for compliance
- Strong regional representation at the SEDW MichiCANS Workgroup
- Tested and notified MDHHS about barriers to implementation related to WSA rules and structure
- Regional volunteers assisted in improving outcomes related to the MichiCANS SEDW Decision Support Model
- Increased tracking, monitoring, and troubleshooting of Medicaid enrollment, SEDW Medicaid program assignments, and SEDW distributed payments resulting in follow-up with MDHHS BCCHPS staff, SPO representative, and local DHHS staff and eventual remediation of issues

FY26 Council Goals (Continued)

- Ensure appropriate provider capacity across region including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy) and MICAS service array
  - ·MSHN to determine current capacity and gaps
  - CMHSPs to strengthen provider recruitment and retention, including reducing barriers for contracting processes
  - CMHSPs to expand access to underserved areas
- Prepare for system-wide changes for FY26
  - Become aware of and understand changes that are implemented by MDHHS
  - Inform network and stakeholders when policy changes are proposed and initiated
  - Support regional SEDW leads with resources and confidence to provide quality care in preparation for the proposed transition
- Assist with exposure to and development of qualified equine therapy providers across the region
  - Outreach to providers within the state to increase opportunities for SEDW enrollees to participate in medically necessary services
  - Share list of available providers with the region
  - CMHSP representatives will connect with available providers in consideration of additional contracts
- Work to decrease barriers for access to SEDW enrollment and/or services
  - Become aware of barriers that exist for families seeking the SEDW
  - Determine current process for families seeking SEDW services and enrollment and identify gaps
  - CMHSPs to implement strategies to reduce barriers or gaps in service delivery
- Increase number of enrollees that are receiving specialty services (music therapy, art therapy, recreation therapy, equine therapy, massage therapy)
  - CMHSPs to inform families of specialty services that are available through the SEDW
  - Ensure that families have a choice of providers for each specialty service
  - Ensure team members are aware of and informed about available services
- Improve confidence in MichiCANS SEDW Decision Support Model recommendations and adhere to the full transition after the maintenance of effort time frame
  - Continue to provide feedback regarding Decision Support Model recommendations
  - Engage in activities to assist in calibration of Decision Support Model to ensure appropriate clinical recommendations
  - Share tips and successes related to Decision Support Model
  - Complete full transition, including internal processes and WSA updates

