MSHN
Mid-State Health Network

Quality Improvement (QI) Council Meeting Snapshot

Meeting Date: April 23rd, 2026, 9:00am-11am

Attendance:

☒ MSHN – Kara Laferty	☒ Central – Jenelle Lynch	☒ MCN – Sally Culey	☒ SHW – Amy Phillips
☐ BABH –Sarah Holsinger	☒ Central – Alysha Fisher	☒ MCN – Melissa MacLaren	☐ SHW – Vicky Hoffman
☐ CEI – Elise Magen	☒ GIHN – Taylor Hirschman	☒ MCN – Joe Cappon	☒ TBHS – Josie Grannell
☒ CEI – Shaina McKinnon	☒ Huron – Levi Zagorski	☒ MCN – Adam Stevens	☒ The Right Door – Susan Richards
☒ CEI – Mica Gardyko	☒ Lifeways – Emily Walz	☒ SCCMH – Holli McGeshick	☒ The Right Door – Jill Carter
☐ CEI – Bradley Allen	☒ Newaygo – Andrea Fletcher	☒ SCCMH – Jenna Brown	☒ Other: BABH- Lisa Nagel, Amy Dillon
☒ CEI – Kaylie Feenstra	☒ Newaygo – Jill Mckay		

AGENDA ITEM TOPIC	KEY DECISIONS/QUESTIONS	ACTION REQUIRED (WHO, WHEN)

Review/Approvals (All)	• Review/Approve Meeting Minutes from March 26th, 2026
	    ○ Minutes approved
	• Any changes/additions to this month's Agenda?
	    ○ No additional edits/changes requested	

Consent Agenda (All)	• No items for consent on this agenda	

MDHHS Waiver Audit (Amy/All)	• **Discussion:** Does anyone have any questions for Amy relating to the current MDHHS Waiver audit documentation/evidence that are currently being requested/provided or any deadlines?
	    ○ **Question from BABH:** Where are the CMHSPs supposed to submit progress notes for reviewers? BABH has notes collected from their providers that aren't located in PCE that need to be uploaded.
	        ▪ MDHHS plans to review files in the EMR- all documents need to be scanned into uploaded documents and let MDHHS know that's where they can be found.
	    ○ **Question from Montcalm:** Who is required to be trained on the PCP documents (what specific staff or qualifications or lack thereof) determines who needs to be trained?
	        ▪ The SFY 2026 Behavioral Health Code Charts and Provider Qualifications (updated 3/30/26), Qualifications Crosswalk tab, requires DSP/Aide level staff to be trained on the IPOS. The training will need to be provided by the case manager, or someone trained by the case manager. MDHHS will review this in aide-level files. Please note that Amy D. sent an email to QIC with the exact language on 4/23/26.	

