



2026 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPIP) PLAN

Prepared by MSHN Quality Manager: October 17th, 2025

Reviewed by MSHN Leadership: October 29th, 2025

Reviewed and Approved by 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* by MSHN Board – January 6th, 2026

*Due to a lack of a quorum by the Board in January, Board approval will take place on March 3rd, 2026

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Scope

The scope of MSHN's Quality Assessment and Performance Improvement Program encompasses all behavioral health and substance use disorder (SUD) services delivered by CMHSP Participants and contracted SUD providers, including those operating Certified Community Behavioral Health Clinics (CCBHCs), Behavioral Health Homes (BHHs), and Substance Use Disorder Health Homes (SUDHHs).

QAPIP performance monitoring spans all critical organizational functions, clinical and non-clinical service areas, and care delivery systems. These monitoring activities may be retained, contracted, or delegated, and in all cases, MSHN maintains responsibility for ensuring reliability, accountability, and regulatory compliance.



Philosophical Framework

MSHN's quality philosophy is rooted in the Continuous Quality Improvement (CQI) model, originally developed by Deming. CQI principles emphasize that health care is a system of interrelated processes where quality issues arise from process defects and are best addressed through team-based problem-solving grounded in measurement and statistical analysis. Improvement efforts focus on consumer needs and high-priority challenges.

MSHN employs the Plan-Do-Study-Act (PDSA) cycle to drive improvement initiatives. Performance measurement is integral to this process and includes both qualitative and quantitative methods. National and statewide benchmarks are used where feasible, and local benchmarks are established when external comparators are unavailable. MSHN ensures data reliability through consistent sampling and analysis practices while recognizing the limitations of subjective and/or variable data sources.

Performance data informs decision-making across the PIHP and its provider network to improve safety, efficiency, productivity, and promote strategic alignment.

MSHN's performance improvement philosophy reflects the following core beliefs:

- Stakeholder input- including consumers, providers, councils, and MDHHS - is essential for success
- Improvement is continuous, system-wide, and integrated
- A culture that encourages reporting of errors and system gaps is vital for Quality progress
- Improvements must be shared, implemented, and sustained systemically
- Leadership must establish priorities based on data and maintain oversight of the system's risk points

Organizational Structure & Leadership

Governance and Leadership

MSHN's QAPIP is governed by the MSHN Board of Directors, which establishes policy, approves the annual QAPIP Plan and Report, and receives quarterly updates on system performance via the Balanced Scorecard and MSHN departmental reports.^[1] The Board reviews and approves the QAPIP Annual Report, which includes performance outcomes and improvement initiatives for submission to MDHHS by February 28th each year.^[2] Attachment 1 provides an overview of the development/communication pathways of the QAPIP within MSHN.

The Chief Executive Officer (CEO), hired by the Board, serves as the designated senior official responsible for QAPIP implementation (42 CFR 438.330(a)(1)). The CEO allocates resources, removes barriers, ensures system wide collaboration, oversees regional provider performance, and ensures contractual compliance. The CEO also designates the Quality Manager as chair of the Quality Improvement Council (QIC) and liaison to MDHHS's Quality Improvement Council. The Quality Manager, under the direction of the Chief Compliance and Quality Officer, leads development, evaluation, and reporting of the QAPIP.

MSHN's Medical Director advises MSHN staff on utilization trends, performance improvement, sentinel events, outcome metrics, and advises on the regional QAPIP. This position guides clinical policy in coordination with CMHSP Medical Directors. The Medical Director also leads the Regional Medical Directors Committee and is an ad hoc member of the MSHN Quality Improvement Council (QIC), demonstrating an ongoing commitment to MSHN's quality improvement processes and program.



Quality Management Structure

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer and stakeholder involvement and participation within the PIHP. Stakeholder and recipient engagement is embedded throughout QAPIP activities and processes and is utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes. MSHN and regional providers strive to involve stakeholders including consumers, providers, family members, community members, and other service agencies whenever possible (and appropriate). Opportunities for stakeholder participation include, but are not limited to: PIHP governing body membership; MSHN's Quality Improvement Council; MSHN's Customer Services Committee; satisfaction surveys; participation on quality improvement work teams; and focus group participation. Communication of process and outcome improvement occurs through the Operations Council, Consumer Advisory Councils, and the MSHN website.

The QIC is the central coordinating body for quality improvement, composed of representatives from each CMHSP, consumers, and MSHN staff. Regional committees and councils including Finance, Information Technology, Clinical Leadership, Utilization Management, Compliance, Customer Services, Provider Network, SUD Advisory Groups, and the Regional Equity Advisory Committee for Health (REACH) provide guidance and operational support of the QAPIP. All councils operate under formally adopted charters aligned with MSHN's Strategic Plan and QAPIP priorities. Charters for all councils can be found on the [MSHN website](#).

[1] Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section I

[2] Contract Schedule A-1(k)(20)(a) QAPIP for Specialty PIHPs, Section I

Organizational Structure & Leadership

Regional Committees and Councils

Each council/committee develops, annually reviews, and approves individualized charters that identify the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities, Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan and QAPIP. Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN QAPIP and report annually on the progress of committee/council accomplishments and goals.

The Operations Council (OC) provides guidance to the CEO on PIHP operations, bringing local perspectives from across the region to ensure service delivery systems remain responsive, effective, and accountable. The OC approves all council and committee charters, reviews recommendations, and advises the CEO and Board on operational and policy matters related to quality improvement.

The Regional Medical Directors Committee (RMDC), composed of the MSHN Medical Director and CMHSP Medical Directors, advises the Chief Medical Officer, CEO, Chief Behavioral Health Officer, and OC on clinical quality and service utilization standards. The RMDC ensures that clinical leadership informs system decisions, promotes best practices, and supports improved quality outcomes across the region.

A full listing of councils/committees that directly impact the QAPIP process can be found under Attachment 2.

Provider Network Participation

The MSHN regional provider network is contractually required to implement compliance monitoring, conducting performance improvement activities, and training staff in alignment with MSHN's QAPIP as well as their individually developed QAPIPs. MSHN retains responsibility for regional oversight, coordination, and annual reporting. MSHN ensures provider adherence to federal and state requirements (42 CFR 438.608) and facilitates policy updates, training, and communication through structured meetings, written guidance, and its public website.

Providers contribute to QAPIP success through:



Participating in valid and reliable data collection for performance measures and indicators



Reporting clinical errors and proposing quality/safety improvements



Providing feedback through councils, committees, and focus groups



Maintaining communication with MSHN via the QIC and affiliated networks



Engaging in regional monitoring, training, and improvement projects

Performance Management

MSHN defines performance management as a forward-looking, data-driven process to set goals, monitor outcomes, and guide continuous improvement. Through its Dashboard and Balanced Scorecard (BSC), MSHN provides a comprehensive view of organizational performance aligned with MDHHS requirements, the Michigan Behavioral Health Quality Program, and MSHN's strategic priorities.



Establishing Performance Measures

Performance measures are selected by MSHN leadership in collaboration with regional councils and workgroups. Measure selection considers:

Focus Area: Clinical (e.g., high-risk, high-volume services, care coordination) and non-clinical domains (e.g., grievances, appeals, recipient rights, service access)

Impact: Potential to affect a significant portion of service recipients or system-level outcomes

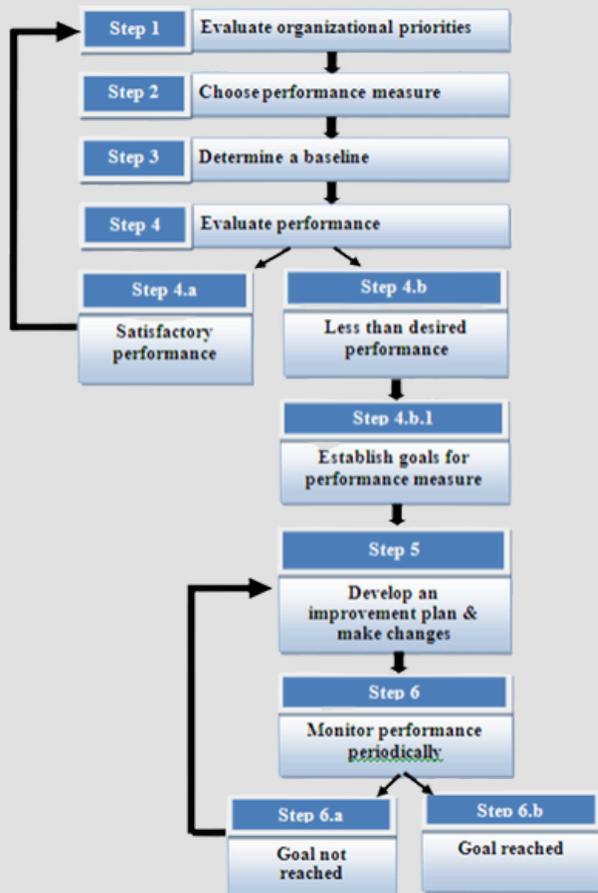
Compliance: Alignment with state/federal regulations, accreditation standards, or evidence-based practices

In addition, input is drawn from internal monitoring, Key Performance Indicators (KPIs), stakeholder feedback, member experience surveys, and external review findings.