2025 WORKPLAN PROGRESS

Area	Goal	Objectives/Activities	Lead	Activity Status
Organizational Structure and Leadership	MSHN will complete and submit a Board approved QAPIP Plan, Evaluation and Workplan with list of members of the Governing Body.	Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN QAPIP Evaluation.	Quality Manager	Completed, Continue in FY26
		Collaborate with committees/councils to develop regional QAPIP workplan.	Quality Manager	Completed, Continue in FY26
		Review/revise QAPIP Plan to include new regulations.	Quality Manager	Completed, Continue in FY26
		Submit to MDHHS via FTP site.	Quality Manager	Completed, Continue in FY26
	MSHN Board of Directors will review QAPIP Progress Reports describing performance improvement projects, actions, and results of actions.	Establish an organizational process to monitor the status of the quality workplan and key performance indicators used to monitor clinical outcomes and process implementation.	Quality Manager	Not Completed, Carry to FY26
		Development of standard templates for use in organizational performance improvement projects and QI plan.	Quality Manager	Not Completed, Carry to FY26
	MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP. MSHN will include the role of recipients of service in the QAPIP. MSHN will have mechanisms or procedures for adopting and communicating processes and outcome improvement.	Evaluate the committee/structure to ensure responsibilities align with the strategic priorities.	Council/Committee Leads	Completed, Continue in FY26
		Review committee charters to ensure effectiveness in carrying out the defined responsibilities.	Council/Committee Leads	Completed, Continue in FY26
		Recipients will provide feedback and have membership in select regional committees for the purpose of advocacy, project/policy planning and development, project implementation and evaluation	Council/Committee Leads	Completed, Continue in FY26
		Document discussion and source of feedback to ensure follow up.	Council/Committee Leads	Completed, Continue in FY26
		Utilize the MSHN website, Newsletter, and regional committee structure for communication and distribution of policies/procedures and reports.	Council/Committee Leads	Completed, Continue in FY26
	MSHN will provide and/or make available to consumers & stakeholders, including providers and the general public, the QAPIP Report, QAPIP Plan and other quality reports. Performance Measurement and Quality reports are made available to stakeholders and general public.	Distribute the completed Board approved QAPIP Effectiveness Review (Report) and QAPIP Plan through: Committee/councils, MSHN Constant Contact, Email, Website	Quality Manager	Completed, Continue in FY26
		Post to the MSHN Website	Quality Manager	Completed, Continue in FY26
		Ensure CMHSP contractors have opportunity to receive the QAPIP (DMC-check websites)	Quality Manager	Completed, Continue in FY26
		Provide to members upon request	Quality Manager	Completed, Continue in FY26
		Distribute QAPIP progress reports	Quality Manager	Completed, Continue in FY26
Performance Improvement Projects	PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/ African American population and the white population.	Collaborate with PIP Team members and relevant committee.	QIC	Completed, Continue in FY26
		Utilize quality tools to identify barriers and root causes.	QIC	Completed, Continue in FY26
		Implement interventions	QIC	Completed, Continue in FY26
		Evaluate the effectiveness of interventions.	QIC	Completed, Continue in FY26
		Submit PIP 1 to HSAG as required for validation.	QIC	Completed, Continue in FY26
		Submit to MDHHS with QAPIP Evaluation.	QIC	Completed, Continue in FY26
	PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Collaborate with PIP Team members and relevant committee.	QIC	Completed, Continue in FY26
		Utilize quality tools to identify barriers and root causes.	QIC	Completed, Continue in FY26
		Implement interventions.	QIC	Completed, Continue in FY26
		Evaluate the effectiveness of interventions.	QIC	Completed, Continue in FY26
		Submit to MDHHS with QAPIP Evaluation.	QIC	Completed, Continue in FY26
Quantitative and Qualitative Assessment of Member Experiences	MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and •Assess issues of quality, availability, accessibility of care, •take specific action as needed, identifying sources of dissatisfaction, •outline systematic action steps, •evaluate the effects of improvement activities and, •communicate results to providers, recipients, and the Governing Body.	Provide /update instructions and tools on the MSHN website for all surveys.	QIC	Completed, Continue in FY26
		Update process and instructions to include the submission of template on the MSHN website.	QIC	Completed, Continue in FY26
		Develop electronic version of the tool and establish process for data distribution once completed.	QIC	Completed, Continue in FY26
		Explore the use of an external contractor to complete the analysis of the survey data and annual report.	QIC	Completed, Continue in FY26
		Develop QI plan for those areas that do not meet the standard.	QIC	Completed, Continue in FY26

2025 WORKPLAN PROGRESS

Area	Goal	Objectives/Activities	Lead	Activity Status
Performance Management	MSHN will meet or exceed the standard for MDHHS standardized indicators in accordance with the PIHP Medicaid contract. •Michigan Mission Based Performance Improvement System •Priority Population Access •Integrated Care Measures-PBIP •Health Home Performance Metrics	Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations).	Measure Stewards	Completed, Continue in FY26
		Develop/identify regional improvement strategies used to identify barriers and interventions in collaboration with committee.	Measure Stewards	Completed, Continue in FY26
		Monitor the effectiveness of interventions.	Measure Stewards	Completed, Continue in FY26
	MSHN will evaluate the impact and effectiveness of the QAPIP •Performance of the measures, •Outcomes and trended results •Results of efforts to support community integration for members receiving LTSS. •Analysis of improvements in healthcare and services as a result of the QI activities. •Trends in service delivery and health outcomes over time including monitoring of progress	Monitor performance measures and complete performance summaries for measures that do not meet the standards, identify barriers, improvement strategies, and effectiveness of improvement strategies.	Measure Stewards	Completed, Continue in FY26
		Establish a standardized process for MSHN committee/council to monitor the impact of intervention (quality improvement) on assigned performance areas.	Measure Stewards	Not Completed, Carry to FY26
		Establish standard process for quality improvement in collaboration with committee/councils to analyze outliers and develop/identify regional improvement barriers, improvement strategies and effectiveness of strategies.	Measure Stewards	Not Completed, Carry to FY26
	MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations).	UMC/SUD	Completed, Continue in FY26
		Develop/identify regional improvement strategies used to identify barriers and interventions.	UMC/SUD	Completed, Continue in FY26
		Centralize access for Withdrawal Management, Residential and Recovery Housing services.	UMC/SUD	Completed, Discontinue
	Establish effective quality improvement programs for CCBHC and Health Homes	Develop/modify data platforms/reports for performance monitoring.	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
		Develop/identify regional improvement strategies.	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
		Will receive CCBHC metrics template quarterly from each clinic quarterly.	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
		Will review metric templates for completeness and accuracy	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
		Will ensure improvement strategies are developed based on clinic and LE performance	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
		Will establish/develop an efficient method to view performance by clinic, comparing to Michigan CCBHC standards and to provide validated detail clinic data as requested to each clinic.	QI subgroups/PIHP Collaboration Team	Completed, Discontinue
(Adverse Events) Event Monitoring and Reporting	MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths), Immediately Reportable events are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy.	Develop training documents and complete training outlining the requirements of reporting critical, sentinel, immediately reportable, and news media events.	QIC/ITC	Not Completed, Carry to FY26
		Validate / reconcile reported data through the CRM.	QIC/ITC	Completed, Continue in FY26
		Establish electronic process for submission of sentinel events/ immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated service. (CRM)	QIC/ITC	Not Completed, Carry to FY26
		Develop dashboard in REMI to monitor timeliness of submissions and remediation response in the CIRS-CRM.	QIC/ITC	Not Completed, Carry to FY26
		Track CIRS changes and barriers through the CIRS Process Improvement Report	QIC/ITC	Not Completed, Carry to FY26
	MSHN will analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	Complete performance summaries with critical incident track and trend data.	QIC	Completed, Continue in FY26
		Identify barriers, develop improvement strategies for events that fall outside of the control limits	QIC	Completed, Continue in FY26