	○ **Question from Shiawassee:** Will the CRM only be used for adding staff and qualifications? ▪ Yes, MSHN also believes that review comment sheets will go through the CRM also. All admin files are also being uploaded to the CRM (MSHN staff are completing this task). • **Action Needed: Please reference Amy's emails for deadlines relating to the Waiver audit and all required elements.**	
CMH Delegated Managed Care (DMC) Review Schedule FY27 and FY28 (Amy/All)	• **Document:** MSHN FY27-FY28 CMH DMC Reviews • **Discussion:** Amy provided an overview of the updated DMC process and reasons for combining previous 3 year schedule down to 2. MSHN suspended DMC reviews for FY26 for the Community Mental Health Services Providers (CMHSPs) and Substance Use Disorder (SUD) Providers due to the uncertainty related to the issuance of the MDHHS Request for Proposal (RFP). As a result, MSHN elected to suspend the DMC reviews until further information was available. Now that the RFP has been withdrawn, a DMC review schedule for FY27 and FY28 is being proposed. Do any of the CMHSPs have questions relating to this document or the proposed process for Amy? ○ Holli pointed out BH-TEDs is going away in FY27, this will be replaced with MH-CLD. Updates to the schedule will be made with this information after consultation from ITC. • **Action Needed:** No action needed at this time.	
HSAG Audit Timelines PMV 2026 (Kara/All)	• **Discussion:** We recently met with HSAG (on 4/13) for the kickoff for the 2026 HSAG audit. Please note that we will need to, once again, complete a PMV review this year along with the ISCAT. The PMV review is ONLY be for indicator 2 (detail files selected will be for FY26Q1). Year 1 HEDIS metrics will also be reviewed, but it is unclear what the outcome of that review may be. Please note that we will be requesting your source code/logic for this activity (due May 8th) and we will be required to do our typical Proof-of-Service (POS) document review where you provide all of the proofs for a sampling to ensure our logic for indicator 2 (this will occur between 6/2-6/9/26) with short time frames again. Final due dates will be provided once we receive that sample from HSAG. MSHN will have a virtual review then between 6/15/26-7/31/26, date unknown at this time. • **Action Needed: Please submit your source code/logic as requested by May 8th to MSHN. Please keep an eye on emails for further PMV review deadlines and information.**	
Performance Improvement Topic (Kara/All)	• **Discussion:** Sandy G. confirmed that MDHHS is looking to begin new PIPs for the upcoming cycle (CY2026-CY2029) and is looking for identification of these by the end of May for the PIHPs. As a reminder, we must identify two PIPs, one clinical, and an additional that can be clinical or non-clinical; in addition, this has to be a regional approach with regional interventions that everyone is able to implement and track/monitor. ○ **The below were ideas collected via email so far- thank you everyone who sent these in!** ▪ Improvements in FUM-30AD metric (currently at 60.39%, benchmark is 60.80% (HEDIS/priority measure and already collecting this with racial breakdowns and gender breakdowns) ▪ Improving Access to Care/Timeliness of Services for Youth within Intensive Crisis Stabilization Services (data collected quarterly/annually. Currently, MSHN is at 93% regionally, and even small increases would ensure statistical significance. Areas for growth in this and already collecting data) ▪ Medicaid Redetermination support and continuity of coverage (aimed at supporting consumers who remain eligible in successfully navigating the redetermination process, with the goal of maintaining continuity of care) • Gratiot supported this PIP as with federal funding cuts to Medicaid, there needs to be an increased focus on the individuals who are falling off because of redeterminations	

	- Montcalm mentioned there's an issue in the accuracy of data coming in within the EMR-local DHS workers that are collaborating with CMHSPs seem to be having the biggest impact as data files with PCE have different issues (everything ties back to CHAMPS and potential inconsistencies in that system). This could be an issue that would be a barrier for the PIP project if this was a topic. The 834/820 master eligibility file is often times different than the 270/271 file specifically with spenddowns. ▪ Improving Medication Review and Psychiatric Evaluation show rates ▪ Increase in penetration rates for LGBTQIA+ population/targeted interventions with LGBTQIA+ population ▪ Target satisfaction areas that are low for all CMHs and begin collection of satisfaction after each contact via text, improvement efforts would include improving satisfaction over time (reminder that satisfaction surveying will be changing in FY27) ▪ Provider Availability ▪ Increasing Consumer goal attainment (method of tracking success of service delivery) ▪ Autism services- maybe looking at projects around high cost services, length of treatment, progress towards goals, maximizing ABA for early ages (UM analysis)- hard to come up with PIP with this, but it is a huge line item ▪ ACC metric - **Action Needed: Please continue to submit Performance Improvement Project ideas to Kara until 4/30. Kara will send out a poll at the beginning of May to determine the top topics of interest to the CMHSPs and we will discuss pros/cons of each in the May QIC meeting for final decision.**	
Satisfaction Surveying- progress and FY26 surveying (Kara/All)	- **Documents:** All FY26 CMHSP Satisfaction survey information and documents - **Discussion:** Surveying timeframe for FY26 will be between June 1st- August 28th (please select a four week period during this window). Surveying can be done electronically, via mail, phone, or in-person (face-to-face). As a reminder, you must be tracking the number of surveys passed out for calculation of distribution rates and response rates. o After discussion with Kim Z., we have decided to continue the data collection the same way as last year in capturing populations, this is not required, but if you are collecting this, please provide a breakdown in populations in the data submitted. This is because I/DD local level data is not being collected within the NCI and provided to us. Saying that, if you are collecting breakouts in population, please continue to submit it that way. If you are unable to collect breakouts in populations due to your process, this is okay. Please note that CCBHC survey elements have all been removed from the documents for FY26 due to change in the oversight of that program. o Please note that for those of you helping SUD providers in completion of consumer satisfaction surveys that all related materials for the FY26 survey can be found on the MSHN website under Reporting Requirements. - **Action Needed: CMHSPs to begin discussions internally relating to surveying timeframe within designated window along with methodology for FY26 survey distribution and materials.**	
MMBPIS FY26Q1 Report (Kara/All)	- **Discussion:** Please review the MMBPIS FY26Q1 report in BOX prior to our meeting. o **Questions:** o For those that are under the benchmarks for indicator 2 (BABH, CEI, Saginaw, and Shiawassee), in reviewing those indicators for Q1, were there any specific areas of improvement that you're going to be working on?	