Data Collection, Analysis & Reporting



Process Map of Performance Management Pathway as defined by the Health Resources and Services Administration (HRSA)



Data collection supports monitoring, intervention evaluation, and strategic decision-making. Each measure includes:

- Defined baseline(s) and target/benchmark(s)
- Timeframes for collection and remeasurement
- Sampling methods (default 95% confidence, 5% margin of error)
- Population/sample, source, and frequency
- Inter-rater reliability and validity safeguards
- Assigned Measure Steward

Aggregated data is statistically analyzed over time to detect patterns, compare results to targets or benchmarks, and guide system-level improvements. When external benchmarks are unavailable, internal baselines inform target setting. Targets may reflect:

- Minimum/Acceptable Standard
- Challenge Goal (aspirational)
- Incremental Change (improvement over prior performance)

Findings are reviewed by the relevant MSHN council or committee(s) and undesirable variation prompts additional analysis or targeted interventions until improvements are achieved.

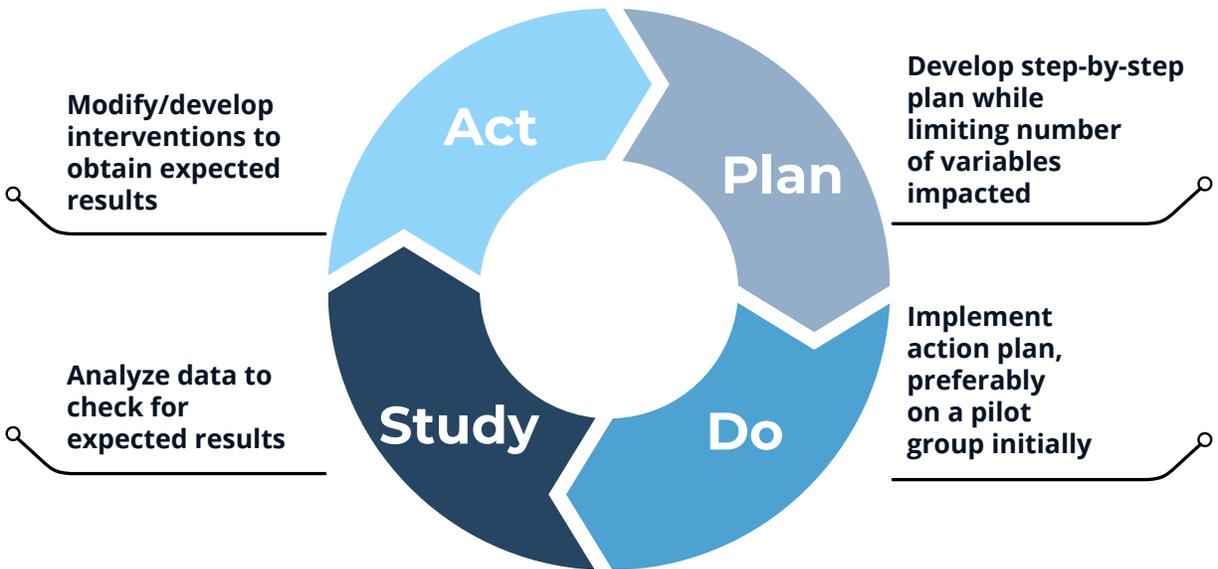
Performance Management

Quality Improvement Process

When performance targets are unmet, regional providers may be required to submit a quality improvement plan, which includes:



In some instances, in lieu of provider level improvement plans, region wide quality improvement efforts may be developed based on the trends identified through data analysis. These efforts will follow the Quality Improvement process established and reviewed for effectiveness at established intervals within the assigned MSHN council, committees, and/or workgroups. Quality improvement plans are reviewed by MSHN leads and content experts. All improvements follow the Plan-Do-Study-Act (PDSA) cycle:



PDSA cycles are repeated as needed. Sustained improvements are monitored for at least one year. Measures may transition to maintenance monitoring unless ongoing oversight is required by MDHHS or federal regulation.



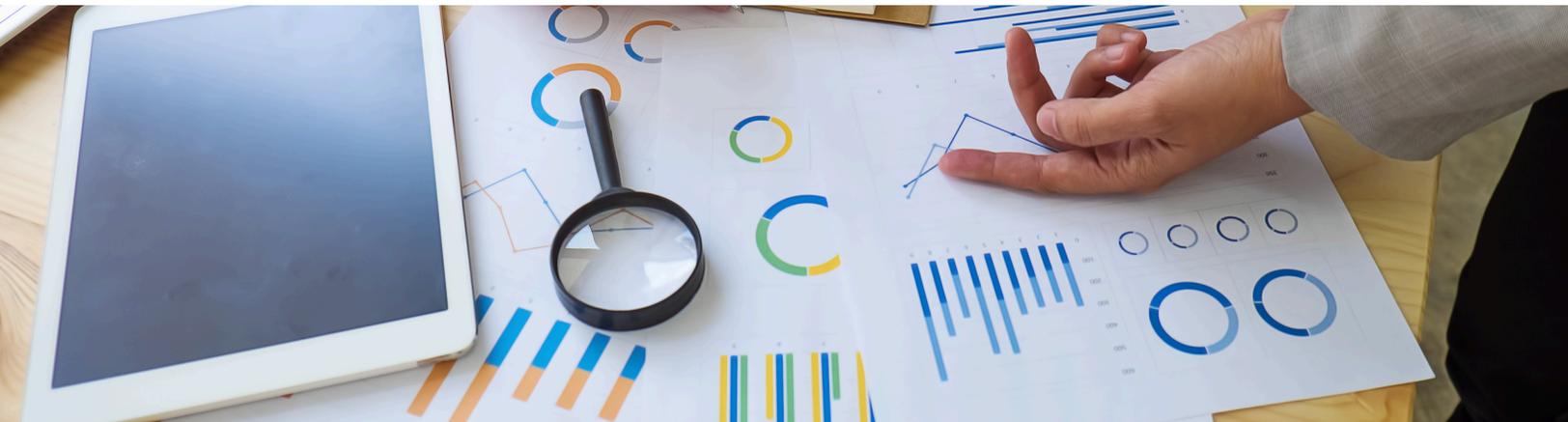
QAPIP Priorities FY2026

Quality Management, Structure, and Oversight

QAPIP Priorities

The QAPIP priorities set the direction for quality improvement efforts each fiscal year and are informed by a comprehensive review of program effectiveness. Priority areas are identified through analysis of key performance indicators that do not meet established standards, findings from External Quality Reviews (EQR), results of the Federal Compliance Review, and recommendations from the annual compliance review of contractually required functions.

All QAPIP priorities are directly aligned with the MSHN Strategic Plan and support the achievement of the region's quality goals. These efforts contribute to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals and communities MSHN serves.



Annual Review of Effectiveness

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness through the QAPIP Report. The QAPIP report is completed in collaboration with MSHN committees/councils to review the effectiveness of improvement initiatives and activities guided by the QAPIP plan; this report is due February 28th each year to MDHHS. The QAPIP report, plan, and other quality reports are made available to consumers and stakeholders (including providers and the general public) on the [MSHN website](#), through provider newsletters/emails, and is made available to members upon request.

The QAPIP evaluation includes the following:

- The performance on the measures on which it is required to report according to MDHHS
- The outcomes and trended results of each PIP
- The results of any efforts to support community integration for members using LTSS
- The annual effectiveness review includes analysis of whether there have been improvements in the quality of health care and services for members as a result of QAPI activities and interventions carried out by the PIHP
- The analysis takes into consideration trends in service delivery and health outcomes over time and include monitoring progress on performance goals and objectives

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Organizational Structure and Leadership	The MSHN Board of Directors will review the QAPIP Report and QAPIP progress reports describing performance improvement projects, actions, and results of actions	Establish a standardized organizational process to continuously monitor the status of QAPIP plan objectives/activities and key performance indicators to monitor clinical outcomes and process implementation	Quality Manager	Annually	September 2026	Better Care
		Develop standardized templates for use in organizational performance improvement projects and the QAPIP plan				

QAPIP Priorities FY2026

Performance Measurement

An effective performance measurement system allows MSHN to systematically evaluate key domains of care and operations, including safety, accessibility, quality, appropriateness, clinical effectiveness, member experience, and clinical outcomes. Performance measurement serves as the foundation for monitoring, improving, and sustaining quality throughout the MSHN region.