2025 WORKPLAN PROGRESS

Area	Goal	Objectives/Activities	Lead	Activity Status
Behavior Treatment	The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where: •intrusive or restrictive techniques have been approved for use with members and •where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members. Data shall include numbers of interventions and length of time the interventions were used per individual.	CMHSP to submit data through the affiliate upload process in REMI.	CMHSPs	**Completed, Continue in FY26**
		MSHN complete performance summary with track and trend data.	BTPRC Workgroup	**Completed, Continue in FY26**
		Identify barriers, develop improvement strategies for events that fall outside of the control limits	BTPRC Workgroup/QIC	**Completed, Continue in FY26**
Medicaid Event Verification	MSHN will address and verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	**Completed, Continue in FY26**
		Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement, and actions taken	MEV Auditor	**Completed, Continue in FY26**
Utilization Management Plan	MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements: •Procedures to evaluate medical necessity, criteria used, information sources, and process to review and approve provision of medical services. •Mechanisms to identify and correct under and over utilization. Procedures include Prospective, concurrent and retrospective procedures are established and include: 1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions. 2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate. 3. The reasons for decisions are clearly documented and available to the member. 4. There are well-publicized and readily available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal. 5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation. 6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction, or other appropriate measures. 7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.	Develop report to monitor service authorization relative to MichiCANS decision support model recommended services. Include services that are not currently considered part of MiCAS array but are necessary such as outpatient, psychiatric, ABA, etc.	UMC	**Not Completed, Carry to FY26**
		Develop regional guidance for documenting clinical decision-making rationale when authorized services fall outside of MichiCANS decision support model recommendations. Consider implication for communicating these decisions to families and external partners such as local MDHHS child welfare staff.	UMC	**Not Completed, Carry to FY26**
		Review tools for determining medical necessity for community living supports; recommend regional best practice.	UMC	**Not Completed, Carry to FY26**
		Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals.	UMC	**Completed, Continue in FY26**
		Develop and monitor reports and identify any areas where improvement is needed.	UMC	**Completed, Continue in FY26**
		Integrate standard assessment tools into REMI- MichiCANS implementation.	UMC	**Not Completed, Carry to FY26**
	Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines	Review existing practices for authorization of respite services and eligibility/service requirements. Recommend regional best practice.	UMC	**Not Completed, Carry to FY26**
	Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	UMC	**Completed, Continue in FY26**
		Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	UMC	**Completed, Continue in FY26**