	▪ BABH- no active improvement efforts are being undertaken as 88% of their out-of-compliance is due to consumer choice (no shows, choosing an appointment outside of 14 days, and reschedules) ▪ No additional improvement efforts were noted at this time from CMHSPs under benchmarks outside of what is already occurring (text follow-ups, appointment reminders and outreach) o Gratiot asked what others are doing relating to manually needing to update MMBPIS submissions relating to individuals who are coming back through to services after having been closed. A reminder was provided relating to the definition of what a "new person" is for MMBPIS reporting. Guidance was provided to seek out source code from others who have this exclusion set up within their PCE system: 4. "New" persons are defined as follows: a. A new person cannot be active in the PIHPs mental health system. "New" is defined as either never seen by the PIHP for mental health services or for services for intellectual and developmental disabilities, or it has been 90 days or more since the individual has received any MH or I/DD service from the PIHP. ➢ **If the person has received SUD services in the last 90 days but no MH or I/DD services, the person is "new" or reportable for Indicator 2.** b. Consumers who come in with a crisis and are stabilized are counted as "new" for indicator #2 when they subsequently make a non-emergency request for MH or I/DD services. The indicator will be tracked from the point of the non-emergent request forward. (See Figure 2a.2). o There was additional discussion with the CMHSPs relating to differences in process for indicator 2, specifically around Lifeways who does not have individuals completing new assessments if they are coming back into services past the 90 day window of what MDHHS defines as a new person. o This is a reminder to all CMHSPs that for MMBPIS reporting (Medicaid consumers only), requirements for MMBPIS state that indicator 2 is measuring "The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service". A request for service is the initial point of contact where a consumer states that they would like services from the CMHSP - an assessment must then be completed within 14 calendar days of that request for service (if a consumer is closed and then reopened within 90 days, they are not considered a "new" consumer and are excluded from MMBPIS calculations. However, if this individual comes in outside of those 90 days, they are a new consumer and MMBPIS criteria and requirements are applicable. • Action Needed: All CMHSPs to review current FY26 MMBPIS PI logic to ensure that your source code and process are compliant with all requirements outlined within the MMBPIS PI logic prior to HSAG review.	
Critical Incident FY26Q1 Report (Kara/All)	• Discussion: Please review the MSHN Critical Incident Process Improvement FY26Q1 report in BOX prior to our meeting. One large area coming that many of you probably heard are significant updates to the CI events and process. This is still not clear how MDHHS will be doing this and there will be more to come on this.	

	○ **Critical Incident Remediations:** there is a lot of back and forth that has to occur for remediations; would CMHSPs like to revisit the ability for you to direct enter into the CRM for remediations? Especially now that EMT and Hospitalizations due to falls are beginning to be collected and needing remediations? Does everyone have access to the CRM that you would be able to do this? ▪ There was no opposition from CMHSPs to direct entering remediations into the CRM – primary concern of the CMHSPs is notification that remediations are due as they don't want to miss these. MSHN is able to maintain ongoing review of the CRM system to send our reminders if there are remediations needing to be completed and due dates, but the direct entering would occur within the CRM itself by the CMHSPs (similar to how Gratiot, CEI, and Lifeways is currently doing that). • **Action Needed: CMHSPs to review if they have an individual within their teams that has access to the remediations section of the CRM for incident reporting. If there is no one that currently has access, please work with your CRM IT lead to be provided this access in the CRM. Carry this topic forward in May QIC meeting for confirmation and a brief training can then be provided on entering remediations.**	
Performance Improvement Projects (PIPs) Report	• Document: Final PIP Disparity Summary • Discussion: CY25 data shows that we have **met statistical significance for both penetration rates (PIP#2) as well as removing the disparity for indicator 3 (PIP #1)!!!** Please review this document in advance to celebrate the amazing accomplishments you've all done. MDHHS is currently reviewing our PIP #2 for all areas of compliance, and then HSAG has moved up our review dates for our PIP #1 write-up/final report to May 15th and I'm currently working on this. • Action Needed: None to note at this time. Please note that Kara may be reaching out if any additional information relating to interventions is needed for the HSAG write-up.	
Upcoming Reporting Requirements	• FY26Q2 BTC Data- due on 4/30/2026 • MDHHS Waiver Audit- 5/18/26-7/31/26- MSHN has developed a process and guidance on documentation submission, timelines, and related matters (Amy D. sending out weekly updates/FAQ's)	
Standing Agenda Item: Committee Updates (Kara/All)	• **MDHHS QIC Updates:** Group met on 4/1/26. Updates were provided from Federal Compliance on CIR changes (please see below from leads meeting), as well as EVV updates and HSW and iSPA amendment changes. Updated Behavioral Transformation benchmarks were provided to the group for HEDIS metrics.	