MSHN utilizes a Balanced Scorecard (BSC) framework to continuously monitor organizational performance on required metrics, ensuring alignment with MDHHS contractual obligations and statewide quality priorities. Any indicators that fall below established performance thresholds are reviewed and included within annual QAPIP plan goals/improvement activities to guide regional and local improvement strategies.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Performance Management	MSHN will evaluate the impact and effectiveness of the following areas within the QAPIP: <ul style="list-style-type: none"> •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 	Monitor key performance metrics and complete performance summaries for those which do not meet the standards, identify barriers and improvement strategies, and review effectiveness of improvement strategies	Measure Stewards	Quarterly	October 2025 January 2026 April 2026 July 2026	Better Care and Better Provider Systems
		Establish a standardized process for MSHN committee/council to monitor the impact of interventions (quality improvement) on assigned performance areas	Quality Manager with Measure Stewards	Annually	September 2026	
		Establish standardized process for quality improvement in collaboration with committee/councils to analyze outliers and develop/identify regional improvement barriers, improvement strategies and effectiveness of strategies				

Michigan Mission Based Performance Indicator System (MMBPIS)

MDHHS has historically required PIHPs to report on a standardized set of access, efficiency, and outcome indicators under the Michigan Mission Based Performance Indicator System (MMBPIS). These indicators have served as foundational measures to assess system performance, identify disparities, and guide continuous quality improvement across the behavioral health network.

Significant changes are being implemented beginning in FY26 for the MMBPIS by MDHHS. All indicators other than indicator 2 (which measures the timeliness of a biopsychosocial assessment after a request for service has been made) will be discontinued and are no longer subject to PIHP/CMHSP reporting requirements. With this change, MSHN will adapt its internal reporting and quality oversight functions accordingly, ensuring continued compliance with state requirements and maintaining the integrity of performance monitoring through local and regional performance measures.

Any indicators removed from the MMBPIS but deemed locally valuable for strategic quality efforts may be retained but will no longer be mandated for reporting.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
MMBPIS	MSHN will meet or exceed the standard (62.3%) for MDHHS indicator 2 in accordance with the PIHP Medicaid contract	Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations)	Quality Manager	Quarterly by QIC	October 2025 January 2026 April 2026 July 2026	Better Care
		Develop/identify regional improvement strategies used to identify barriers and interventions in collaboration with committee				
		Monitor the effectiveness of local and regional interventions				
MSHN will address the findings of the External Quality Review (EQR)- Performance Measure Validation Review through its QAPIP	A sample will be reviewed prior to submission to MDHHS to ensure accurate submission of data	Quality Manager	Quarterly by Quality Manager	December 2025 March 2025 June 2025 September 2026	Better Provider Systems	

Performance Improvement Projects (PIPs)

In accordance with 42 CFR §438.330(d) and MDHHS contract requirements, MSHN implements a minimum of two Performance Improvement Projects (PIPs) per waiver renewal period. QIC selects PIP topics based on data analysis, process reviews, satisfaction trends, and outcome measures to submit a recommendation on selection to the Operations Council for final approval.

One PIP is selected by MDHHS based on recommendations from the Michigan Quality Improvement Council and is subject to validation by the Health Services Advisory Group (HSAG). All PIPs are reviewed collaboratively across relevant MSHN committees and councils to ensure alignment and accountability.

QAPIP Priorities FY2026

Performance Improvement Projects (PIPs)

In alignment with the MDHHS Comprehensive Quality Strategy, the PIP focus for FY22–FY25 has been on reducing racial and ethnic disparities in access to services. MDHHS has extended the PIPs into FY26, designating the year as Remeasurement Period 3 due to the upcoming procurement process for PIHPs within the State of Michigan for new contracts beginning in FY27. Outcomes relating to a reduction or elimination in disparity will continue to be assessed for improvements with results reported in the QAPIP Annual Report and submitted for validation.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
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/Coordinate with PIP Team members and relevant committees	Quality Manager	Semi-annually by QIC	October 2025	Better Care
		Evaluate the effectiveness of local and/or regional interventions			March 2026	
		Utilize quality tools to identify barriers and root causes		May 2026		
		Submit PIP 1 to HSAG as required for validation		June 2026		
		Submit to MDHHS with QAPIP Evaluation		February 2026		
	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/Coordinate with PIP Team members and relevant committees		Semi-annually by QIC	October 2025	
		Utilize quality tools to identify barriers and root causes			March 2026	
		Evaluate the effectiveness of local and/or regional interventions		May 2026		
		Submit to MDHHS with QAPIP Evaluation		February 2026		

Performance Based Incentive Payment Measures (PBIP)

The Performance Bonus Incentive Program (PBIP) is a financial incentive initiative established by MDHHS to advance the goals of the Medicaid Managed Care Quality Strategy. It supports high performance in key quality domains by rewarding PIHPs based on their achievement of standardized criteria determined by the State. PBIP awards are distributed annually to contractors that demonstrate performance across domains, including:

- 
Quality of Care – Clinical outcomes, evidence-based practices, and service effectiveness
- 
Access to Care – Timeliness and availability of services across populations
- 
Administrative Performance – Reporting accuracy, network adequacy, and data submission

Each year, MDHHS communicates the PBIP criteria and scoring methodology in advance of the performance measurement period. These criteria are standardized across all PIHPs to ensure transparency and consistency. For FY26, the established PBIP metrics remain consistent with those outlined in the FY25 PBIP criteria published by MDHHS.

PBIP results are also used to inform system-level quality improvement efforts, reinforce alignment with the MDHHS Comprehensive Quality Strategy (CQS), and promote regional collaboration on key outcomes. MSHN incorporates PBIP performance monitoring into its Balanced Scorecard and quality review processes and engages with providers and stakeholders to improve upon these standardized measures. The Attachment 3 - MDHHS Standardized Performance Measures outlines all PBIP metrics for the FY26 PBIP measurement period along with other key performance metrics.

QAPIP Priorities FY2026

Stakeholder Experience of Care

MSHN values the voices of consumers, families, providers, and community partners as essential contributors to improving the quality, accessibility, and effectiveness of services. Input is gathered through standardized surveys, focus groups, and feedback loops at both the regional and provider levels to improve processes and outcomes. In addition to formal surveys, MSHN and its regional providers use methods such as focus groups, person-centered plan reviews, and discharge planning sessions to gather qualitative feedback throughout the care experience.

Surveys used to assess stakeholder and member experiences include, but are not limited to, the following:

- Mental Health Statistics Improvement Program (MHSIP) – for adults with mental illness, substance use disorders, and/or long-term supports and services (LTSS)
- Youth Satisfaction Survey (YSS) – for youth with serious emotional disturbances and/or LTSS
- National Core Indicators (NCI) – for individuals receiving LTSS
- Provider Network Survey – for contracted providers
- Committee/Council Survey – for provider and stakeholder representatives involved in governance

Survey and assessment results are aggregated, benchmarked (regionally and nationally when available), and reviewed by the Quality Improvement Council (QIC), Regional Consumer Advisory Council (RCAC), SUD Providers, and other relevant committees.

MSHN incorporates this feedback into quality improvement planning and shares results/findings with stakeholders on a local level through council and committee reports, governance presentations, provider meetings and newsletters, printed materials, and through public access via the MSHN website (as identified in Contract Schedule A—1(K)(2)(a)QAPIPs for Specialty PIHPs, Section X(A-D)).

All stakeholder input contributes to system improvements and may prompt immediate follow-up at the provider level in cases of individual dissatisfaction. Regional progress on satisfaction goals is documented in the annual QAPIP Report and shared with MDHHS, the MSHN Board, Operations Council, and stakeholder groups.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Quantitative and Qualitative Assessment of Member Experiences	MSHN will obtain a qualitative and quantitative assessment of member experiences for all populations (including those receiving LTSS) and will: <ul style="list-style-type: none"> • 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 • Communicate results to providers, recipients, and the Governing Body 	Provide updated process, instructions, and tools on the MSHN website for all survey types	Quality Manager	Annually by QIC	May 2026	Better Care and Better Provider Systems
		Develop electronic version of surveying tools and establish process for data distribution once completed				
		Develop QI plan for those areas that do not meet the 80% standard			September 2026	

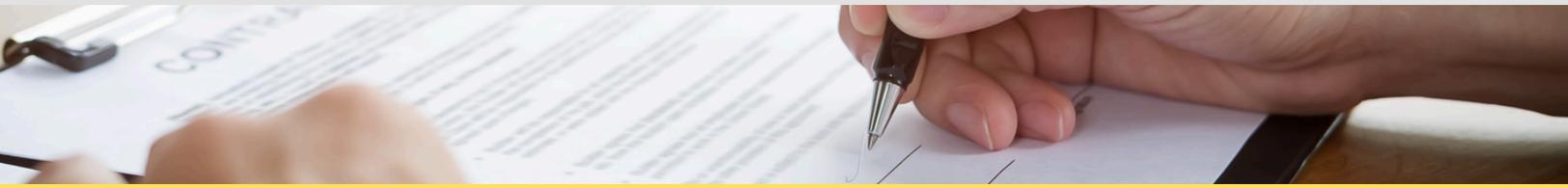


Adverse Events

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant a PIHP review. These include Immediately Reportable Events (IREs), Sentinel Events, Critical Incidents, and Risk Events, as defined by MDHHS. A subset of adverse events are classified as reportable under the MDHHS Critical Event Reporting System.

MSHN ensures that all providers within its network maintain effective systems for detecting, reporting, investigating, and remediating adverse events using credentialed staff appropriate to the scope of care for review and follow-up within required timeframes.