2025 WORKPLAN PROGRESS

Area	Goal	Objectives/Activities	Lead	Activity Status
Oversight of "Vulnerable People"/Long Term Supports and Services	The PIHP shall continually evaluate its oversight of "vulnerable" individuals to determine opportunities for improving oversight of their care and outcomes. The MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable individuals.	Monitor Performance Measures for adverse trends	CLC	Completed, Continue in FY26
	MSHN QAPIP program will include mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including •An assessment of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. •Mechanisms to comprehensively assess each Medicaid beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. •The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the Contractor as appropriate. •The results of efforts to support community integration for members using LTSS should be included in the evaluation.	Establish a process and identify report to monitor aggregate data for assessment of care between care settings.	CLC	Completed, Continue in FY26
		Review efforts for community integration during site review.	CLC	Completed, Continue in FY26
		Providers without full compliance will develop a corrective action plan to address community integration.	CLC	Completed, Continue in FY26
Practice Guidelines	The PIHP must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. The PIHP disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request	Recommend improvement strategies where adverse utilization trends are detected.	CLC/UMC	Completed, Continue in FY26
	MSHN will adhere to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	Monitor utilization summary of the average.	UMC	Completed, Continue in FY26
		Recommend improvement strategies where adverse utilization trends are detected.	UMC	Completed, Continue in FY26
	MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans.	CMHSPs, MSHN, and workgroup members will collaborate to ensure that approved CAPS have been fully implemented within 90 days of approval.	MSHN BTPRC Work Group	Completed, Continue in FY26
		Explore and develop ways to expand the knowledge of direct care workers about the standards related to implementation of restrictive and/or intrusive techniques	MSHN BTPRC Work Group	Completed, Continue in FY26
		Improve understanding about the requirements of a Behavior Treatment Plan and Behavior Support Plan (Positive Support Plan) and work to ensure that plan writers have the resources available to successfully complete this task.	MSHN BTPRC Work Group	Completed, Continue in FY26
		Adjust, advocate, and educate on the updates to the Technical Requirements (9.13.24) and the established provider qualifications for codes used for Behavior Treatment Planning	MSHN BTPRC Work Group	Completed, Continue in FY26

2025 WORKPLAN PROGRESS

Area	Goal	Objectives/Activities	Lead	Activity Status
Provider Monitoring	MSHN annually monitors its provider network(s), including any affiliates or sub- contractors to which it has delegated managed care functions, including service and support provision. MSHN shall review and follow-up on any provider network monitoring of its subcontractors. MSHN shall review and approve corrective action plans that result from identified areas of non-compliance and follow up on the implementation of the plans at the appropriate interval.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	Compliance Administrator	**Completed, Continue in FY26**
		Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Compliance Administrator	**Completed, Continue in FY26**
	MSHN must address the findings of the External Quality Review (EQR)-Performance Measure Validation Review through its QAPIP.	Develop and implement performance improvement goals, objectives and activities in response to the external review findings	QIC	**Completed, Continue in FY26**
		Review a sample prior to submission of those CMHSPs that had findings during the HSAG review. - Medicaid eligibility, - Associated population designations are accurately reported - Accurate disposition, exceptions are coded correctly for Indicator 4	QIC	**Completed, Discontinue**
		Ensure completion of the CMHSP/SUD Provider corrective action plans related to internal review of primary source verification.	QIC	**Completed, Continue in FY26**
	MSHN must address the findings of the External Quality Review (EQR)-Compliance Review.	Develop and implement performance improvement goals, objectives and activities in response to the external review findings	Functional area leads	**Completed, Continue in FY26**
	MSHN must address the findings of the External Quality Review (EQR)-Encounter Review through its QAPIP.	Develop and implement performance improvement goals, objectives and activities in response to the external review findings	Functional area leads	**Completed, Continue in FY26**
	MSHN will demonstrate an increase in compliance with the MDHHS Federal Compliance Review	Provide technical assistance to CMHSPs related to standards.	Waiver Staff	**Completed, Continue in FY26**
		Develop and implement performance improvement goals, objectives and activities in response to the review findings	Waiver Staff	**Completed, Continue in FY26**
		Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	Waiver Staff	**Completed, Continue in FY26**
Provider Qualifications	The QAPIP contains written procedures: •To determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services •To ensure that non- licensed providers of care or support are qualified to perform their jobs •For the credentialing process which are in compliance with the MDHHS Credentialing and Re-Credentialing Processes, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying, and/or reappointment of practitioners •These procedures must describe how findings of the QAPIP are incorporated into this re- credentialing process Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: • Educational background • Relevant work experience • Cultural competence • Certification, registration, and licensure as required by law A program shall: •Train new personnel regarding their responsibilities, program policy, and operating procedures •Identify staff training needs and provide in-service training, continuing education, and staff development activities	Will implement Universal Credentialing	Compliance Administrator	**Completed, Discontinue**
		Will evaluate the MDHHS credentialing report for CMHSP timeliness in decision making and credentialing activities.	Compliance Administrator	**Completed, Discontinue**
		Will complete additional monitoring for those CMHSP who demonstrate a compliance rate of =<90% based on the credentialing report.	Compliance Administrator	**Completed, Discontinue**
		Will complete primary source verification and review of the credentialing/recredentialing policy and procedure during the DMC review.	Compliance Administrator	**Completed, Continue in FY26**
		Will complete primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	Waiver Staff	**Completed, Discontinue**

GLOSSARY OF TERMS AND ACRONYMS

DEFINITIONS

Adverse Event: An incident that deviates from expected outcomes and may present a risk to the health, safety, or welfare of an individual, including hospitalizations, injuries, or medication errors.