Measure	Proposed Benchmark (%)
ADD-INT	52.60
ADD-CONT	61.20
FUH-30CH	79.00
FUH-30AD	58.00
FUH-30	70.87
APM-TOTG	27.60
APP-TOT	65.59
FUA-30	35.13
FUM-30CH	78.24
FUM-30AD	54.87
FUM-30	60.76
IET34-TOT	14.00

YR1 benchmarks will be used in 2026 to assess PIHPs' 2025 rates, but the comparison between the benchmarks and the PIHPs' actual rates will only be informational.

Measure	Proposed Benchmark (%)
SSD-AD	79.21
OUD-AD	70.41
SAA-AD	65.9

For YR2 benchmarks rolled out in 2026, their evaluation in 2027 will no longer be information-only, and individual PIHPs will be assessed in comparison to the benchmark rates.

YR3 benchmarks will be rolled out in 2027, used in 2028 to evaluate PIHPs' 2027 rates, and will serve as a true assessment rather than an information-only comparison.

- PIHP Quality Workgroup Updates (Kara): April workgroup was cancelled- next meeting in May
- CIR PIHP Leads Meeting: Meeting was held on 4/14/26. Significant changes coming to CI reporting due to Final Access to Care Rules; these changes must be implemented by July 9th, 2026 (please see below highlights). MDHHS shared they will be asking for any changes to begin at start of FY28. MDHHS having internal discussions as to what needs to be built within the system and how this is all going to be done in a conflict-free way. They are looking at current processes between ORR and CI's to see what might be duplicated and how to streamline efforts, but MDHHS stated that the ORR offices are not operating consistently across the state so they're trying to standardize elements as it relates to this effort. More to come on this.

HCBS Access Rule

Changes to Critical Incident Reporting (CIR)

Requires states to define critical incidents to include, at a minimum:

- Verbal, physical, sexual, psychological, or emotional abuse;
- Neglect;
- Exploitation including financial exploitation;
- Misuse or unauthorized use of restrictive interventions or seclusion;
- A medication error resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or
- An unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

NorrisChapman, Shelley (DHHS)

	HCBS Access Rule Changes to Critical Incident Reporting (CIR) NorrisChapman, Shelley (DHHS) • Requires states to operate and maintain an electronic incident management system to identify report, triage, investigate, resolve, track, and trend critical incidents. • Requires states to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes. • Requires states to report on an incident management system assessment every 24 months (may be reduced to every 60 months for states that meet incident management system requirements. **HCBS Access Rule** Changes to Critical Incident Reporting (CIR) NorrisChapman, Shelley (DHHS) Establishes standardized annual reporting requirements and sets a 90% minimum performance level for states related to whether the following occur within state-specified timeframes: • Critical incident investigations are initiated; • Critical incidents are investigated and resolved; and • Corrective actions related to critical incidents are completed.		

HCBS Access Rule

Changes to Critical Incident Reporting (CIR)

MDHHS has begun work on this.

- Internal meetings to discuss these requirements and the implications of these changes.
- Met with the CRM team and will begin making those changes in May.
- Requires amendments of all 1915 (c) Waivers and iSPA.
- Requires updates with policy and contract changes.
- Requires system training and time needed for API changes.

- **Quality Transformation Workgroup:** Meeting took place on 3/25/26. Updates from last meeting included MDHHS follow up with Optum relating to HEDIS measures- please note that Medicaid County is determined through the County of Residence as of the event date. Place of Service Codes for IET were asked to previously be updated, however no determination has yet been made from MDHHS leadership on this. FY26 PBIP was discussed and updates were recently posted to MDHHS's website, please note that weighting for the PBIP was changed. IET benchmark for engagement increased to 15%; lots of conversation around allowable codes for IET and how current set does not include detox residential and health homes- MDHHS will be looking in to this. There are a group of proposed changes for the Joint Care Planning measure that were reviewed note that and feedback was due from PIHPs on March 12th. CCBHC individuals will continue to be included within PBIP measures. There was an updated FY26 MMBPIS handbook provided on 2/26/26. Several removals and changes to the BH Transformation measures that should be of note. MSHN's 3 year MDHHS behavioral rollout plan was updated to account for these changes and can be found here.