QAPIP Priorities FY2026



Adverse Events

Regional Responsibilities- MSHN is responsible for the following areas:

- Reporting IREs to MDHHS within 48 hours of discovery, per contractual requirements
- Submitting event data via the Behavioral Health CRM system
- Providing quarterly analysis of all adverse events including trends, completed interventions, and recommended system-level prevention strategies via relevant MSHN committees and councils
- Monitoring regional provider processes related to reporting, follow-up, and resolution of events

Provider Responsibilities- MSHN contractually requires oversight of adverse events to regional providers in the following areas:

- The reporting, investigation, and remediation of sentinel events, critical incidents, and risk events
- Reporting IREs to MSHN upon discovery
- Sentinel event determination within three (3) business days of a critical incident
- Initiation of a root cause analysis (RCA) within two (2) business days following sentinel identification conducted by appropriately credentialed staff
- Development and implementation of an action plan based on RCA findings to ensure safety and prevent recurrence, including assigned accountability, timelines, and outcome measurement

Adverse Event Types and Definitions:

- Immediately Reportable Events (IREs) – Must be reported to MDHHS within 48 hours and includes deaths resulting from staff action/inaction under recipient rights, licensing, or law enforcement investigation
- Sentinel Events – include unexpected deaths, permanent harm to the consumer, or severe temporary harm requiring intervention to sustain life (per The Joint Commission, 2025)
- Critical Incidents – are required to be reviewed and reported and include: Suicide and non-suicide deaths, Arrests, Emergency medical treatment or hospitalization (due to injury, illness, or medication error), Serious challenging behaviors, Use of physical management, and 911 calls made by staff in a behavioral crisis. Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories included for emergency medical treatment and hospitalizations include falls and injuries during physical management.
- Risk Events – are required to be reviewed include: harm to self, harm to others, and actions that result in two or more unplanned medical hospital admissions within a 12-month period (excluding planned procedures or end-stage chronic illness)

MSHN integrates analysis of adverse events into its broader QAPIP structure, ensuring that findings drive preventive actions, inform system improvement, and meet regulatory compliance requirements. Results are shared with regional leadership and MDHHS to promote transparency and quality assurance.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
(Adverse Events) Event Monitoring and Reporting	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	Complete training of providers outlining the requirements of reporting critical, sentinel, immediately reportable, and news media events as identified in the new MDHHS training documents	Quality Manager	Annually by QIC	June 2026	Better Care and Better Provider Systems
		Validate/reconcile reported data through the CRM	Quality and Compliance Coordinator	Quarterly	October 2025 January 2026 April 2026 July 2026	
		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	Quality Manager	Annually by QIC	September 2026	
	MSHN will analyze, at least quarterly, critical incidents, sentinel events, and risk events to determine what action(s) need 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 and trend data	Quality Manager	Quarterly by QIC	October 2025 January 2026	
		Identify barriers and develop improvement strategies regionally, as well as locally, to prevent occurrence of additional events and incidents		Quarterly by QIC	April 2026 July 2026	

QAPIP Priorities FY2026

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.

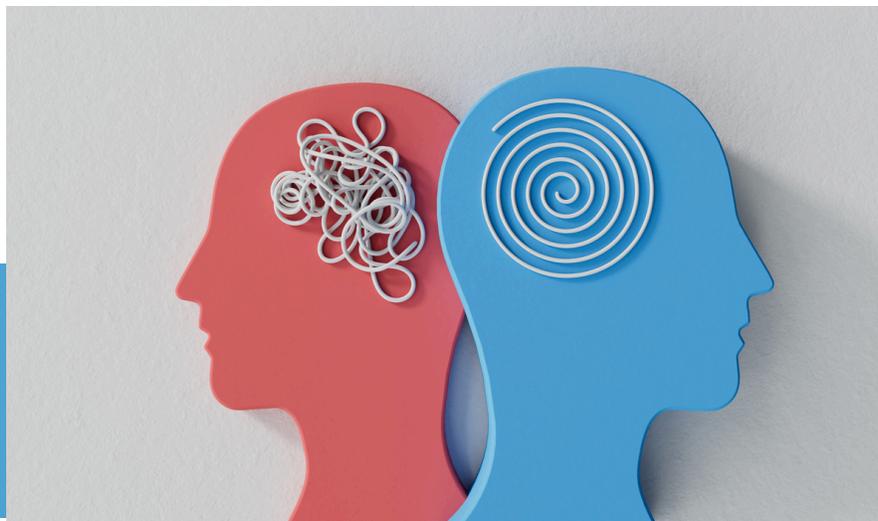
Only restrictive or intrusive interventions permitted under the MDHHS Behavior Treatment Technical Requirements and approved through the Person-Centered Planning process may be used with individuals receiving services. CMHSPs submit quarterly reports to MSHN where intrusive and restrictive techniques 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 must include 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).

MSHN provides regional oversight through:

- Quarterly data analysis to identify trends and opportunities for improvement
- Delegated managed care site reviews to ensure accurate reporting and compliance with Behavioral Treatment Standards
- Clinical chart reviews for individuals with recommended restrictive/intrusive interventions
- Annual review of BTRC policies and procedures

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.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Behavior Treatment	The BTPRC reviews quarterly analysis of data where:	CMHSP to submit data through the affiliate upload process in REMI	CMHSPs	Quarterly by BTPRC Workgroup	October 2025 January 2026 April 2026 July 2026	Better Care and Better Provider Systems
	• Intrusive or restrictive techniques have been approved for use with members	MSHN to provide quarterly regional performance summaries to the BTPRC workgroup to identify CMHSP performance outliers and barriers to inform the development of regional/local improvement strategies	Waiver Administrator and Quality Manager		December 2025 February 2026 June 2026 August 2026	
	• Where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis	MSHN to provide quarterly regional performance data on reductions in the number of restrictive/intrusive techniques as well as the number of plans discontinued that contain restrictive/intrusive interventions				
	Data shall include numbers of interventions and length of time the interventions were used per individual	Explore and develop ways to expand the knowledge of direct care workers about the standards related to implementation of restrictive and/or intrusive techniques	Waiver Administrator	Ongoing monitoring by BTPRC Workgroup		
	MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans	Adjust, advocate, and educate on the updates to the Technical Requirements, established provider qualifications, and codes used for Behavior Treatment Planning				



QAPIP Priorities FY2026

Clinical Quality Standards

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 contractual requirement to regional providers, operates a comprehensive Utilization Management (UM) system. Regional providers are responsible for UM functions for individuals they serve, whether through directly operated or contracted services.

Contractually Required Responsibilities of Regional Providers:

- Regional Providers manage:
 - Initial screening and authorization for psychiatric inpatient, partial hospitalization, and community-based services
 - Ongoing service authorizations based on medical necessity
 - Communication of UM decisions, including Adverse Benefit Determinations, Right to Second Opinions, and Grievance and Appeals processes
 - Prospective, concurrent, and retrospective reviews consistent with PIHP policy and standards
 - SUD Providers- Initial service eligibility decisions for SUD services are contractually required through the use of screening and assessment tools



MSHN Retained Responsibilities

- Oversight of all required UM functions to ensure compliance with policy, contract, and regulatory requirements
- Retention of utilization review for SUD services, including prospective, concurrent, and retrospective reviews of authorization and utilization decisions
- Operation of the Regional Utilization Management Committee, composed of representatives from each CMHSP, to review standards, utilization trends, and region-wide improvement opportunities
- Development, maintenance, and monitoring of UM policies, criteria, and procedures

MSHN's UM system integrates quality assurance and improvement activities, ensuring consistent application of eligibility criteria, protection of beneficiary rights, and effective management of network resources. MSHN and its regional providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

Medical Necessity Criteria

- Decisions are based on standardized, population-specific assessments and level of care determination tools required by MDHHS
- Multiple assessment sources are combined with clinical judgment and individual input to inform decisions on amount, scope, and duration of services
- Medical necessity criteria are consistently applied across the network and are publicly available upon request

Oversight and Safeguards

- MSHN and delegated entities maintain mechanisms to identify and address both under- and over-utilization of services
- All UM decisions are reviewed or approved by qualified health professionals with appropriate licensure and expertise
- Denial or reduction of services may only be made by licensed health care professionals experienced in treating the beneficiary's condition
- Documentation of decision rationale, notice of appeal rights, and customer services support are provided in accordance with the Medicaid Managed Specialty Supports and Services Contract

QAPIP Priorities FY2026

Utilization Management



The MSHN Utilization Management plan further identifies regional processes, defines established metrics and associated interventions, and identifies annual regional priorities.