Balanced Scorecard (BSC): A performance management tool that tracks organizational progress toward strategic objectives across multiple domains.

Behavior Treatment Plan (BTP): A written plan of interventions to address challenging behaviors, developed and approved in accordance with MDHHS Behavior Treatment Technical Requirements and based on least-restrictive, positive behavioral supports.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code (Public Act 258 of 1974, as amended) that is responsible for delivering and managing publicly funded behavioral health services within a defined geographic service area.

Corrective Action Plan (CAP): A documented plan identifying corrective steps, responsible parties, and timeframes to address non-compliance or performance deficiencies identified through monitoring or review processes.

CMHSP Participant: Refers to one of the twelve Community Mental Health Services Programs (CMHSPs) participating in the Mid-State Health Network (MSHN) region.

Contractual Provider: An individual or organization under contract with the MSHN Prepaid Inpatient Health Plan (PIHP) to provide administrative or service-related functions, including CMHSP Participants holding retained function contracts.

Critical Incident Reporting System (CIRS): The system used to report, track, and analyze sentinel events, critical incidents, and other reportable events such as suicide, non-suicide death, arrest, emergency medical treatment, injury or medication error, and hospitalizations related to physical management.

Customer: For MSHN purposes, a customer includes all Medicaid-eligible individuals (and their families) within the MSHN service area who are receiving or may receive covered services and supports. Terms such as clients, recipients, consumers, enrollees, beneficiaries, or persons served are synonymous with this definition.

Evidence-Based Practice (EBP): A clinical intervention or service approach supported by research demonstrating its effectiveness in improving outcomes for individuals receiving behavioral health treatment.

Health Services Advisory Group (HSAG): The external quality review organization (EQRO) contracted by MDHHS to conduct independent compliance, performance measurement validation, and encounter data validation reviews for Michigan PIHPs.

Home and Community-Based Services (HCBS): Services that enable individuals to live and receive care in their own homes or community-based settings rather than institutional facilities, consistent with federal HCBS Rule requirements.

Long Term Services and Supports (LTSS): Services and supports provided to older adults and individuals with disabilities who require ongoing assistance due to physical, cognitive, developmental, or chronic health conditions. LTSS are designed to promote independence and community integration and may be delivered in home- and community-based settings or facilities such as nursing homes (42 CFR §438.208(c)(1)(2)).

Performance Improvement Project (PIP): A structured, data-driven initiative required by MDHHS and governed by federal regulation (42 CFR §438.330) to achieve sustained improvement in specific clinical or non-clinical areas.

Plan-Do-Study-Act (PDSA) Cycle: A continuous quality improvement framework used to test, implement, and evaluate changes in processes or interventions.

Prepaid Inpatient Health Plan (PIHP): An organization authorized by the State of Michigan to manage Medicaid specialty behavioral health services under the approved Concurrent 1915(b)/(c) Waiver Program on a prepaid, shared-risk basis. PIHPs are responsible for managing inpatient and outpatient behavioral health, substance use disorder, and developmental disability services, consistent with federal regulations (42 CFR Part 438).

Provider Network: Refers collectively to MSHN's CMHSP Participants, Substance Use Disorder (SUD) Providers, and other behavioral health organizations under contract with the PIHP to deliver services and supports through direct operations or subcontracted arrangements.

Quality Assessment and Performance Improvement Program (QAPIP): MSHN's system-wide program designed to monitor, evaluate, and improve the quality, safety, accessibility, and effectiveness of behavioral health and SUD services across the region.

DEFINITIONS/ACRONYMS

DEFINITIONS

Research: As defined by 45 CFR §46.102, research is a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Root Cause Analysis (RCA): A structured process used to identify the underlying causes of variation in performance or the occurrence of adverse events. The RCA focuses on system-level factors rather than individual fault to support prevention and quality improvement (Joint Commission, 1998).

Sentinel Event (SE): An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, not related to the natural course of a health condition. Sentinel events include any injury or death resulting from the use of a behavioral intervention (Joint Commission, 1998).