  The 3/25/26 meeting included discussion around benchmarks for Year 2, these will be published on the MDHHS reporting requirements website under the Behavioral Transformation section. Sha discussed IET data validation in FY26 along with discussion around new methodology for calculating CY2024 shared metrics. The new methodology loses points for the majority of PIHPs. More information to be shared in the April meeting.
- **BH-TEDs Updates:** Holli- any updates in this area?
- **National Core Indicator Advisory Council:** Email from Dana Moore on 4/15 cancelling the April 23rd NCI advisory council meeting, next meeting is in July. Some updates of note: NCI Data Spotlight- MI-DDI has created Michigan 2023-2024 NCI Survey "data spotlights" to highlight the 2023-2024 Michigan NCI State Report results on guardianship, self-determination, service coordination, and health. There will be additional data spotlights on other topics. The data spotlights are posted on MI-DDI's social media (Facebook, X/Twitter, Instagram). Status update on 2025-2026 Michigan NCI Surveys: As of 4/10/2026, the current survey numbers are: 325 completed surveys, 52 scheduled, and 120 (pre-survey, background, and

	survey) have been completed in ODESA, the national NCI survey data system. The 2024-2025 Michigan NCI State Report should be released soon. We look forward to sharing the results at an upcoming meeting.	
Standing Agenda Item: Open Discussion/Consultation (All)	• Holli- Saginaw: Staff has brought up frustrations from persons served when they are transferring from other counties to our services because they indicate they are not aware that there will be a lapse in their services, specifically CLS services and that the process essentially starts over with Intake. My question/conversation with the group would be what are their transfer procedures like? Do they speak with the person that is transferring about the lapse in service, is it the responsibility of the incoming CMH, what can we do better to improve this process, etc.	
Relevant Informational Documents that may be of Interest:	• PBIP FY26 Joint Care Specifications • MDHHS Final Year One HEDIS Metrics Report • HSAG Final Reports and Results for Priority Measure Validation (PMV), Encounter Data Validation (EDV), and Compliance from 2025	
Previous Action Item Follow-up	• **FY26 QAPIP Plan and FY25 QAPIP Report-** The FY26 QAPIP Plan and FY25 QAPIP report were approved by the Board of Directors and were approved for MDHHS submission. Please note that these documents can be found on our website here. • **Priority Measure Report FY25Q4:** Kara to put together an informational document/presentation around expectations and HEDIS measures for the CMHSPs to begin looking at (Estimated Completion: May/June 2026)	

Summary Action Items from Meeting	
CMHSP's	• **MDHHS Waiver Audit- CMHSPs-** Please reference Amy's emails for deadlines relating to the Waiver audit and all required elements. • **HSAG Audit Timelines PMV 2026-** Please submit your source code/logic as requested by May 8th to MSHN. Please keep an eye on emails for further PMV review deadlines and information. • **Performance Improvement Topic-** Please continue to submit Performance Improvement Project ideas to Kara until 4/30. • **Satisfaction Surveying-** CMHSPs to begin discussions internally relating to surveying timeframe within designated window along with methodology for FY26 survey distribution and materials. • **MMBPIS FY26Q1 Report-** All CMHSPs to review current FY26 MMBPIS PI logic to ensure that your source code and process are compliant with all requirements outlined within the MMBPIS PI logic prior to HSAG review. • **Critical Incident FY26Q1 Report-** CMHSPs to review if they have an individual within their teams that has access to the remediations section of the CRM for incident reporting. If there is no one that currently has access, please work with your CRM IT lead to be provided this access in the CRM.
MSHN/Kara	• **Performance Improvement Topic-** Kara will send out a poll at the beginning of May to determine the top topics of interest to the CMHSPs and we will discuss pros/cons of each in the May QIC meeting for final decision. • **Critical Incident FY26Q1 Report-** Kara will carry this topic forward in May QIC meeting for confirmation of CMHSP access to the CRM and a brief training can then be provided on entering remediations.