MSHN's Utilization Management Plan further outlines the following requirements:

- 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.
- Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate for any utilization management decisions.
- The reasons for utilization management decisions are clearly documented and made available to each member.
- 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 all appeal rights including how to file an appeal.
- Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
- There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction, or other appropriate measures.
- If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Utilization Management	MSHN will establish a Utilization Management Plan in accordance with MDHHS requirements	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.	Director of Utilization Management	Biannual by UMC	January 2026 July 2026	Better Care and Better Provider Systems
		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			January 2026 July 2026	
		Review tools for determining medical necessity for community living supports and recommend regional best practice		Annually by UMC	April 2026	
		Continued analysis of differences in amount/duration of services received by individuals enrolled in waivers and non-waiver individuals		Biannual by UMC	January 2026 July 2026	
		Develop and monitor reports to identify any areas where improvements are needed			January 2026 July 2026	
		Integrate standard assessment tools into REMI- MichiCANS implementation		Quarterly by UMC	November 2025 February 2026 May 2026 August 2026	
	MSHN will ensure that decisions for utilization management, member education, coverage of services, and other areas are consistent with established guidelines	Review existing practices for authorization of respite services and eligibility/service requirements. Recommend regional best practice	Director of Utilization Management	Annually by UMC	April 2026	
	The Service Authorization Denial Report will demonstrate 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	Director of Utilization Management	Quarterly by UMC	November 2025 February 2026 May 2026 August 2026	
		Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans				
	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)	Director of Utilization Management	Quarterly by UMC	October 2025 January 2026 April 2026 July 2026	
Develop/identify regional improvement strategies used to identify barriers and interventions						

QAPIP Priorities FY2026

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. Of note, due to the PIHP procurement process, MSHN has extended the FY24/FY25 Population Health and Integrated Care plan to FY26.

These initiatives are monitored through:

- Population health analysis to identify disparities and priority needs
- A core set of performance measures to evaluate health outcomes and model effectiveness
- Program-specific Continuous Quality Improvement (CQI) plans to ensure compliance and drive improvement

MSHN currently participates in the following integrated care programs:

- Behavioral Health Homes (BHH)
- Substance Use Disorder Health Homes (SUDHH)
- Complex Care Management (CCM)

Each program is reviewed regularly to assess impact, refine strategies, and aligns with MDHHS quality and service requirements.



Improvement Area	Goal	Improvement Activity	Lead(s)	Frequency of Review	Review Date(s)	Strategic Alignment
Integrated Health	Establish effective quality improvement programs for Health Homes	Develop/modify data platforms/reports for performance monitoring	Director of Utilization Management & Access and Quality Manager	Quarterly by BHH QI Subgroup	November 2025 February 2026 May 2026 August 2026	Better Care
		Develop/identify regional improvement strategies based on clinic and Lead Entity (LE) performance				
		Maintain performance metric reports to view performance by clinic and region to compare and exceed Michigan BHH standards				

Practice Guidelines

MSHN requires the consistent use of nationally accepted and mutually agreed upon clinical practice guidelines (including evidence-based practices (EBP)) to ensure that services are delivered using research-validated methods that produce the best outcomes while providing optimal value for resources invested. These guidelines encompass clinical standards, evidence-based practices, practice-based evidence, and promising practices that are relevant to the needs of individuals served.

The selection, adoption, and implementation of practice guidelines are guided by principles of recovery, resilience, wellness, person-centered and individual treatment planning, self-determination, and cultural competence. Guidelines are selected to match presenting clinical or community needs, as well as the demographic and diagnostic characteristics of those served. This process is locally driven, developed in collaboration with MSHN's councils and committees, and ensures that all individuals receive the most effective and appropriate services. Clinical programs must demonstrate documented competencies in approaches such as motivational interviewing, trauma-informed and trauma-focused care, positive behavioral supports, and appropriate behavior treatment planning.



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Practice Guidelines

The application of practice guidelines is monitored through data analysis, fidelity reviews, and MSHN's site review process to verify that regional providers integrate these guidelines into service delivery. Evidence-based practice use is further tracked through the annual network adequacy assessment. Fidelity reviews are conducted and evaluated as part of local quality improvement programs or as required by MDHHS.

MSHN's expectation for the use of approved practice guidelines is incorporated into provider contracts. Guidelines are reviewed and updated at least annually, or as needed, and are disseminated through relevant committees, councils, and workgroups. All MDHHS and regional practice guidelines adopted by MSHN are publicly accessible through the MSHN website located here: [Mid-State Health Network Practice Guidelines](#).

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Practice Guidelines	The PIHP will adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.	Recommend improvement strategies when adverse utilization trends are detected within reporting	Chief Behavioral Health Officer	Annually by CLC/UMC	January 2026	Better Care
	The PIHP disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request					
	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 Recommend improvement strategies when adverse utilization trends are detected within reporting	Director of Utilization Management & Access	Biannual by UMC	January 2026 July 2026	

Long Term Supports and Services (LTSS)/Home and Community Based Services (HCBS)

MSHN ensures that the need for Long-Term Supports and Services (LTSS) is assessed for each individual and included in the person-centered plan of service when indicated. LTSS are delivered in a manner that prioritizes the health, safety, and welfare of consumers, their families, providers, and other stakeholders. When concerns are identified, they are acknowledged, documented, and addressed through appropriate corrective actions.

In alignment with the Michigan 1115 Waiver, LTSS include the following covered services: Respite; Community Living Supports (CLS); Private Duty Nursing (PDN); Supported and Integrated Employment; Out-of-Home Non-Vocational Habilitation; Goods and Services; Environmental Modifications; Supports Coordination; Enhanced Pharmacy; Personal Emergency Response System (PERS); Community Transition Services; Enhanced Medical Equipment and Supplies; Family Training; Non-Family Training; Specialty Therapies (Music, Art, Massage); Children's Therapeutic Foster Care; Therapeutic Overnight Camping; Transitional Services; Fiscal Intermediary Services; and Prevocational Services.

MSHN evaluates the quality and appropriateness of LTSS through coordinated specialized foster care home visits with CMHSP staff, review of documentation in the MSHN electronic medical record, aggregated outcomes from site reviews, satisfaction surveys, grievance and appeal data, and analysis of adverse events (sentinel, critical, and risk). Clinical chart reviews are conducted to verify that services are provided as documented in the individual's plan of service and that opportunities for community integration are occurring.

System-level monitoring is conducted using population health data analytics to identify patterns of service utilization, detect disparities, and develop interventions that promote equitable access and outcomes for individuals receiving LTSS.

The MSHN QAPIP program includes 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

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Long Term Supports and Services (LTSS)/Home and Community Based Services (HCBS)

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
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. MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable individuals	Monitor Performance Measures for adverse trends	Chief Behavioral Health Officer	Quarterly by CLC	October 2025 January 2026 April 2026 July 2026	Better Care
	MSHN QAPIP program will include mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS	Establish a process and identify report to monitor aggregate data for assessment of care between care settings	Chief Behavioral Health Officer	Quarterly by CLC		
		Review efforts for community integration during site reviews Providers without full compliance will develop a corrective action plan to address community integration				

Cultural Competence

MSHN and its Provider Network maintain a sustained commitment to linguistic and cultural competence to ensure equitable access and meaningful participation for all individuals across the region. This commitment is embedded in policy, training, service delivery, and performance monitoring practices that respect and integrate the cultural values, beliefs, and traditions of the diverse communities served, while recognizing how language, culture, and lived experience influence the delivery of supports and services.

Cultural competence within MSHN's network encompasses an understanding and responsiveness to diversity in race, ethnicity, culture, religion, regional influences, gender, gender identity, sexual orientation, marital status, education, employment, economic status, and other social determinants of health. Providers are expected to demonstrate the ability to adapt care to meet these diverse needs while promoting dignity, respect, and inclusion.

Aligned with MSHN's strategic priority of Better Equity, this commitment extends beyond cultural competence to encompass active efforts to identify and mitigate implicit bias, reduce health disparities, and embed equity-driven practices into system design, provider expectations, and quality oversight. Equity efforts are data-informed, stakeholder-guided, and integrated into quality improvement initiatives to ensure culturally responsive behavioral health and substance use disorder services for all populations.

Mid-State Health Network is committed to achieving better equity throughout the region to diversify the workforce to provide a sufficient and diverse mix of providers as well as obtain diverse input from stakeholders, and service participants to grow in the understanding and inclusion of all residents of Region 5.

Monitoring and Oversight

MSHN monitors the cultural competence of its Provider Network through its [Provider Network Network Adequacy Assessment \(NAA\)](#) processes. Monitoring activities include:

- **Provider Staff Training and Education:** Review of Provider documentation of annual cultural competence and DEI training completion for all staff. This includes a review of training content that includes implicit bias awareness, trauma-informed care, health equity, and culturally responsive service delivery. In addition, MSHN conducts verification of training records maintained and updated during credentialing and re-credentialing cycles for cultural competency
- **Linguistic Accessibility and Interpretation Services:** Verification that providers offer translation and interpretation services for individuals with Limited English Proficiency (LEP) through assessment of signage, materials, and communications being available in multiple languages
- **Accommodations:** MSHN conducts verification that all providers offer services in locations with physical access for Medicaid beneficiaries in accordance with the American Disabilities Act
- **Policies and Procedures:** Monitoring that providers maintain formal Cultural Competence and Nondiscrimination policies addressing equity in service delivery

In addition to the above, MSHN collects and provides public information via the MSHN website related to persons served by Race as well as Penetration Rates by Race/Ethnicity.

Providers demonstrating deficiencies are required to develop and implement corrective action plans, which are tracked through follow-up monitoring and regional reporting.