Stakeholder: Any person, group, or organization with an interest in MSHN operations or outcomes, including consumers, family members, guardians, providers, staff, advocates, and community partners.

Subcontractors: An individual or organization under contract with a CMHSP or other entity to deliver services, supports, or administrative functions within the behavioral health network.

SUD Providers: A contracted provider delivering Substance Use Disorder (SUD) treatment, prevention, and recovery support services under agreement with MSHN.

Utilization Management (UM): A set of coordinated activities ensuring services are medically necessary, provided at the appropriate level of care, and delivered efficiently to optimize consumer outcomes and resource use.

Vulnerable Person: An individual with functional, mental, or physical limitations that reduce their ability to care for themselves or protect their own welfare.

ACRONYMS

ABA: Applied Behavioral Analysis
ABD: Adverse Benefit Determination
ACT: Assertive Community Treatment
BTPRC: Behavior Treatment Plan Review Committee
BHH: Behavioral Health Home
BSC: Balanced Scorecard
BTP: Behavior Treatment Plan
BTPRC: Behavior Treatment Plan Committee
CAP: Corrective Action Plan
CAHPS: Consumer Assessment of Healthcare Providers and Systems
CBHO: Chief Behavioral Health Officer
CCBHC: Certified Community Behavioral Health Clinic
CFR: Code of Federal Regulations
CLS: Community Living Supports
CMHSP: Community Mental Health Services Program
CMS: Center for Medicare/Medicaid Services
CQS: Comprehensive Quality Strategy
CWP: Child Waiver Program
CY: Calendar Year
EBP: Evidence-Based Practice
EDV: Encounter Data Validation
EQR: External Quality Review
FY: Fiscal Year
HCBS: Home and Community Based Services
HEDIS: Healthcare Effectiveness Data and Information Set
HSAG: Health Services Advisory Group
HSW: Habilitation Supports Waiver
LTSS: Long- Term Services and Supports
MDHHS: Michigan Department of Health and Human Services
MEV: Medicaid Event Verification
MHSIP: Mental Health Statistics Improvement Program
MMBPIS: Michigan Mission Based Performance Indicator System
MSHN: Mid-State Health Network
NCQA: National Committee for Quality Assurance
NCI: National Core Indicators
PBIP: Performance Based Incentive Program
PDSA: Plan-Do-Study-Act
PIHP: Prepaid Inpatient Health Plan
QAPIP: Quality Assessment and Performance Improvement Program
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver
SUD: Substance Use Disorder
SUDHH: Substance Use Disorder Health Home
UM: Utilization Management
YSS: Youth Satisfaction Survey

ASSOCIATED DOCUMENTS

DOCUMENT LINKS

Document	Description
MSHN QAPIP Communication Process Flow	This process flow outlines the communication process of the QAPIP program within Mid-State Health Network.
MMBPIS FY2025Q3 Performance Summary	MSHN monitors provider network performance in the areas of access, efficiency, and outcomes through standardized performance indicators established by MDHHS through the Michigan Mission Based Performance Indicator System (MMBPIS). This report outlines the FY25Q3 summary performance for MSHN.
FY25 Performance Based Incentive Program (PBIP) Narrative	As required by MDHHS, the Performance Based Incentive Program narrative report includes performance of the MSHN region relating to employment and housing and associated supporting data.
Population Health and Integrated Care Plan 2024-2025	The purpose of the MSHN Population Health and Integrated Care plan is to establish regional guidance relating to integrated care needs and best practices as well as describe specific population health and integrated care initiatives currently underway in the MSHN region.
MSHN Experience of Care Survey Analysis FY25	The annual FY25 satisfaction survey results and associated analysis can be found within this report. Satisfaction surveys obtain feedback related to the perception of care for a representative sample of individuals served within the MSHN region to highlight the areas that providers are excelling and to identify improvement opportunities for future growth.
MSHN Critical Incident Performance Report Summary FY25Q3	Mid-State Health Network prioritizes the safety of individuals within its Provider Network. The critical incident report monitors and reviews adverse events to identify root causes, monitors and reviews adverse events to identify root causes, and reviews interventions to enhance individual safety.
MSHN Behavior Treatment Review Summary FY25	MDHHS mandates the analysis of behavior treatment data and MSHN delegates data collection and evaluation to local CMHSP Behavior Treatment Review Committees (BTRCs). On a quarterly basis, data is reviewed to assess the effectiveness of the BTPRCs and review data on approved intrusive/restrictive techniques, physical management, and emergency 911 calls.

THANK YOU

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