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Provider Network Oversight

Provider Qualifications



MSHN maintains written policies and procedures consistent with the MDHHS Credentialing and Re-Credentialing Policy to ensure that all network providers meet qualification requirements prior to delivering services, and at least every three years thereafter. These standards apply whether credentialing activities are conducted directly by MSHN, through delegation, or by contract. The process also ensures that non-licensed care and support staff meet the qualifications outlined in the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification, and qualification of MSHN-employed or contracted staff are the direct responsibility of MSHN. For Regional Providers, these functions are contractually required, with MSHN retaining oversight to verify compliance with federal, state, and local regulations. Oversight activities may include desk reviews, on-site verifications, and other monitoring and enforcement strategies. MSHN tracks credentialing timeliness and recredentialing status on a bi-annual basis; any CMHSP falling below 90% compliance is subject to increased monitoring and reporting is included within the QAPIP report.

MSHN policies also address the selection, orientation, and ongoing training of all directly employed and contracted staff. Annual performance and competency reviews are conducted, with staff development plans implemented to address identified needs. MSHN is responsible for ensuring that all employed and contracted providers meet applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant education, work experience, and demonstrated cultural competence. Regional providers hold the same responsibility for their own staff and subcontractors, including selection, orientation, training, and competency evaluation.

Provider monitoring is in place:

- 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 must be 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

Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for educational background, relevant work experience, cultural competence, and certification, registration, and licensure as required by law.

Provider Qualifications/ Credentialing	MSHN will ensure that all health care professionals and non-licensed professionals are qualified to perform services and that policies and that procedures for credentialing and recredentialing related activities comply with MDHHS requirements	MSHN will verify regional compliance of credentialing and recredentialing requirements for licensed providers within the network	Compliance Administrator	Ongoing following MSHN review cycle dates	Better Provider Systems and Better Care
		MSHN will verify regional compliance of qualifications for non-licensed providers within the network			

Provider Monitoring and Follow-up

MSHN uses a standardized written contract with all regional providers, requiring compliance with federal and state regulations, including the Balanced Budget Act (BBA), the Medicaid Provider Manual, and the Master Contract between MSHN and MDHHS. These contracts obligate providers to ensure that all eligible recipients have access to the full scope of required services, either through direct delivery or by maintaining a qualified and competent provider panel.

Regional providers must maintain written subcontracts with all organizations or practitioners on their provider panel. SUD Providers must obtain written authorization from MSHN before subcontracting any portion of their agreement. All subcontracts must include the same compliance requirements outlined in the primary agreement, including adherence to the BBA, the Medicaid Provider Manual, and the PIHP/MDHHS Master Contract.

QAPIP Priorities FY2026

Provider Monitoring and Follow-up

Each regional provider is required to conduct and document annual monitoring of each subcontractor, consistent with BBA and MDHHS requirements. Monitoring structures must include provisions for requiring corrective action and, when necessary, imposing sanctions up to and including contract termination.

MSHN supports regional standardization and reciprocity through common contracts, provider performance protocols, policies, and outcome measures, reducing duplication and administrative burden for shared contractors. Compliance is monitored annually through a combination of desk reviews, site verification visits, and other oversight strategies. Providers that cannot demonstrate acceptable performance may be required to implement corrective action plans, may be placed under increased PIHP oversight, and may face sanctions, including termination of their agreement with MSHN.

The PIHP undergoes external reviews conducted by MDHHS and/or an external quality review organization (EQR) contracted by MDHHS to evaluate quality, timeliness, and access to care, as well as compliance with all regulatory requirements. An action plan is developed for each required improvement, outlining specific goals, objectives, activities, timelines, and measures of effectiveness and all findings requiring improvement from these external reviews are incorporated into the QAPIP priorities for the following fiscal year.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
Provider Monitoring	MSHN annually monitors its provider network(s), including affiliates and subcontractors 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	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUD providers	Compliance Administrator	Annually	Ongoing following MSHN review cycle dates	Better Provider Systems
		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				
	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	Review a sample prior to submission of those CMHSPs that had findings during the HSAG review: - Medicaid eligibility - All documentation being present for indicator 2	Quality Manager	Quarterly	October 2025 January 2026 April 2026 July 2026	
		Ensure completion of the CMHSP/SUD Provider corrective action plans related to internal review of primary source verification	Functional area leads	Annually	September 2026	
	MSHN will demonstrate an increase in compliance with the MDHHS Federal Compliance Review	Develop and implement performance improvement goals, objectives and activities in response to the external review findings	Waiver Staff	Annually	September 2026	
		Provide technical assistance to CMHSPs related to standards				
Develop and implement performance improvement goals, objectives and activities in response to the review findings						
	Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data					

MSHN maintains written policies and procedures for conducting site reviews to monitor and oversee Medicaid and Healthy Michigan-funded claims and encounters submitted within the Provider Network. These reviews verify that billed services were actually delivered, in accordance with federal regulations and state technical requirements.

Data from the Medicaid Event Verification process is aggregated, analyzed, and reviewed to identify local and regional opportunities for improvement. When follow-up actions are necessary, they are documented and tracked to resolution. Findings, along with the methodology used, are reported through an annual report.

Improvement Area	Goal	Improvement Activity	Lead	Frequency of Review	Review Date(s)	Strategic Alignment
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	Compliance Administrator	Ongoing following MSHN review cycle dates		Better Provider Systems
		Complete the MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement, and actions taken				

QAPIP Priorities FY2026

Financial Oversight

MSHN maintains written policies and procedures to ensure sound financial management and regulatory compliance. As part of its oversight responsibilities, MSHN conducts financial reviews of the SUD Provider Network, evaluating performance against eight established standards:

- Review of the provider's Certified Public Accountant (CPA) Audit
- Verification of compliance with previous corrective actions
- Examination of financial management policies and procedures
- Documentation confirming proper segregation of duties
- Evidence supporting Financial Status Report (FSR) billing
- Verification of board-approved sample financial reports
- Evaluation of the provider's Risk Management Plan
- Assessment of any additional regulatory compliance requirements identified during the review

Findings from these reviews are used to identify areas for improvement and, when necessary, corrective actions are implemented in accordance with MSHN's oversight monitoring process.

Additionally, all CMHSP Participants and MSHN have implemented the generation of a summary of Explanations of Benefits (EOB) in compliance with the MDHHS Specialty Mental Health Services Program contract. This step provides consumers with an additional safeguard, ensuring they are aware of service activity billed to their insurance.



Definitions/Acronyms

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

BHH: Behavioral Health Home - these health homes provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. BHH beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care.

CCBHC: Certified Community Behavioral Health Clinics- were originally developed by SAMHSA (Substance Abuse and Mental Health Services Administration) and CMS (Centers for Medicare and Medicaid Services) through a grant process. CCBHCs are an outpatient, integrated care model incorporating care coordination and a cost-based payment methodology.

CMHSP: Community Mental Health Service Providers are programs that contract with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay and are established through the Michigan Mental Health Code 330.1100a, 330.1206.

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

Contractual Provider: Refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) providing administrative type services including CMHSP participants who hold retained functions contracts.

Critical Incident: Critical Incidents are defined as the following events: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

Customer: Includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

Delegation: An agreement between Contractor and an individual, provider, CMHSP or other organization to perform certain functions that otherwise would be the responsibility of Contractor to perform. Contractor oversees and is accountable for any functions or responsibilities that are delegated to other entities whether the functions are provided by Contractor or other entities.

EQR: External Quality Review is conducted quarterly by CMS and MDHHS.

LTSS: Long Term Supports and Services are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identify the Home and Community Based Services Waiver. MI-Choice as recipients of LTSS.

MEV: Medicaid Event Verification is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS CQS: Michigan Department of Health and Human Services Comprehensive Quality Strategy - the MDHHS CQS provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

Definitions/Acronyms

MDHHS: Michigan Department of Health and Services

SUDHH: Substance Use Disorder Health Home - the SUDHH provides comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. For enrolled beneficiaries, the SUDHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care.

PIP: Performance Improvement Projects - must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on consumer's health outcomes.

PIHP: Prepaid Inpatient Health Plan- is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.

QAIP: Quality Assessment Performance Improvement Program

QM/QA/QI: Quality Manager/Quality Assurance/Quality Improvement

QAIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Root Cause Analysis (RCA): A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

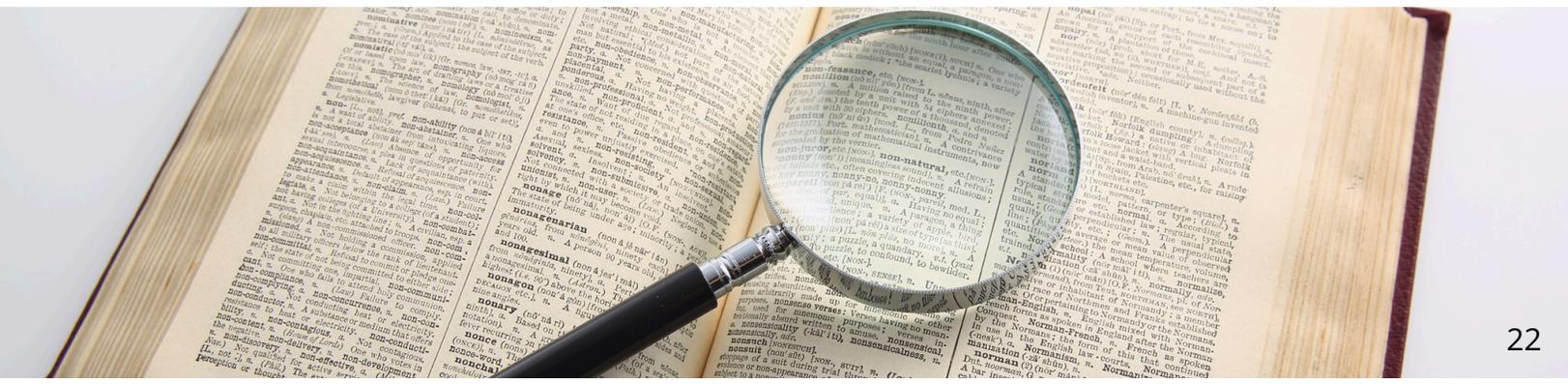
Sentinel Event (SE): A sentinel event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. Include but are not limited to incidents that result in the following: Unexpected deaths, permanent harm, severe temporary harm and intervention required to sustain life. (The Joint Commission 2025)

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.

SUD Providers: Refers to substance use disorder (SUD) providers directly contracted with MSHN to provide SUD treatment and prevention services.

Vulnerable Individual: An individual with a functional, mental, physical inability to care for themselves.



Relevant Resources

Centers for Medicare and Medicaid Services (CMS). (2025, February 7). *What are Long-Term Supports and Services (LTSS)*. <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-overview>

Chidambaram, P & Burns, A. (2024, July 8). *10 Things About Long-Term Services and Supports (LTSS)*. <https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/>

Michigan Department of Health and Human Services Behavioral & Physical Health and Aging Services Administration (2022, December). *Medicaid Managed Specialty Supports and Services Contract Quality Assessment and Performance Improvement Technical Requirement*. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder13/Folder3/Folder113/Folder2/Folder213/Folder1/Folder313/QA_and_IP_for_Specialty_Prepaid_Inpatient_Health_Plans.pdf?rev=d4dc2f2bff104f199c2c38c5d460185c&hash=20C5EFACE65B3F8592989A91EC06490E

Joint Commission Resources. (2024). *2025 Comprehensive Accreditation Manual for Behavioral Health Care and Human Services*. The Joint Commission.

The W. Edwards Deming Institute. (2025). *The PDSA Cycle*. <https://deming.org/explore/pdsa/>

Scholtes, P. R. (1991). *In The Team Handbook*. Joiner Associates, Inc.

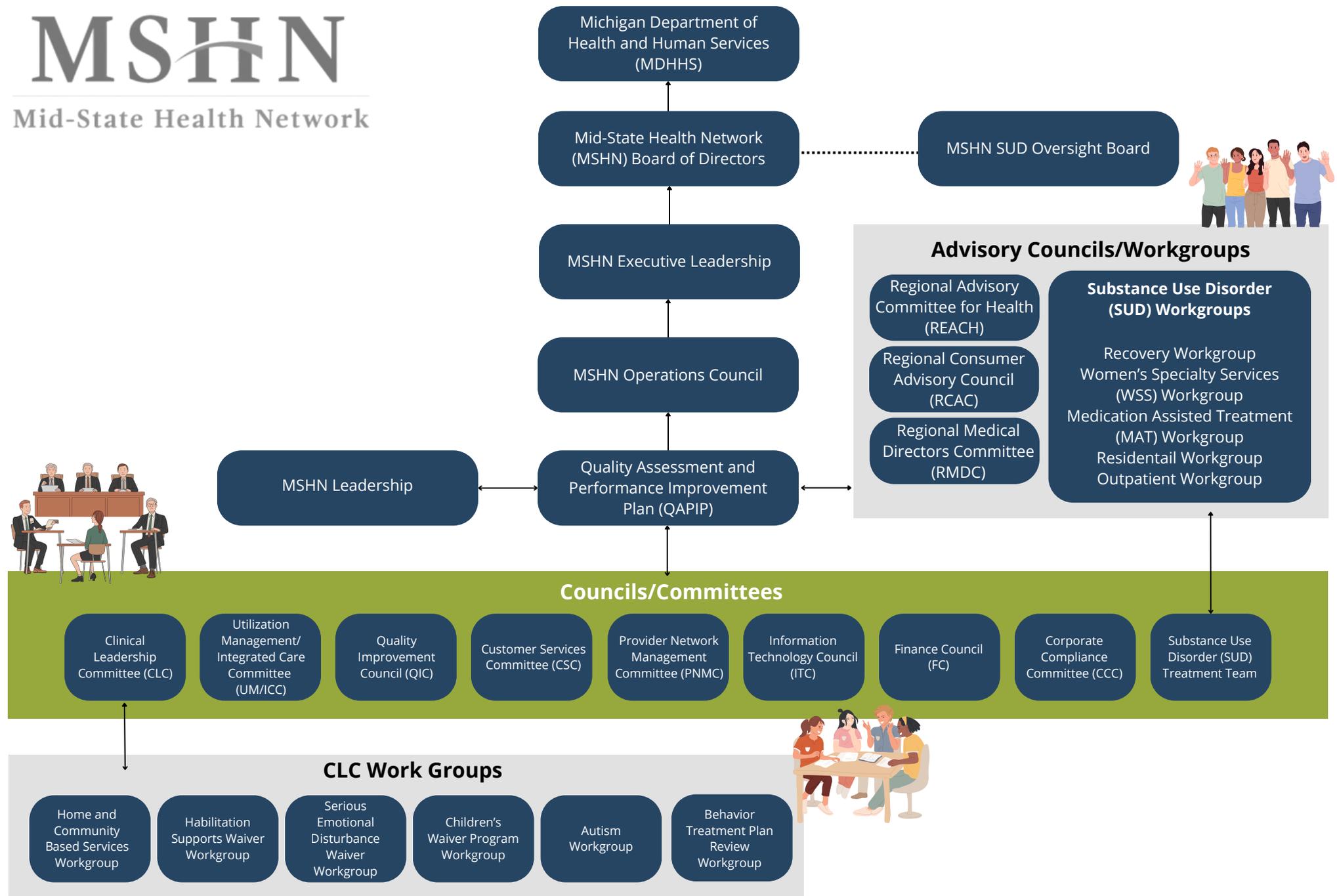
Relevant Policies & Procedures

QAPIP Section	Relevant Policies/Procedures	Requirements
Overall QAPIP Program	<ul style="list-style-type: none"> Quality Management MSHN Policy 	<ul style="list-style-type: none"> 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs
Organizational Structure and Leadership	<ul style="list-style-type: none"> Quality Management MSHN Policy 	<ul style="list-style-type: none"> Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—I QAPIPs for Specialty PIHPs—II(d) QAPIPs for Specialty PIHPs—III
MMBPIS	<ul style="list-style-type: none"> Michigan Mission Based Performance Indicator System MSHN Policy MMBPIS Reporting Procedure 	<ul style="list-style-type: none"> 42 CFR §438.330(b)(2) 42 CFR §438.330(c)(2) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—V
Performance Improvement Projects (PIP)	<ul style="list-style-type: none"> Performance Improvement MSHN Policy 	<ul style="list-style-type: none"> 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—VII(A-B) QAPIPs for Specialty PIHPs—VII(E)
Quantitative and Qualitative Assessment of Member Experiences	<ul style="list-style-type: none"> Assessment of Member Experiences MSHN Policy Member Experience of Care Assessment Procedure 	<ul style="list-style-type: none"> Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section X(A-D)
Adverse Events Monitoring and Reporting	<ul style="list-style-type: none"> Critical Incidents MSHN Policy Critical Incidents - SUD Only MSHN Policy Sentinel Events MSHN Policy Adverse Event Reporting Procedure 	<ul style="list-style-type: none"> 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.302(h) 42 CFR §441.730(a) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12) QAPIPs for Specialty PIHPs—VIII
Behavior Treatment	<ul style="list-style-type: none"> Behavior Treatment Plans MSHN Policy Behavior Treatment Plan Review Procedure 	<ul style="list-style-type: none"> Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX

Relevant Policies & Procedures

QAPIP Section	Relevant Policies/Procedures	Requirements
Utilization Management	<ul style="list-style-type: none"> • Access System MSHN Policy • Level of Care System MSHN Policy • Utilization Management MSHN Policy • Utilization Management Procedure 	<ul style="list-style-type: none"> • 42 CFR §438.330(b)(3) • 42 CFR §457.1240(b) • Contract Schedule A—1(L)(2)(a) • Contract Schedule A—1(L)(4)(a) • QAPIPs for Specialty PIHPs—XIV(B)
Integrated Care	<ul style="list-style-type: none"> • Population Health and Integrated Care MSHN Policy 	<ul style="list-style-type: none"> • 42 CFR §438.330(b)(4) • 42 CFR §457.1240(b) • Contract Schedule A—1(L)(2)(a)
Practice Guidelines	<ul style="list-style-type: none"> • All regional practice guidelines can be found here. These include skill building assistance, community living supports, Supported Employment, Respite Care, amongst other clinical practices/services. 	<ul style="list-style-type: none"> • 42 CFR §438.236(b)(1-4). QAPIPs for Specialty PIHPs, Section XI. 42 CFR §438.236(c) • Contract Schedule A—1(K)(5)(a). Contract Schedule A—1(K)(2). 42 CFR §438.330(b)(4)(5)(i)
Oversight of Vulnerable People/Long Term Supports and Services	<ul style="list-style-type: none"> • Children’s Home and Community Based Service Waiver MSHN Policy • Habilitation Supports Waiver MSHN Policy • Serious Emotional Disturbance Waiver MSHN Policy 	<ul style="list-style-type: none"> • 42 CFR §438.330(b)(5)(i) • 42 CFR §457.1240(b) • Contract Schedule A—1(L)(2)(a) • Contract Schedule A—1(L)(2)(c)
Provider Qualifications	<ul style="list-style-type: none"> • Provider Network Credentialing/Re-Credentialing MSHN Policy • Provider Network Management MSHN Policy • Provider Network: Credentialing and Recredentialing - Individual Practitioners Procedure • Provider Network: Credentialing and Recredentialing - Organizational Providers Procedure • Provider Network: Non-Licensed Provider Qualifications Procedure • Provider Network: Substance Use Disorder Credentialing and Qualifications Procedure 	<ul style="list-style-type: none"> • Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section XII(A-B)
Medicaid Event Verification	<ul style="list-style-type: none"> • Medicaid Event Verification MSHN Policy • Medicaid Event Verification Procedure 	<ul style="list-style-type: none"> • Contract Schedule A—1(K)(2)(a). QAPIPs for Specialty PIHPs, Section XII(A-B)
Provider Monitoring	<ul style="list-style-type: none"> • External Quality Review MSHN Policy • Regional Provider Monitoring and Oversight MSHN Policy • Regional Monitoring and Oversight Procedure 	<ul style="list-style-type: none"> • Contract Schedule A-K.2.b

ATTACHMENT 1- QAPIP PROCESS FLOW



ATTACHMENT 2

COMMITTEES/COUNCILS

Operations Council (OC)

The OC was established 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. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council, who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends. The RMDC was established 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.

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

Quality Improvement Council

The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Primary and/or secondary consumer representatives are appointed through an application process. Substance Use Disorder (SUD) Treatment Providers are represented on the Council by MSHN SUD Staff on an as needed basis. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

Finance Council (FC)

The FC will 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 FC 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.

ATTACHMENT 2

Information Technology Council (ITC)

The ITC was 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.

Clinical Leadership Committee (CLC)

The CLC was established 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.

Utilization Management Committee (UMC)

The UMC was established 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.

Compliance Committee (CC)

The CC was 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.

Customer Services Committee (CSC)

The CSC was established 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 assure the handbook is maintained in a compliant format, and to support the development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Provider Network Management Committee (PNMC)

PNMC was 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 contractually required by Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

ATTACHMENT 2

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is specific to a Level of Care (LOC) and functional area including, Women's Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

Regional Equity Advisory Committee for Health (REACH)

To address MSHN's strategic priority of better equity, MSHN has established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners from historically marginalized populations with lived experience. REACH goals are 1) to 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; 2) to inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI); 3) to incorporate a trauma-informed perspective that accounts for historical and racialized trauma; 4) to address stigma and bias that may impact health outcomes.





Governing Body Form

To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Mid-State Health Network		
List of members of the Governing Body (add additional rows as needed)		
Name	Credentials	Organization (if applicable)
1. Brad Bohner	2025	LifeWays CMHA
2. Vacant	2025	CEI CMH
3. Greg Brodeur	2027	Shiawassee Health & Wellness
4. Joan Williams	2026	Saginaw County Community Mental Health
5. Ken DeLaat	2026	Newaygo County Mental Health
6. David Griesing	2027	Tuscola Behavioral Health
7. Dan Grimshaw	2026	Tuscola Behavioral Health
8. Tina Hicks	2027	Gratiot Integrated Health
9. John Johansen	2027	Montcalm Care Network
10. Cindy Garber	2027	Shiawassee Health & Wellness
11. Pat McFarland	2026	Bay Arenac Behavioral Health
12. Deb McPeek-McFadden	2027	The Right Door for Hope, Recovery & Wellness
13. Paul Palmer	2025	CEI CMH
14. Linda Purcey	2025	The Right Door for Hope, Recovery & Wellness
15. Irene O'Boyle	2026	Gratiot Integrated Health
16. Kurt Peasley	2027	Montcalm Care Network
17. Joseph Phillips	2026	CMH for Central Michigan
18. Tracey Raquepaw	2025	Saginaw County CMHA
19. Kerin Scanlon	2025	CMH for Central Michigan
20. Ed Woods	2027	LifeWays CMHA



21. Patrick Conley	2028	Bay Arenac Behavioral Health
22. Richard Swartzendruber	2026	Huron Behavioral Health
23. Patty Bock	2026	Huron Behavioral Health
24. Lori Schultz	2028	Newaygo County Mental Health

Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*

Date: 01/07/2025

Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*

Date: 9/9/2025

Date: 7/1/2025

Date: 5/13/2025

Date: 3/04/2025

Date: 1/07/2025

MDHHS Feedback

Click or tap here to enter text.

*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.

Standardized Performance Measures 2026

Michigan Mission Based Performance Indicator System (Measurement Year FY26 10/1/2025 through 9/30/2026)

- **Indicator #2 Access- Timeliness/First Request**
 - The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four subpopulations: MI-adults, MI-children, I/DD-adults, I/DD-children).
 - MDHHS Benchmark for this metric: 62%

Behavioral Health Quality Program (Measurement Year CY26 1/1/2026 through 12/31/2026)

- Follow-up care for children prescribed ADHD medication (Initiation Phase, ages 6-12) (ADD-CH)
- Follow-up care for children prescribed ADHD medication (Continuation and Maintenance phase, Ages 6-12 (ADD-CH)
- Antidepressant Medication Management Acute Phase (Ages 18+) (AMM-AD)
- Antidepressant Medication Management Continuation Phase (Ages 18+) (AMM-AD)
- Follow-Up After Hospitalization for Mental Illness within 7 days Adults (FUH-7)
- Follow-Up After Hospitalization for Mental Illness within 7 days Children (FUH-7)
- Follow-Up After Hospitalization for Mental Illness within 30 days Adults (FUH-30)
- Follow-Up After Hospitalization for Mental Illness within 30 days Children (FUH-30)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (Glucose and Cholesterol) (APM)
- Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Adults (FUA-7)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Children (FUA-7)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Adults (FUA-30)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Children (FUA-30)
- Follow-Up After Emergency Department Visit for Mental Illness Initiation. Adults (FUM-7)
- Follow-Up After Emergency Department Visit for Mental Illness Initiation. Children (FUM-7)
- Follow-Up After Emergency Department Visit for Mental Illness Engagement. Adults (FUM-30)
- Follow-Up After Emergency Department Visit for Mental Illness Engagement. Children (FUM-30)
- Initiation of Alcohol and Other Drug Dependence Treatment within 14 days (IET-14)
- Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET-34)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Performance Improvement Projects (Measurement Years CY21-1/1/2022 through CY25-12/31/2025)

- 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- Reducing or eliminating the racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate

ATTACHMENT 4

Performance Bonus Incentive Program (Measurement Year CY26-1/1/2026 through 12/31/2026)

Contractor Only Pay for Performance Measures

- P.1. Implement data driven outcomes measurement to address social determinants of health (Analyze and monitor BH-TEDS records to improve housing and employment outcomes for persons served)
- P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) (Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period)
- P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
 - The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
 - Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis
 - 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
- P.4. Increased participation in patient centered medical homes (Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof))

Joint Metrics-PIHP and MHP combined

- J.1. Implementation of Joint Care Management Processes. Collaboration between entities for the ongoing coordination and integration of services
- J.2 Follow-up After Hospitalization for Mental Illness within 30 Days using HEDIS descriptions (the percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days) (FUH)
- J.3 Initiation and engagement of Alcohol and other drug dependency treatment (Adult members who had new substance use disorder (SUD) episodes that result in treatment initiation and engagement.
 - Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.
 - 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.
- J.4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days) (FUA)

Behavioral Health Home Metrics (Measurement Year FY26 - 10/1/2025 through 9/30/2026 (QBP denotes Quality Bonus Payment metrics))

- (QBP) Adults Access to Preventive/Ambulatory Health Services (AAP)
- (QBP) Increase in Controlling High Blood Pressure (CBP-HH)
- (QBP) Follow-up After Hospitalization for Mental Illness 7/30 days (FUH-HH-7)
- Screening for Depression and Follow-up Plan (CDF-HH)
- Colorectal Cancer Screening (COL-HH)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7/30 days (FUA-HH)
- Follow-up After Emergency Department Visit for Mental Illness 7/30 days: Age 6 and older (FUM-HH)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 14/34 days (IET-HH) only MSHN claims
- Inpatient Utilization (IU-HH)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)
- Plan All-Cause Readmission Rate (PRC-HH)
- Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)